Washington State Health Care Authority

STATE OF WASHINGTON
HEALTH CARE AUTHORITY

REQUEST FOR PROPOSALS (RFP)

RFP NO. 2020HCA28

NOTE: *If you download and respond to this RFP from the Health Care Authority website, you are responsible for sending your name, address, e-mail address, and telephone number to the RFP Coordinator in order for your organization to receive any RFP amendments or bidder questions/agency answers. HCA is not responsible for any failure of your organization to send the information or for any repercussions that may result to your organization because of any such failure.*

PROJECT TITLE: Pharmacy Point of Sale (POS) Module Replacement Project

PROPOSAL DUE DATE: April 12, 2021 by 12:00 p.m. (noon) *Pacific Standard Time or Pacific Daylight Time*, Olympia, Washington, USA.

Only E-mailed bids will be accepted. Physical mail and faxed bids will not be accepted.

ESTIMATED TIME PERIOD FOR CONTRACT: September 17, 2021 to March 16, 2027.

The Health Care Authority reserves the right to extend the contract for up to 3 additional years at the sole discretion of the Health Care Authority.

BIDDER ELIGIBILITY: This procurement is open to those Bidders that satisfy the minimum qualifications (see Section 1.11) stated herein and that are available for work in Washington State.

DEFINITIONS: A list of definitions for this RFP are found in Attachment 1, *Definitions*.

LETTER OF INTENT TO PROPOSE: To be eligible to submit a Proposal, a Bidder must submit a Letter of Intent to Propose in accordance with Section 7.5, *Letter of Intent to Propose*.

SECTIONS REQUIRING A RESPONSE: See Section 7.6.3, *Proposal Format Instructions* for a list of the sections and attachments requiring a response for this RFP, in addition to the Letter of Intent to Propose. Response forms are attached on the last page of this document.

ATTACHMENTS: A list of all attachments for this RFP is located on the last page of this document.

SECTION 1. OVERVIEW AND BACKGROUND

1.1 PURPOSE AND SCOPE OF REQUEST FOR PROPOSAL

The Washington State Health Care Authority (HCA) is initiating this Request for Proposals (RFP) to solicit Responses from qualified Bidders for the Design, Development and Implementation (DDI) and maintenance of a modular Pharmacy Point of Sale (POS) solution. The POS solution encompasses the automated functions necessary to receive and adjudicate all pharmacy Fee-for-Service (FFS) claims, Managed Care Organization encounters, and process drug rebate invoicing. The overall services and components to be acquired through this RFP encompass the following:

- Fully functioning Pharmacy POS solution that will seamlessly integrate with HCA's Medicaid Management Information System (MMIS) named ProviderOne;
- Flexible and configurable rules for easy program updates by state staff;
- Prior Authorization (PA) database that allow staff to perform prior authorization request processing and determination;
- Drug Rebate database that allows staff to manage the invoicing and dispute resolution processes;
- Self-service portal features for providers to submit prior authorizations online, inquire on status and to retrieve PA correspondence;
- Robust PA workflow processes and procedures including dashboard and reporting capabilities to effectively manage workloads;
- Self-service portal features for manufacturers to retrieve drug rebate invoices and claim level detail;
- Operational reports that provide for the effective management of pharmacy and drug rebate programs;
- DDI project management and staffing services, staff and provider training and certification support; and
- Ongoing system operations and maintenance.

HCA intends to award one contract to provide the services described in this RFP, which includes the DDI effort. On-going operations and maintenance services will begin at the conclusion of DDI after the Vendor meets the State's system acceptance criteria.

1.2 BACKGROUND AND OBJECTIVES

The Health Care Authority is a cabinet level agency led by a Governor-appointed executive, the HCA Director. HCA is Washington's largest health care purchaser, responsible for administering programs that provide health coverage to more than 2.5 million residents through the Washington Apple Health (Medicaid), the Public Employees Benefits (PEBB) Program, the School Employee Benefits (SEBB) Program and the Compact of Free Association (COFA) Islander Health Care Program. More information about the HCA mission and organization can be found at https://www.hca.wa.gov.

The high-level goals and objectives of the ProviderOne POS Replacement Project include the following:

- Select a qualified vendor to design, develop, implement and/or analyze, configure, deploy a Commercial-Off-The-Shelf (COTS) or service hosted model (e.g., SaaS) that meets or exceeds the requirements listed in this RFP to support WA State's Medicaid pharmacy and drug rebate programs.
- Procure all major components including a pharmacy point of sale (POS) system, as well as prior authorization and drug rebate databases that offer a web-based solution with flexible architecture that is scalable and able to accommodate future State business needs and Federal requirements.

- Automate labor-intensive manual processes by providing self-service features through online portals for providers and manufacturers.
- Meet or exceed Federal enterprise architecture and security certification standards, and the Center for Medicare and Medicaid (CMS) conditions referenced in 42 C.F.R 433.112(b) that are required for enhanced Federal funding.
- Ensure compliance with all applicable federal and state security and privacy requirements including, but not limited to, HIPAA, HITECH and OCIO.
- Enable integration, interoperability and sharing of information with the ProviderOne system.
- Increase Medicaid Information Technology Architecture (MITA) maturity and maintain an emphasis for the reuse of solutions that can be shared with other entities.

1.3 HCA'S NEED TO PROCURE CURRENT POS

Several factors contribute to HCA's need to replace the current POS. Primarily, the current system does not address the State's business needs. Additional drivers include the need to align with CMS requirements related to the Modularity standard within the Seven Standards and Conditions and the CMS Final Rule. CMS requires states to follow a modular approach; loose coupling of components or services is central to the modern implementation of modularity. ProviderOne was implemented prior to CMS modularity requirements. While ProviderOne was architected using modular principles, the subsystems are tightly coupled and remain highly dependent upon each other.

In planning for the future, the HCA is developing a modular strategy that enables flexibility to replace core ProviderOne components as regulations, technologies and business/user needs change. HCA's ProviderOne strategy seeks to incrementally replace ProviderOne modules in order to maintain a modern MMIS into the future. The POS is the first module to be replaced.

More information regarding CMS policy and regulations can be found here:

https://www.medicaid.gov/federal-policy-guidance/index.html

1.3.1 **CMS Certification**

All State MMIS and MMIS-related implementations must adhere to federal guidance for HCA to receive enhanced federal funding for the operation of the MMIS and other modular replacement projects. HCA will seek enhanced funding to the maximum extent possible and therefore the POS solution will undergo required certification as specified by CMS. The Apparent Successful Bidder (ASB) will need to fully support this process through all activities and artifacts requested by HCA and QA/IV&V vendor(s). HCA has been approved as a pilot state for Outcomes-Based Certification (OBC) by CMS. CMS has begun transitioning its system certification process to one that evaluates how well Medicaid technology systems support desired business outcomes while reducing burdens on states. Additional information regarding Outcomes-Based Certification can be found here:

https://www.medicaid.gov/medicaid/data-systems/outcomes-based-certification/index.html

1.4 OPERATIONS AND MAINTENANCE MODEL

The current MMIS (including the POS) is largely configured in-house. State staff manage key processes while CNSI, the current MMIS vendor, operates the MMIS using cloud computing and provides ongoing maintenance and modification to the MMIS. Teams of state staff perform the bulk of operational services including the following:

- Provider enrollment and relations
- Clients services and relations
- Call Center staffing and management
- Prior Authorization
- Claims processing

- Pharmacy services
- Imaging and document automation services
- Reference file and rules engine (MMIS) configuration and updates
- Coordination of Benefits/Third Party Liability
- Drug Rebate services
- Financial Operations
- Financial Recovery
- Program Integrity and Audit functions

When the new POS is in place, the HCA will continue with this Facilities Management operations and maintenance model, where state staff perform the majority of operations as identified above, and the ASB provides system maintenance and operations support.

1.5 OVERVIEW OF CURRENT MEDICAID ENTERPRISE SYSTEM

Washington's Medicaid enterprise system is a compilation of an integrated architecture of three systems named ProviderOne, Automated Client Eligibility System (ACES), and HealthPlanFinder (HPF), including additional subsystems to ProviderOne and ACES. ACES is administered by Department of Social and Health Services, and HPF is administered by Health Benefit Exchange. ProviderOne interfaces with ACES, which was enhanced in 2013 to include a modular Eligibility Service (ES) that determines eligibility for new Modified Adjusted Gross Income (MAGI) based Medicaid clients as well as Qualified Health Plan (QHP) clients. The ES and ProviderOne interface with Washington's state-based Health Insurance Exchange system, HealthPlanFinder (HPF). This modular architecture aligns with MITA principles and provides the flexibility to support efficient operations of an enterprise MMIS.

ProviderOne was implemented in May 2010 and was certified by CMS in July 2011. The system supports over 1.9 million Medicaid clients; approximately 83% are enrolled in managed care and 17% are fee-for-service. ProviderOne paid over $12 billion in SFY20 to over 230,000 providers that include medical and social service providers. This includes reimbursing over $1.6 billion to pharmacy providers.

ProviderOne is a web-based Java system running on an Oracle RDBMS database platform. The system leverages an enterprise service bus to interact with Commercial Off-The-Shelf (COTS) products and web services to facilitate data sharing across some components. ProviderOne is built on modular principles with a rules engine at the core of business processing. Overall services and functions include the following:

- Client, provider, reference, prior authorization, claims receipt and adjudication, managed care, coordination of benefits and financial components;
- Integrated Pharmacy POS module including a drug rebate invoicing component;
- Data warehouse including Fraud and Abuse Detection System (FADS);
- Contact/call management system and integrated voice response components; and
- Imaging and Document Management system.

Washington's MMIS also includes other COTS products and subsystems that integrate with ProviderOne. The current environment includes the following modules that were not procured under the ProviderOne contract with Client Network Services, Inc. (CNSI): Individual ProviderOne (IPOne), Enterprise Data Warehouse and Fraud and Abuse Detection System. IPOne provides payroll-like functions for individual social service providers.

The figure below illustrates the components and subsystems that make up the Washington Medicaid Enterprise System.

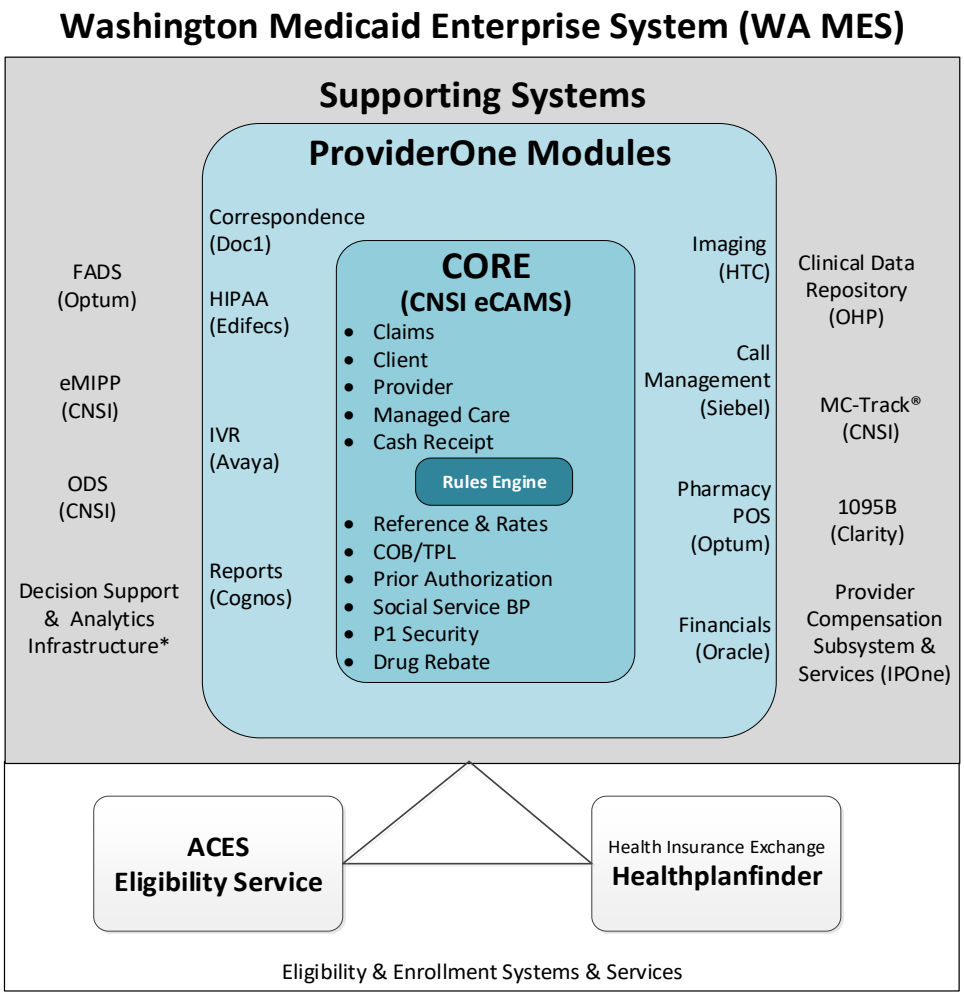


Figure 1. WA MES Enterprise

1.5.1 Overview of current Pharmacy Point of Sale (POS) subsystem

The Pharmacy Point of Sale (POS) subsystem was procured in 2005 as a subsystem of ProviderOne. The POS was implemented in an early release in October 2008 and was certified with the MMIS in 2011. Optum is the POS vendor and sub-contractor under the HCA-CNSI MMIS contract.

The POS supports real-time and batch adjudication of pharmacy claims and encounters for HCA-eligible clients. ProviderOne is the system of record for all POS information except for the following:

- Detailed pharmacy benefit plan design specifications;
- Drug file data including National Drug Code (NDC) definitions and historical pricing data; and
- Pharmacy Prior Authorization (PA) records, both current and historical.

Below is a description of common functions between the POS and ProviderOne.

1.5.1.1 **Eligibility Information** – Eligibility information is passed from ACES to ProviderOne via a nightly batch. Based upon ACES data and other client attributes, ProviderOne assigns benefit plan codes. ProviderOne then feeds all applicable eligibility information to the POS system. POS maintains a copy of that information as well as receive and process eligibility updates from ProviderOne every 15 minutes if changes occur.

1.5.1.2 **Pharmacy and Prescriber Information** – Detailed pharmacy and prescriber information is transmitted to POS from ProviderOne every night. During the batch load process, pharmacies that share the same reimbursement rate are placed in the same pharmacy network. Each variation of reimbursement rate will have a separate pharmacy network and is based on dispensing volume, unit dose specialization and pharmacy 340B status. These networks of pharmacies and prescribers are used later in the creation of plan definitions.

1.5.1.3 **Prior Authorization** – The POS supports centralized capture, administration, tracking and ultimate resolution of prior authorization requests regardless of their source of origin (e.g., fax, phone and paper). Faxes are received and processed through the imaging subsystem via optical character recognition and are loaded into the PA subsystem of the POS. Outgoing correspondence is initiated in the POS PA subsystem and then integrated within ProviderOne where letters are generated and sent to the state printing facilities for mailing. State staff also fax letters to applicable parties.

1.5.1.4 **Drug Reference File Information** – Weekly updates to POS drug detail and pricing information are provided by Medi-Span. Following the updates, changes are calculated to the HCA programs AMAC (Automated MAC Maximum Allowable Cost). A number of Medi-Span elements can be overridden to meet the operational needs of the HCA. First Data Bank information is also available in the system and used primarily to determine rebate status of products.

1.5.1.5 **Transaction Processing**: **Pharmacy Claims** – Fee-For-Service (FFS) Pharmacy claims are passed to the POS via switch vendor. Detailed drug coverage specifications, benefit plans, provider networks, compound processing, step therapy, days' supply, prior authorization and drug utilization review rules are developed and maintained by HCA personnel and entered into the POS production environment directly without vendor intervention. All pharmacy claims are adjudicated using user-maintained edits. The POS provides functionality to perform corrections and/or adjustments to pharmacy claims already in the system. POS has the ability to reverse and/or reprocess claims for payment or for no payment. These claims and the adjudicated results are passed to ProviderOne on a daily basis for inclusion in the weekly payment cycle.

1.5.1.6 **Transaction Processing: Managed Care Organization (MCO) Pharmacy Encounters** – MCO pharmacy encounter claims are claims paid by the MCO and reported to HCA in the NCPDP format. These files are accepted or rejected by ProviderOne. Files in an accepted status are passed to the POS for encounter claim creation. A pharmacy encounter claim is created for each claim record in the NCPDP file. Encounter claim records are not paid, but instead are adjudicated and "shadow priced" within the POS. Each encounter claim gets a status of either accepted/captured or rejected based on rules applied during adjudication. Encounter claims in an accepted status will receive a shadow price which displays the applicable price the product would have been reimbursed under the FFS program and this information is also passed to ProviderOne on a daily basis.

1.5.1.7 **Transaction Processing; Medical FFS Claims and MCO Encounter Claims with NDC's.** Some physician-provided drugs, primarily injectables, are submitted to the ProviderOne system via an 837 and are processed as medical FFS claims or MCO encounter claims. Once the claims have been fully adjudicated in the ProviderOne system and is in a "to be paid" status, ProviderOne creates an extract of the claim line with the NDC to pass to the POS system for adjudication and inclusion in the drug rebate process. A response file with the POS adjudication information is sent back to ProviderOne and associated with the claim line. The claim in the ProviderOne system then moves on to the payment process. These claims are not paid out of the POS system.

1.5.1.8 **Drug Rebate** – Claims and pricing information is passed from the POS system to the drug rebate component, which adjudicates invoice information for the calendar quarter by consolidating data from pharmacy and ProviderOne claims with covered outpatient drug information, producing separate invoices for federal and supplemental rebates. The drug

rebate component then feeds all information to ProviderOne. The drug rebate component maintains this quarterly information in order to process prior period corrections. State staff manage the drug rebate invoicing and dispute processes, including corrections and adjustments. Collection of monies from manufacturers occurs outside any system, but the accounts receivable data is recorded within a drug rebate subsystem of ProviderOne.

Below is a diagram that indicates the current data flow and interaction between the POS and ProviderOne.

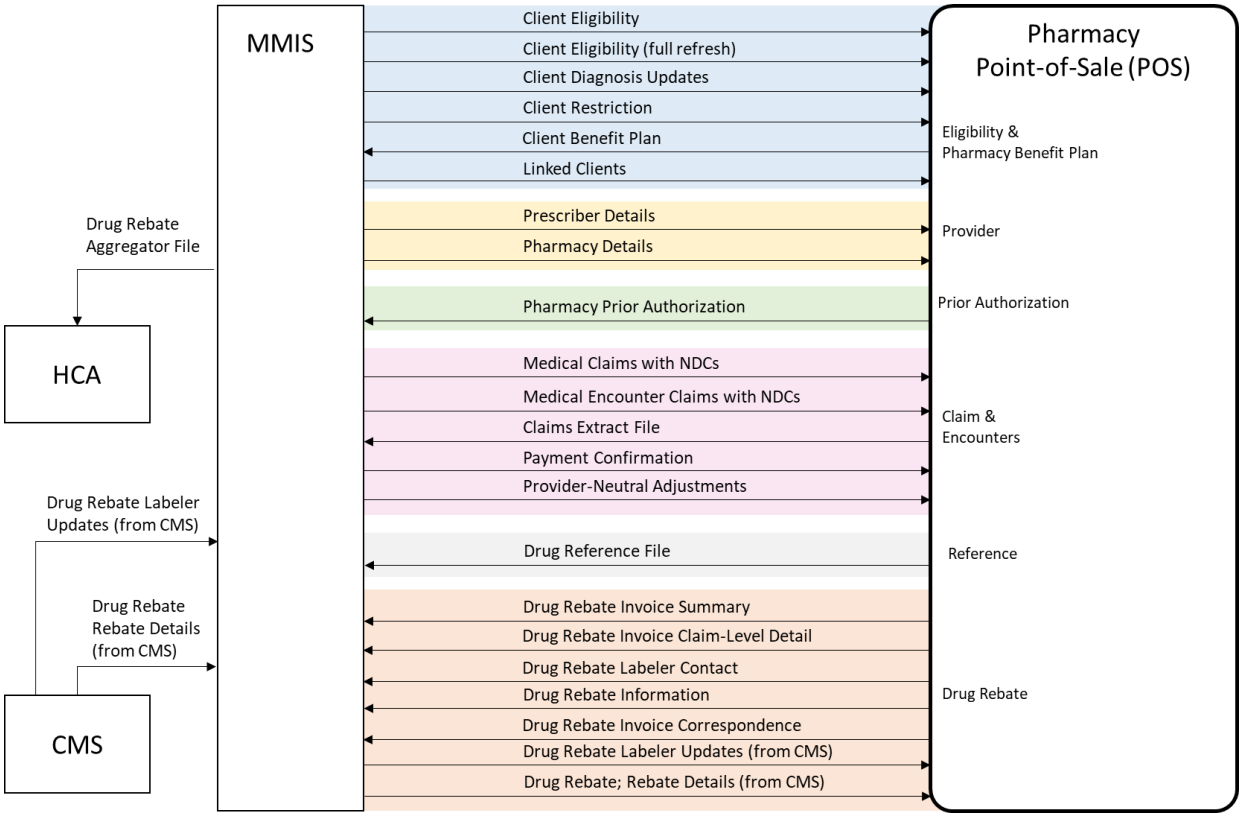


Figure 2. Current MMIS/POS Interactions

1.5.2 **Transaction Volumes**

The Washington State Medicaid program pays in excess of $12 billion a year in provider payments for health care services to needy Washingtonians. Of the over $12 billion, it is estimated that $1.6 billion are paid Fee-for-Service (FFS) to pharmacy providers. Approximately 1.96 million clients are supported by the ProviderOne and the POS system, of which 83% of the client base receive services via the Medicaid Managed Care program, referred to as Apple Health, each month. The current POS processes approximately 300,000 fee-for-service and managed care encounter transactions per month, and payments are processed weekly by the MMIS and managed by the Office of the State Treasurer.

The Health Care Authority's Division of Clinical Quality and Care Transformation manages the Prior Authorization process and receives on average 3000-3500 pharmacy prior authorization requests (new and previously denied) a month. The vast majority of the requests arrive by toll-free line and fax; however, providers can also mail in prior authorization requests.

1.6 BUSINESS PROCESS CHANGES

The HCA is very interested in working with the ASB to effectively manage any business process changes resulting from this procurement. The current POS has been in place for over 12 years and changes are anticipated and welcomed.

The HCA expects to learn much from the ASB as the new system is introduced and business processes inherent to the new system are explained to key staff within the Pharmacy program, Prior Authorization, Drug Rebate, Coordination of Benefits (Third Party Liability), Systems and Operations, Call Center, Data Warehouse and Audit staff. It is expected that the ASB will assist in training HCA staff to assume responsibility for business operations.

1.7 LEADERSHIP AND GOVERNANCE

1.7.1 Medicaid Enterprise Steering and Governance Committees

Washington's Medicaid systems and operations are managed in a distributed enterprise across multiple state agencies/organizations. In 2018, the State of Washington Health and Human Services (HHS) Enterprise Coalition was established as a multi-organization collaborative that provides strategic direction, cross-organizational project support and federal funding guidance across Washington's health and human services organizations.

The agencies comprising the enterprise coalition include:

- The Health Care Authority (HCA)
- The Washington Health Benefit Exchange (HBE)
- The Department of Social and Health Services (DSHS)
- The Department of Children, Youth and Families (DCYF)
- The Department of Health (DOH)

The Washington State Office of the Chief Information Officer (OCIO) and the Washington State Office of Financial Management (OFM) are non-voting members of the HHS Coalition.

The Medicaid Enterprise Governance structure focuses on three areas: (1) cross-agency/organization governance and management; (2) modernization and modular replacement of technology; and (3) improving the client/customer experience.

Goals of the Enterprise Governance structure include:

- Establish a collaborative decision-making and management structure and culture across the enterprise
- Leverage and reuse technology investments (IT infrastructure, resources and assets) and increase operational efficiencies
- Consider system enhancements that improve client/consumer experience for enterprise applications
- Ensure coordination among projects when Design Development Implementation (DDI) efforts cross multiple agencies
- Provide the HCA with the authority and the information needed to effectively perform their role as the State's Single Medicaid Agency
- Ensure enterprise compliance with federal Medicaid requirements/guidance

The State has implemented a four-tiered governance structure:

Level 1: Executive Sponsor Committee provides the mechanism by which Medicaid Enterprise investments are vetted, approved, prioritized and monitored through their lifecycle by providing strategic insight, cross-organizational project support and federal funding guidance across Washington's health and human services enterprise. The HCA POS Replacement Project has been approved by the HHS ESC.

Level 2: Enterprise Steering Committee ensures business alignment and provides operational direction for enterprise projects in support of the Executive Sponsor Committee and acts as the Steering Committee for Coalition-led projects.

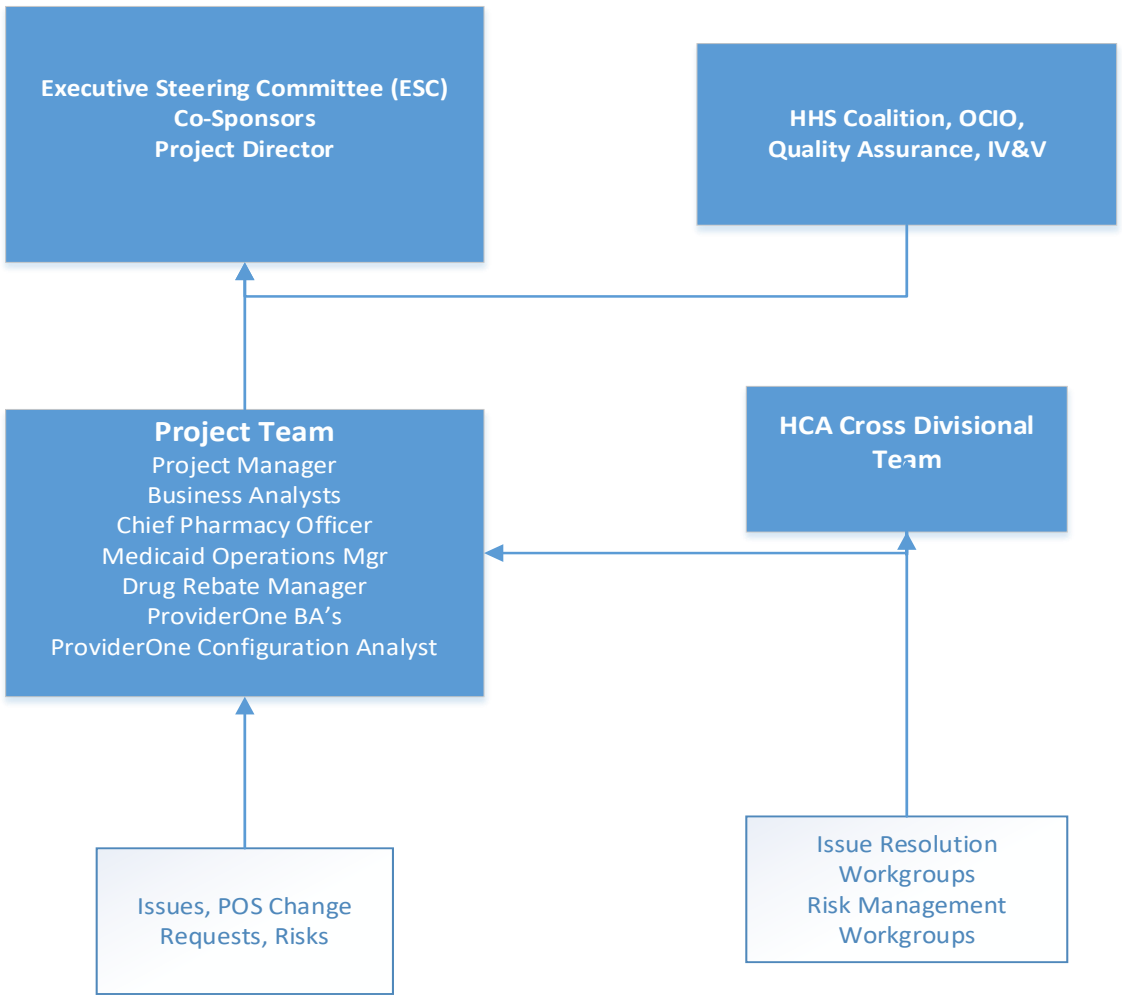
Level 3: Integrated Enterprise Project Group brings Project Management functions from the organizations/agencies together to ensure holistic project coordination with an Enterprise view of projects with a cross-agency Medicaid system impact.

Level 4: Project Delivery Teams are agency-sponsored and responsible for operational and tactical oversight of a specific project. The POS Replacement Project is an HCA-sponsored project team.

1.7.2 The POS Replacement Project Leadership and Governance

An HCA Executive Steering Committee (ESC) along with an Executive Sponsor (ES) will set the direction and support the planning and subsequent development of the POS Replacement Project. The ESC will make decisions for the agency, set priorities, provide oversight and governance, and ensure that properly skilled resources are available across the agency. The ESC is chartered and interacts closely with the HHS Coalition and four-tiered governance structure as indicated above. The following diagram illustrates the Project Organization and Governance, anticipated Project Team as well as other the HCA supporting teams that will contribute to the success of the project.

Figure 3. The POS Replacement Project Organization and Governance



1.8 **PROJECT SCHEDULE**

The following table shows the proposed timeline for the procurement tasks, as well as the Design, Development, and Implementation tasks for the Pharmacy POS system. The dates provided are estimates based on goals established by the Health Care Authority. As the procurement tasks progress, the start dates for some of the tasks may change based on the amount of time required to secure review and approval of the plans by CMS and state oversight bodies.

Task	Phase/Milestone/Deliverable	Planned Start Date	Planned End Date
1.	**POS Replacement Project**	08/1/2019	08/30/2023
Planning and Requirements Analysis			
1.1	**Planning/Requirements Definition**	08/1/2019	06/30/2020
1.1.1	Project Planning	08/1/2019	12/31/2019
1.1.2	Prepare Project Partnership Understanding (PPU)	08/1/2019	08/14/2019
1.1.3	Submit PPU to CMS	08/14/2019	08/14/2019
1.1.4	Prepare Planning Advance Planning Document (P-APD) to CMS	08/15/2019	08/31/2019
1.1.5	Submit P-APD to CMS	09/10/2019	09/10/2019
1.1.6	CMS approval of P-APD	09/10/2019	11/10/2019
1.1.7	Requirements Planning and Analysis	09/01/2019	06/30/2020
Acquisition			
1.2	**Procurement**	08/15/2020	03/31/2021
1.2.1	Prepare Request for Proposal (RFP)	08/15/2020	12/31/2020
1.2.2	Submit RFP to CMS	12/21/2020	12/17/2020
1.2.3	CMS Approval	12/21/2020	01/19/2021
1.2.4	Release RFP	01/26/2021	01/26/2021
1.3	**Select DDI Contractor**	01/27/2021	05/28/2021
1.3.1	Bidders Prepare Responses	01/27/2021	04/12/2021
1.3.2	Prepare Implementation Advance Planning Document (I-APD)	02/18/2021	04/01/2021
1.3.3	HCA Receives Responses	04/12/2021	04/12/2021
1.3.4	HCA Evaluates Responses	04/13/2021	05/27/2021
1.3.5	HCA Announces Apparent Successful Bidder (ASB)	05/28/2021	05/28/2021
1.4	**Negotiate DDI Contract**	06/01/2021	07/15/2021
1.4.1	Conduct Negotiations	06/01/2021	07/15/2021
1.4.2	OCIO Review and Approval	06/15/2021	07/15/2021
1.4.3	CMS Review and Approval of the I-APD and Contract	07/16/2021	09/16/2021
1.4.4	Sign Contract	09/17/2021	09/17/2021
Design			
1.5	**Design**	10/01/2021	02/28/2022
1.5.1	Complete Technical Design	10/01/2021	02/28/2022
1.6	**Development**	03/01/2022	08/01/2022
1.6.1	Complete Development	03/01/2022	08/01/2022
1.7	**Testing**	08/02/2022	10/30/2022
1.7.1	User Acceptance Testing (UAT)	10/01/2022	12/15/2022
1.8	**Implementation**	10/01/2022	12/15/2022
1.8.1	Readiness	11/01/2022	12/15/2022

1.8.2	Go-Live	12/16/2022	12/16/2022
Certification			
1.9	**Pharmacy Replacement Module Certification**	12/17/2022	06/16/2023
1.9.1	Prepare for Certification	12/17/2022	06/16/2023
1.9.2	Conduct POS Certification	06/16/2023	07/16/2023
Maintenance			
1.10	**Begin Pharmacy POS Module Maintenance**	12/17/2022	On-going

1.9 FUNDING

HCA has budgeted an amount not to exceed $35.9 million ($35,900,000), inclusive of tax, for this project. Proposals in excess of $35.9 million will be considered non-responsive and will not be evaluated. This $35.9 million budget is comprised of $5.5 million for DDI and $30.4 million for O&M over the potential 8.5-year term of the awarded contract (5.5-year initial term with 3 optional extension years). See Section 5.1,**Error! Reference source not found.** *Identification of Costs* for more details.

Any contract awarded as a result of this procurement is contingent upon the availability of funding.

1.10 PERIOD OF PERFORMANCE

The period of performance of any contract resulting from this RFP is tentatively scheduled to begin on or about September 17, 2021 and will continue for 5.5 years from the effective date. Amendments extending the period of performance, if any, will be at the sole discretion of HCA.

HCA reserves the right to extend the contract for 3 additional years, in any time increments. Due to the varying nature of DDI work, the initial term of the resulting contract will be extended, at HCA's sole discretion, to include 4 full years of Operations and Maintenance without affecting HCA's option to extend the contract for an additional 3 years.

1.11 BIDDER MINIMUM QUALIFICATIONS

This section will not receive a score; however, Bidder and its proposed Project Manager **are required to meet** the following minimum qualifications (See Section 7.5):

1.11.1 The Bidder must have at least 5 years' experience managing and staffing projects of comparable size and complexity to that required by HCA for the POS.

1.11.2 The Bidder's proposed Project Manager must have at least 5 years' experience leading projects of comparable size and complexity to that required by HCA for the POS.

1.12 CONTRACTING WITH CURRENT OR FORMER STATE EMPLOYEES

Specific restrictions apply to contracting with current or former state employees pursuant to chapter 42.52 of the Revised Code of Washington. Bidders should familiarize themselves with the requirements prior to submitting a proposal that includes current or former state employees.

1.13 AMERICANS WITH DISABILITIES ACT

HCA complies with the Americans with Disabilities Act (ADA). Bidders may contact the RFP Coordinator to receive this RFP in Braille or on tape.

END OF SECTION 1

SECTION 2. MANAGEMENT PROPOSAL

Bidder's Management proposal must respond to each of the subsections below. Sections labeled as Mandatory Requirements ("MR") means that prompt will be evaluated on a pass/fail basis and no numerical score will be given. Sections labeled as Mandatory Scored ("MS") means that prompt is both required and will receive a numerical score. **DO NOT include any marketing material in your responses**.

2.1 GENERAL INFORMATION OF BIDDER (MR)

The prompts within this section consists of Mandatory Requirements, and will be evaluated on a pass/fail basis.

Respond to the following:

2.1.1 Identify the name, address, principal place of business, telephone number, and e-mail address of legal entity or individual to be named as a party to the contract.

2.1.2 Identify the name, address and the telephone number(s) of the Principal Officers or Owners of Bidder's company/corporation.

2.1.3 Identify the legal status of the Bidder (sole proprietorship, partnership, corporation, etc.) **and** the year the entity was organized to do business as the entity now substantially exists.

2.1.4 Federal Employer Tax Identification number or Social Security number and the Washington Uniform Business Identification (UBI) number issued by the state of Washington Department of Revenue. If the Bidder does not have a UBI number, the Bidder must state that it will become licensed in Washington within 30 calendar days of being selected as the Apparent Successful Bidder.

2.1.5 Identify and describe any merger or acquisition in which the Bidder is involved or may become involved during the period of this contract. State "Not applicable" if this section does not apply.

2.1.6 Identify the location of the facility from which the Bidder would operate.

2.1.7 Identify any state employees or former state employees employed or on the firm's governing board as of the date of the proposal. Include their position and responsibilities within the Bidder's organization. If following a review of this information, it is determined by HCA that a conflict of interest exists, the Bidder may be disqualified from further consideration for the award of a contract. State "Not applicable" if this section does not apply.

2.1.8 If the Bidder or any subcontractor contracted with the state of Washington during the past 24 months, indicate the name of the agency, the contract number, and project description and/or other information available to identify the contract. State "Not applicable" if this section does not apply.

2.1.9 If the Bidder's staff or subcontractor's staff was an employee of the state of Washington during the past 24 months, or is currently a Washington State employee, identify the individual by name, the agency previously or currently employed by, job title or position held, and separation date. State "Not applicable" if this section does not apply.

2.1.10 If the Bidder has had a contract terminated for default in the last five years, describe such incident. Termination for default is defined as notice to stop performance due to the Bidder's non-performance or poor performance and the issue of performance was either (a) not litigated due to inaction on the part of the Bidder, or (b) litigated and such litigation determined that the Bidder was in default. State "Not applicable" if this section does not apply.

2.1.10.1 If applicable, submit full details of the terms for default including the other party's name, address, and phone number. Present the Bidder's position on the matter.

HCA will evaluate the facts and may, at its sole discretion, reject the proposal on the grounds of the past experience.

2.1.11 If Bidder's proposal includes subcontractors, provide similar and separate information for every proposed subcontractor in response to all Section 2.1 requirements. State "Not applicable" if this section does not apply.

2.1.12 Any information in the proposal that the Bidder desires to claim as proprietary and exempt from disclosure under the provisions of RCW 42.56 must be clearly designated. The page must be identified and the particular exemption from disclosure upon which the Bidder is making the claim must be listed. Each page claimed to be exempt from disclosure must be clearly identified by the word "Proprietary" printed on the lower right-hand corner of the page. In your response, Bidder **must** list which pages and sections that have been marked "Proprietary" and the particular exemption from disclosure upon which the Bidder is making the claim. State "Not applicable" if this section does not apply.

2.1.13 Agree that Bidder will collect, report, and pay all applicable State taxes if selected as the Apparent Successful Bidder.

2.2 EXECUTIVE SUMMARY (MS) 10 Page Limit

The prompts within this section consists of Mandatory Scored Requirements, and will be scored. Limit the **overall response to all** requirements in this section to a maximum of 10 pages.

Respond to the following:

2.2.1 Identify and describe the product the Bidder proposes as the basis of its Pharmacy POS solution.

2.2.2 Briefly summarize the proposed project management (PM) approach and overall services in order to give the evaluators a strong general overview of the Management, Technical, and Functional proposals of the Bidder.

2.2.3 Identify any unique or innovative features.

2.2.4 Provide a brief overview of the risks associated with this project, critical success factors, and actions HCA should consider during the analysis and implementation stages.

2.2.5 Explain how the proposed solution represents to HCA the best option for its Pharmacy POS, and why HCA should select the proposed solution.

2.2.6 Briefly describe Bidder's, and any subcontractor's, experience in implementation and/or operation of the proposed Pharmacy POS solution in other **state's** Medicaid programs. Include timeframe, cost of implementation, number of users or other solution sizing information, and whether the system was certified or pre-certified by CMS.

2.2.7 Briefly describe Bidder's, and any subcontractor's, experience in implementation and/or operation of the proposed Pharmacy POS solution for **non-state**, comparably sized organizations. Include timeframe, cost of implementation, and number of users or other solution sizing information.

2.2.8 Agree that the Bidder will comply with the procurement process described in the RFP.

2.2.9 Agree that the Bidder understands the scope and objectives of the project and agrees to meet the requirements specified in the RFP.

2.2.10 Agree that the Bidder will perform the services described in the RFP.

2.2.11 Agree that the Bidder will work cooperatively with HCA and HCA's designees.

2.2.12 Agree that the Bidder's proposed solution will meet all federal MMIS Certification requirements relevant for a Pharmacy POS solution.

2.2.13 Agree that the Bidder's proposed solution is fully HIPAA compliant.

2.3 SOFTWARE DEVELOPMENT LIFECYCLE METHODOLOGY (MS)

The prompts within this section consists of Mandatory Scored Requirements, and will be scored.

Respond to the following:

2.3.1 Describe the proposed system development lifecycle (SDLC) methodology you will use to set-up, configure, and if needed, customize the proposed Pharmacy POS solution to meet all HCA requirements, including the integration with the current MMIS.

2.3.2 Describe the proposed SDLC to be used during the Operations and Maintenance phase.

2.3.3 Explain the benefits of the recommended methodologies.

2.4 PROJECT APPROACH / METHODOLOGY (MR & MS)

This project will be assessed by internal and external oversight for its compliance with project management practice standards defined in the Project Management Institute's Project Management Book of Knowledge. For example, independent non-HCA Quality Assurance monitoring will be conducted throughout the term of the project. The ASB will be expected to apply industry best-practices to manage this project. In addition to bi-weekly project status reports, the ASB may be required to generate status materials and attend additional meetings with oversight/stakeholders upon the request of the HCA project manager.

The prompts within this section consists of both MR and MS Requirements. Only the "Agree" prompts are MR.

Respond to the following:

2.4.1 Describe the Bidder's proposed project management approach and methodology for the project. This description should convey Bidder's understanding of the proposed project and should include, but not be limited to, planning, organizing, and managing the staff and activities throughout the life of the project.

2.4.2 Explain with specificity the Bidder's approach to promoting teamwork, facilitating open and timely communication, and ways the Bidder's staff will support a collaborative effort among the Bidder, any subcontractors, HCA, and HCA designees.

2.4.3 Describe how the Bidder will coordinate efforts with the HCA project team to address multiple stakeholder needs.

2.4.4 Agree that the Bidder will provide on-going assistance to HCA and its contracted MMIS vendor (and any other contracted entity) throughout the contract phase and will work directly with HCA when coordination and collaboration efforts are needed. Bidder will not directly contact any contracted entity of HCA without HCA's prior approval.

2.4.5 Agree that the Bidder will either conduct internal quality assurance or will retain an independent firm to conduct quality assurance.

2.4.6 Agree that the Bidder will provide to HCA any quality assurance reports that are produced during the project.

2.4.7 Agree that the Bidder will provide overall management of the Bidder's proposed solution.

2.4.8 **Project Risk Assessment and Mitigation Requirements**

Respond to the following:

2.4.8.1 Describe an overall approach to risk management and mitigation for the project.

2.4.8.2 Describe the Bidder's process for documenting, monitoring and reporting risks and risk status to HCA. Include information related to the proposed tools you will use to manage this process.

2.4.8.3 Describe potential risks currently foreseeable to the Bidder for this engagement, rank in order of highest risk, **and** identify recommended steps to mitigate those risks.

2.4.8.4 Explain the benefits of the Bidder's proposed risk management process to HCA.

2.4.8.5 Agree that the Bidder's proposed risk management tools will be accessible by Bidder staff, HCA staff, and HCA designees.

2.4.9 **Project Issue Resolution Requirements**

Respond to the following:

2.4.9.1 Describe the Bidder's approach and process for issue identification, communication, resolution, escalation, tracking, approval by HCA, and reporting.

2.4.9.2 Identify and describe the Bidder's proposed tool to track, manage, and report on issues/action items and facilitate its issue resolution process that includes an automated tracking and management system.

2.4.9.3 Explain the benefits of the Bidder's issue resolution approach.

2.4.9.4 Agree that the Bidder's issue resolution tool will be accessible by Bidder staff, HCA staff, and HCA designees.

2.4.10 **Project Change Control Requirements**

Controlling scope and providing for system changes caused by legislative mandates or other causes is extremely important to HCA in maintaining project accountability. Change control will be ongoing throughout the entire duration of the contract. During DDI, HCA may exercise its option for change requests for system enhancements consistent with the change control process outlined below. During Operations and Maintenance, HCA may exercise its option for change requests for system enhancements as outlined below. These system enhancements are more complex in nature, may require customized coding and cannot be accomplished by state staff. See SECTION 5, *Cost Proposal* for more details.

Respond to the following:

2.4.10.1 Describe both graphically (e.g., via a flowchart) and in text a recommended approach to change control, including steps, roles and responsibilities, and decision points.

2.4.10.2 Describe the Bidder's cost estimating steps and process for providing a written estimate to HCA of the cost and duration for every change.

2.4.10.3 Identify and describe the Bidder's proposed tool(s) to track, manage, and report on change control items and to facilitate the Bidder's change control approach, including an automated tool that tracks history in a database.

2.4.10.4 Describe steps for updating the work plan for changes identified during DDI and approved by HCA.

2.4.10.5 Explain the benefits of the recommended change control approach for HCA.

2.4.10.6 Agree that written approval by HCA is mandatory for every change before the Bidder begins development of that change.

2.4.10.7 Agree that written approval by HCA is mandatory for every change before the Bidder begins implementation of that change.

2.4.10.8 Agree in the proposed change control process that the Bidder will provide HCA with justification of every change suggested by the Bidder.

2.4.10.9 Agree that any changes must be provided at a reasonable price to be negotiated between the Bidder and HCA, and that if the Bidder and HCA cannot come to an

agreement on price and schedule to implement such mandated changes, the Bidder agrees to perform the work at the price proposed by the State's project manager and to pursue the dispute resolution process to resolve open issues.

2.4.10.10 Agree that the Bidder's proposed change control tools will be accessible by the Bidder, HCA, and HCA designees.

2.4.10.11 Agree that the Bidder must include the estimate and actual cost and duration for every change request as well as cumulative cost and schedule impacts for all changes for all periods HCA specifies.

2.4.11 **Project Communication and Coordination Requirements**

Respond to the following:

2.4.11.1 Describe the Bidder's approach to communication and coordination **and** the Bidder's proposed tools to facilitate its approach.

2.4.11.2 Describe the proposed lines of authority, coordination, and communication to include communication between the parties. At a minimum it should describe lines of authority/communications between HCA and Bidder executives, directors, and officers and lines of authority/communications between HCA and Bidder project management.

2.4.11.3 Provide an example status report(s) from past projects of Bidder and a recommended sample report format.

2.4.11.4 Agree that every other week the Bidder will provide such reports in a format and level of detail subject to HCA acceptance.

2.4.11.5 Agree that the status reports will describe the following: (1) the previous two weeks' activities, including problems encountered and their disposition, results of tests (if applicable), what was accomplished as expected and on-time, what was not accomplished as expected and on time, recommendations on meeting missed deadlines; (2) plans for the coming two weeks; (3) tasks behind schedule, e.g., tasks at risk of not being completed by their deadline, and what the Bidder is doing to mitigate the risks; and (4) any action items or problems that have arisen that need to be addressed immediately.

2.4.11.6 Agree that HCA reserves the right to formally state disagreements with status reports and may, at the discretion of HCA, require revised status reports.

2.4.11.7 Agree that the Bidder's Project Manager will attend weekly status meetings, with the understanding that HCA may agree to the Project Manager's remote attendance to the extent that it will not jeopardize project progress.

2.4.11.8 Agree that the Bidder will actively participate with project staff to ensure effective communication and coordination within the project, including Bidder staff, subcontractor staff, HCA, and other stakeholders within and external to the agency, including providers.

2.4.11.9 Agree that the Bidder will cooperate with internal and external oversight to this project whenever necessary in the State's opinion.

2.4.11.10 Agree that the Bidder will attend additional, albeit infrequent, oversight/stakeholder management meetings at HCA's request.

2.4.11.11 Agree that the Bidder's proposed communication and coordination process is subject to HCA approval.

2.4.12 **Project Work Plan**

Keeping a structured work plan that facilitates tracking of the stages, activities, and implementation phases required to implement the Pharmacy POS solution is critical to project

success. The ability to identify, discuss and report on the critical path of the project is required. HCA expects the Bidder to track all tasks assigned to Bidder staff, and any subcontractors.

Respond to the following:

2.4.12.1 Include a preliminary proposed project work plan in electronic form using Microsoft Project that aligns with HCA's Design, Development, and Implementation (DDI) stages in Section 2.8. This should be separately attached to your proposal.

2.4.12.2 Include in the schedule the tasks, milestones, deliverables, task dependencies and resources, including HCA resources, for delivering the proposed solution.

2.4.12.3 Identify activity start and completion dates and the planned dates for initial submission, HCA's initial review, HCA's return to Bidder for revision/correction, and HCA acceptance of each deliverable.

2.4.12.4 Identify all proposed resources by name.

2.4.12.5 Show tasks requiring HCA resources, summarize the proposed use of HCA resources, and state any assumptions regarding anticipated involvement of these resources.

2.4.12.6 Show task and individual time assignments and schedules in a Gantt type chart.

2.4.12.7 Provide a critical path diagram showing all significant tasks/activities and inter-dependencies.

2.4.12.8 Agree that throughout the Contract period, all deliverables will be developed in the form and format agreed to by HCA and the Bidder using a Deliverable Expectations Document (DED) delivered within timeframes outlined in the Project Work Plan.

2.4.12.9 Agree that the Project Work Plan must have tasks delineating the deliverable process and all approval and review periods.

2.4.12.10 Agree that the Bidder must allow 10 business days for State approval of each submission of each Deliverable. If re-submission of a deliverable is needed, agree that dates of final acceptance are negotiable and may not take an additional 10 days.

2.4.12.11 Agree that the Bidder retains final responsibility for the quality of the deliverables.

2.4.12.12 Agree that the Bidder will finalize and baseline the Work Plan, developed jointly with and accepted by HCA no later than 45 calendar days after contract signing.

2.4.12.13 Agree that the finalized Work Plan becomes part of the Bidder's response and that it will be incorporated in the contract by reference upon its acceptance by HCA.

2.4.12.14 Agree that the Bidder will meet with HCA every two weeks to walk-through proposed updates and to obtain HCA's consent to updates proposed by the Bidder.

2.4.12.15 Agree that the Bidder will maintain its detailed work plan and publish the plan where the Bidder, HCA, and HCA designees have access.

2.5 BIDDER QUALIFICATIONS (MR & MS)

The prompts within this section consist of both MR and MS Requirements. Only the "Agree" prompts are MR.

2.5.1 **Bidder's Prior Experience Requirements**

Respond to the following:

2.5.1.1 Complete the following table for each POS solution that the Bidder has implemented or is implementing in other states that support that state's Medicaid program:

State	Start & End Month/Year	Certification Month/Year	Platform	Primary Language	Database	Annual Claim Volume	Annual Claim Dollars	# of Users	Contract Amount	Client Contact (name/role/phone/email)

2.5.1.2 Complete the following table for any other relevant, large-scale components the Bidder has implemented or is implementing that **are not** identified above:

Client	Start & End Month/Year	Platform	Primary Language	Database	Annual trans. Volume	Annual trans. Dollars	# of Users	Contract Amount	Client Contact (name/role/phone/email)

2.5.1.3 Explain why this is the system the Bidder is proposing and the degree of fit with Washington's requirements, including the percentage of Washington's requirements that the system meets without modification and the basis for that assessment.

2.5.1.4 Describe the Bidder's role in each engagement described above **and** state Bidder's level of responsibility (for example, primary, subcontractor) for all phases of the project including requirements analysis, process design, construction, testing, and final implementation. **Also**, describe any pilot implementation phases.

2.5.1.5 Clearly describe the scope and scale of those projects, including the Bidder's performance in terms of schedule and budget. **Also**, explain positive and negative variances from the schedule and budget.

2.5.1.6 Describe the Bidder's experience in developing and operating systems on the hardware (if applicable) and software platforms proposed for Washington.

2.5.1.7 Identify and describe any units in Bidder's organization that have reached Capability Maturity Model (CMM) Level 3 or higher certification, **and** describe those units' involvement in this project.

2.5.1.8 Describe how Bidder will employ CMM processes and practices in this project.

2.5.1.9 Agree that HCA reserves the right to contact all above client contacts and any other contacts provided by current or former clients, and that HCA reserves the right to disqualify Bidder based upon said contact.

2.5.2 Bidder Customer References Requirements

This section is mandatory and will receive a score. These references are for the Bidder organization (Section 2.6.2.2 relates to Key Staff references). HCA reserves the right to conduct checks of Bidder references, by telephone or other means, and evaluate the Bidder based on these references. HCA considers references to be extremely important, and HCA reserves the right to disqualify Bidder based upon poor reviews/references. It is the Bidder's responsibility to ensure that every reference contact is available during the evaluation period. (See Section 7.2, Estimated Schedule of Procurement Activities, for the planned RFP evaluation period). HCA will e-mail Bidder's references a questionnaire to complete and return to HCA. HCA will evaluate and score this section based on the references' responses to the questionnaire. HCA may also call references.

Respond to the following:

2.5.2.1 Refer to Attachment 2, *Bidder References Form* and complete a copy of that form for the Bidder organization. Bidder must include 3 customer references for the Bidder organization. At least 2 of these references must be from POS comparable projects. For every reference, the Bidder's proposal must provide the company name, contact name, contact job title, address, telephone number and email for that reference. **Combine** completed Bidder Reference Forms into one document and include as a separate attachment to your proposal.

2.5.2.2 Provide similar and separate references for every proposed subcontractor.

2.5.2.3 Agree that all references must be independent of the Bidder's and subcontractor's company/corporation (e.g., non-Bidder owned, in whole or in part, or managed, in whole or in part).

2.5.2.4 Agree that HCA reserves the right to contact all above customer references, and that this contact will be considered by HCA in scoring the Bidder.

2.5.2.5 Agree that HCA reserves the right to contact any other entity or person it wants to contact with regard to the Bidder and subcontractor, including parties in addition to those recommended by the Bidder. This contact may be used by HCA in scoring the Bidder.

2.5.2.6 Agree that the Bidder and subcontractor has or will timely notify each customer reference that they may be contacted by HCA and has assured that each reference will be available during the evaluation period. (See Section 7.2, *Estimated Schedule of Procurement Activities* for the approximate RFP evaluation period).

2.6 APPROACH TO ORGANIZATION AND STAFFING (MR & MS)

The prompts within this section consists of both MR and MS Requirements. Only the "Agree" prompts are MR.

The organization of Bidder staff and the appropriate assignment of tasks are extremely important to HCA to ensure the overall success of this project. HCA expects that Bidders will propose their best-qualified staff for this project. Should proposed staff not be available when work begins, Bidder must provide evidence in the form of résumés and descriptions of relevant experience for any staff proposed as alternates to the proposed team members.

2.6.1 **Overall Project Organization Approach**

Respond to the following:

2.6.1.1 Include a description of the overall approach to project organization and staffing, including subcontractors if applicable, that addresses the entire scope of the project.

2.6.1.2 Include a project organization chart identifying by name and position the Bidder's staff (e.g., down to at least the lead level), including subcontractors, responsible for carrying out the entire scope of the project.

2.6.1.3 Identify by name and position in the project organization chart the Key Staff person(s) that will perform the following during the DDI phase (individuals may fill more than one role):

a. Account Director
b. Project Manager
c. Pharmacy Business Lead
d. Drug Rebate Business Lead
e. Solutions/Technical Manager
f. Test Manager
g. Implementation Manager
h. Certification Manager

2.6.2 **Project Management and Key Staff Qualifications Requirements**

Scores for this section will be based on the proposed Key Staff's qualifications and experience. Experience from projects where the work performed was different than this project may not score as well as experience where the work performed was similar to this project. At its discretion, HCA will contact the project manager and key staff references.

Respond to the following:

2.6.2.1 Refer to Attachment 3, *Résumé Form* and complete a copy of that form for each of the proposed Key Staff. **Combine** completed Résumé Forms into one document and include as a separate attachment to your proposal.

2.6.2.2 Refer to Attachment 4, *Key Staff References Form* and complete a copy of that form for each of the proposed Key Staff. Bidder must include 3 customer references for each Key Staff. **Combine** completed Key Staff Reference Forms into one document and include as a separate attachment to your proposal. HCA will e-mail Key Staff references a questionnaire to complete and return to HCA. HCA will

evaluate and score this section based on the references' responses to the questionnaire. HCA may also call references.

2.6.3 **Project Staffing Requirements**

For the purpose of this section, "Project Staff" includes Bidder personnel and all subcontractor staff.

Respond to the following:

2.6.3.1 State the minimum number of staff that will be assigned to this project throughout the life of the project. If this number will change throughout the life of the project, identify when those changes will take place and the minimum number of staff that will be assigned to this project during those changes.

2.6.3.2 Identify where all staff assigned to this project, including developers, will be geographically located (city, state, country) throughout the lifecycle of the project.

2.6.3.3 Explain how and to what extent they will be accessible to the HCA project team.

2.6.3.4 For staff geographically located outside of Olympia, Washington, identify what Bidder staff will come on-site to work with stakeholders (e.g., for requirements validation, testing, and business process change) and describe in detail the tasks or phases for which they will come on-site, when, and for how long. HCA recognizes the seriousness of COVID-19, and this local/on-site requirement will be adjusted to conform to state and HCA COVID-19 requirements and guidelines.

2.6.3.5 Describe the process and timeline for bringing proposed staff onto the project.

2.6.3.6 Agree that the Project Manager will be in Olympia full-time throughout the project or as otherwise agreed to in contract negotiations. HCA recognizes the seriousness of COVID-19, and this local/on-site requirement will be adjusted to conform to state and HCA COVID-19 requirements and guidelines.

2.6.3.7 Agree that the Bidder must provide all office space and equipment for its staff.

2.6.4 **Continuity of Project Personnel Requirements**

In order to ensure the success of this project, it is important that there is a continuity of Key Staff assigned to the project.

Respond to the following:

2.6.4.1 Describe policies, plans, and intentions with regard to maintaining continuity of personnel assignments throughout the performance of any agreement resulting from this RFP.

2.6.4.2 Address whether availability of any of the proposed personnel could be impacted from existing or potential contracts to which such staff are assigned or proposed.

2.6.4.3 Describe what priority HCA would have in cases of conflict between existing or potential contracts.

2.6.4.4 Discuss the Bidder's plans to avoid and minimize the impact of personnel changes.

2.6.4.5 Identify planned backup personnel assignments.

2.6.4.6 Agree that Bidder's proposed project personnel may not be reassigned, replaced, or added during the project without the prior written consent of the HCA Project Manager. Should a key staff position be vacated, Bidder must give HCA résumés of, and an opportunity to interview and approve, potential replacements for that employee.

2.6.4.7 Agree that the HCA Project Manager reserves the right to require a change in Bidder's project personnel at the HCA Project Manager's sole discretion and that

HCA must be given an opportunity to interview and approve potential replacements for that employee. However, HCA will not unreasonably exercise this option and will take reasonable steps to work with the Bidder toward a solution.

2.6.4.8 Agree to HCA's use of the Key Staff personnel identified in the proposal **and** agree to HCA's right to approve proposed personnel changes to Key Staff during the term of the contract.

2.6.4.9 Agree that responses to Section 2.6.3 requirements apply to proposed Subcontractor key staff as well as Bidder's proposed staff.

2.7 PROJECT DELIVERABLES (MR & MS)

The prompts within this section consists of both MR and MS Requirements. Only the "Agree" prompts are MR.

The Bidder must identify its approach to developing and submitting the project deliverables identified in this RFP. The approach to project deliverables must identify the proposed steps in the deliverable development process, from development of Deliverable Expectation Documents, templates, and acceptance criteria through review, finalization, and acceptance. Bidders are encouraged to deliver partial drafts (e.g., section by section) especially when deliverables are lengthy to manage mutual expectations and to ensure the satisfactory completion of deliverables. Bidders also must consider the impact on reviewers when multiple deliverables are under review simultaneously by the same stakeholder group and adjust review and correction periods accordingly.

Respond to the following:

2.7.1 Include a full list of all deliverable titles and expected delivery dates.

2.7.2 Describe the Bidder's general approach to deliverables development, acceptance criteria, draft submission, revisions, and final acceptance.

2.7.3 Agree that Bidder will submit for State approval acceptance criteria before work begins on the deliverable.

2.7.4 Agree that Bidder will produce deliverable outlines or templates for HCA acceptance before work begins on the deliverable.

2.7.5 Agree that the Bidder will incorporate comments and distribute revised draft deliverables to HCA project staff for review and comment.

2.7.6 Agree that the Bidder will include a change log specifying the section, page number and brief description of any changes with the submission of a revised deliverable.

2.7.7 Agree that upon HCA request, the Bidder will conduct formal walk-throughs of draft deliverables with identified HCA stakeholders.

2.8 DESIGN, DEVELOPMENT AND IMPLEMENTATION REQUIREMENTS (MR & MS)

The prompts within this section consists of both MR and MS Requirements. Only the "Agree" prompts are MR.

HCA has defined the following high-level stages for this project:

1. Planning and Start-Up
2. Requirements Verification and Design
3. Set-up, Configuration, and Customization (including integrations)
4. Data Conversion
5. System and Integration Testing
6. Operational Readiness
7. User Acceptance Testing

8. Deployment/Implementation
9. Certification

Within this section, Bidders are asked to respond to the requirements of each major stage. Responsibilities include, but are not limited to, the following:

State Responsibilities:

- Review and acceptance of the proposed Deliverable Expectation Document (DED) of all Deliverables prior to development;
- Review ASB deliverables, determine whether the deliverable complies with applicable specifications, and provide written comments to the ASB within timeframes mutually agreed to;
- Participate in bi-weekly status meetings with the ASB to review progress against the work plan;
- Review bi-weekly written status reports and bi-weekly work plan/task schedule updates;
- Monitor ASB progress to task milestones; and
- Work with the ASB to resolve issues.

Pharmacy POS ASB Responsibilities:

- Prepare a DED and obtain acceptance from HCA for the contents and format for each Deliverable before beginning work on the Deliverable;
- Obtain written acceptance from HCA on the final Deliverables;
- Revise Deliverables, if required, using HCA review findings to meet content and format requirements and comply with applicable specifications;
- Report progress and status through bi-weekly status reports;
- Conduct bi-weekly work plan reviews;
- Attend bi-weekly status meetings with the HCA Project Manager and project team members;
- Deliver written status reports and updated work plans/schedules 1 business day, at least 24 hours, before the status meeting; and
- Identify scope of work issues and seek HCA acceptance before commencing changes to work described in the RFP.

2.8.1 **Approach to Planning and Startup**

Respond to the following:

2.8.1.1 Agree that the Bidder must produce, at a minimum, the following deliverables in this stage:

Deliverable Name	Description
Revised Project Work Plan	See section 2.4.12
Project Management Plan	A formal, approved document used to guide both Project execution and control of the Project consistent with the guidance of the Project Management Body of Knowledge that includes processes Bidder proposes in response to section 2.4
Certification Plan	A formal planning document that details the approach for achieving federal Certification. The plan describes the processes for assisting HCA in the Operational Readiness Review and Certification Review stages of Outcome Based Certification.

Risk Register	See section 2.4.8
Bi-weekly Status Reports	See section 2.4.11

2.8.1.2 Describe any recommended changes or additions to the deliverables listed in the table above. State "Not applicable" if Bidder does not have any such recommendations.

2.8.1.3 Demonstrate the Bidder's understanding of the certification requirements and the process for obtaining CMS certification by describing in detail the steps that Bidder will take to achieve certification, including how the Bidder will support HCA in the CMS certification process.

2.8.1.4 Describe Bidder's approach to developing the Deliverables required for this DDI stage. List the responsibilities for HCA, MMIS vendor and Bidder staff during this stage.

2.8.1.5 Describe Bidder's approach to coordinating the responsibilities of HCA and the current MMIS vendor with those of the Bidder's to ensure overall project success.

2.8.2 **Approach to Requirements Verification and Design**

Respond to the following:

2.8.2.1 Agree that the Bidder must produce, at a minimum, the following deliverables in this stage:

Deliverable Name	Description
Requirements Traceability Matrix (RTM) – Interim	An interim document that links requirements throughout the requirements validation process showing how HCA requirements, user stories, and use cases will be certified as functional and complete during solution configuration.
Solution Requirements Documentation	Documentation including Business Requirements document (BRD), System Requirements Specifications (SRS) or equivalent, features, epics and user stories
Solution Integration Plan	A document describing plans to achieve modularity and how the Pharmacy solution will interact with ProviderOne to provide a fully functional system that operates as one module of the interconnected MMIS.
Solution Design Documentation	Final documentation of the functional and technical designs traceable back to the Requirements Traceability Matrix (RTM) and process flows, including at a minimum: • Configuration elements such as business rules • Reporting (dashboards, reports, cadence) • Interface specification documents • System architecture, including security and database designs

2.8.2.2 Describe any recommended changes or additions to the deliverables listed in the table above. State "Not applicable" if Bidder does not have any such recommendations.

2.8.2.3 Describe Bidder's proposed Solutions Requirements Documentation to include the items above and other items the Bidder feels are necessary.

2.8.2.4 Describe Bidder's proposed content of a Solution Integration Plan to include the items above and other items the Bidder feels are necessary.

2.8.2.5 Describe Bidder's proposed Solution Design Documentation to include the items above and other items the Bidder feels are necessary.

2.8.2.6 Describe Bidder's approach to developing the Deliverables required for this DDI stage. List the responsibilities for HCA, MMIS vendor and Bidder staff during this stage.

2.8.2.7 Describe Bidder's approach to coordinating the responsibilities of HCA and the current MMIS vendor with those of the Bidder to ensure overall project success.

2.8.3 **Approach to Set-up, Configuration and Customization**

Respond to the following:

2.8.3.1 Agree that the Bidder must produce, at a minimum, the following deliverables in this stage:

Deliverable Name	Description
Solution Configuration Documentation	Documentation provided that conveys how the solution is configured to meet HCA start-up business needs.
DDI Environment and Configuration Management Plan	Documentation of the development, test, and training environments to be used throughout the Contract period, including definition of responsibilities for set-up and configuration tasks for each. Must describe how the Bidder will identify, control, and manage code releases throughout DDI.

2.8.3.2 Describe any recommended changes or additions to the deliverables listed in the table above. State "Not applicable" if Bidder does not have any such recommendations.

2.8.3.3 Describe Bidder's proposed content of a DDI Environment and Configuration Management Plan to include the items above and other items the Bidder feels are necessary.

2.8.3.4 Describe approach to developing the Deliverables required for this DDI stage. List the responsibilities of HCA, MMIS vendor and Bidder staff during this stage.

2.8.3.5 Describe approach to coordinating the responsibilities of HCA and the current MMIS vendor with those of the Bidder to ensure overall project success.

2.8.4 **Approach to Data Conversion**

Respond to the following:

2.8.4.1 Agree that the Bidder must produce, at a minimum, the following deliverables in this stage:

Deliverable Name	Description
Data Conversion Plan	A description of the strategy, preparation, and specifications for converting data, including but not limited to claims and prior authorizations, from the source system(s) to the target system(s) or within an existing system.
Data Conversion Test Results	Documentation of the Data Conversion Test Results which detail issues encountered and the impact upon other table or file conversions: • Methods used to resolve issues or an action plan for resolving outstanding issues

	• Pre-conversion and post-conversion versions of each table or file converted and each interface file • Auto-generated reports as required by HCA to spot-check and validate pre-conversion and post-conversion results at a detail and summary record levels • A summary and metrics for the status of the conversions, including the effect of any findings on the implementation schedule

2.8.4.2 Describe any recommended changes or additions to the deliverables listed in the table above. State "Not applicable" if Bidder does not have any such recommendations.

2.8.4.3 Describe Bidder's approach to defining detailed conversion requirements.

2.8.4.4 Describe Bidder's final conversion verification process.

2.8.4.5 Describe Bidder's approach for making converted files available for review online, where appropriate.

2.8.4.6 Describe approach to developing the Deliverables required for this DDI stage. List the responsibilities of HCA staff, MMIS vendor and Bidder staff during this stage.

2.8.4.7 Describe approach to coordinating the responsibilities of HCA and the current MMIS vendor with those of the Bidder to ensure overall project success.

2.8.4.8 Agree that Bidder will convert 4 years of data from the current Pharmacy POS including any lifetime or special limit information over the 4 years.

2.8.4.9 Agree that Bidder will work directly with HCA to coordinate receipt of conversion files from current POS vendor.

2.8.5 **Approach to System and Integration Testing**

Respond to the following:

2.8.5.1 Agree that the Bidder must produce, at a minimum, the following deliverables in this stage:

Deliverable Name	Description
Master Test Plan	A technical document that details a systematic approach to testing the new Pharmacy solution to ensure it will successfully perform to HCA's requirements as a module of the overall MMIS. • Testing must include end-to-end testing of all interfaces. • Demonstrations of working software (e.g., module demo, interaction with other modules/systems) must be provided as specified by HCA
System and Integration Test Results and Demonstration	Documentation of the System and Integration test scenarios and test cases, testing results, issues and defects identified during testing, as well as the scenarios and degree of system functionality demonstrated for HCA.
Requirements Traceability Matrix (RTM) – Final	A final document that links requirements throughout the requirements validation process showing how HCA requirements will be certified as functional and complete during solution configuration.

Training Plan	A document for defining the strategies, tasks, and methods that will be used to meet the training requirements.

2.8.5.2 Describe any recommended changes or additions to the deliverables listed in the table above. State "Not applicable" if Bidder does not have any such recommendations.

2.8.5.3 Describe any automated testing capabilities that you may utilize and include those to test specific business scenarios.

2.8.5.4 Agree that the Bidder will adopt, implement and document rigorous and professionally sound unit, system, integration, and regression test procedures.

2.8.5.5 Agree that Bidder will agree to demonstrate functionality identified by HCA that will ensure system is ready to enter UAT.

2.8.5.6 Agree that the Bidder will ensure that preproduction testing of the solution validates capability of required test objectives and will produce required data to support objectives and identified key performance indicator measures.

2.8.5.7 Describe Bidder's proposed tool and procedures for tracking, managing, reporting and correcting system bugs or discrepancies discovered during testing.

2.8.5.8 Describe Bidder's approach for updating documentation based on test results.

2.8.5.9 Describe Bidder's proposed training model for the project which must include Knowledge Transfer sufficient to ensure operational readiness of the HCA team that will support the solution in Operations

2.8.5.10 Describe Bidder's approach to developing the Deliverables required for this DDI stage. List the proposed responsibilities for HCA, MMIS vendor and Bidder staff during this stage.

2.8.5.11 Describe Bidder's approach to coordinating the responsibilities of HCA and the current MMIS vendor with those of the Bidder to ensure overall project success.

2.8.6 **Approach to Operational Readiness**

Respond to the following:

2.8.6.1 Agree that the Bidder must produce, at a minimum, the following deliverables in this stage:

Deliverable Name	Description
Operational Readiness Plan	A document detailing the approach to validating all the operations processes, system environments, software, and connectivity aspects of the solution to ensure it will be fully operable upon implementation. Describes how the Bidder will achieve certification of Operational Readiness.
Operations Guide	A document that describes all required systems operational activities and provides guidance on data management, incident management, root cause analysis, corrective action plans, performance management, system maintenance, change management, tools, and approaches.
Training Materials	Documentation used to perform provider and user training (user guides and tutorials) on the solution.

2.8.6.2 Describe any recommended changes or additions to the deliverables listed in the table above. State "Not applicable" if Bidder does not have any such recommendations.

2.8.6.3 Describe Bidder's approach to demonstrating operational readiness and proposed content of an Operational Readiness Plan to include the items above and other items the Bidder feels are necessary.

2.8.6.4 Describe contents of the Operations Guide to include the items above and other items the Bidder feels are necessary.

2.8.6.5 Describe Bidder's procedures for maintaining the Operations Guide throughout operations, including distribution of amendments.

2.8.6.6 Describe the roll-out of training materials to ensure staff and providers/manufacturers are ready to use the system.

2.8.6.7 Describe Bidder's approach to developing the Deliverables required for this DDI stage. List the responsibilities of HCA, MMIS vendor and Bidder staff during this stage.

2.8.6.8 Describe Bidder's approach to coordinating the responsibilities of HCA and the current MMIS vendor with those of the Bidder to ensure overall project success.

2.8.7 **Approach to User Acceptance Testing**

Respond to the following:

2.8.7.1 Agree that the Bidder must produce, at a minimum, the following deliverables in this stage:

Deliverable Name	Description
User Acceptance Testing (UAT) Test Results	Test results should include the following: • Summary of testing results • Pass/fail rate • Defect IDs and severity level of failed test cases
Certification Artifacts (CMS' Operational Readiness Review stage)	A series of system demonstrations necessary including a collection of information, including but not limited to, data, documents, automated test results, 508 compliance test reports, screenshots, other reports and/or artifacts produced in coordination with the HCA UAT cycle to support the CMS "Operational Readiness Review" certification process.

2.8.7.2 Describe any recommended changes or additions to the deliverables listed in the table above. State "Not applicable" if Bidder does not have any such recommendations.

2.8.7.3 Agree that Bidder will fully and promptly cooperate with HCA in the UAT process to include providing any Certification Artifacts for CMS review.

2.8.7.4 Agree that Bidder will be solely responsible for making changes; providing refinements and/or upgrades; providing software, hardware, programming, and professional and/or technical services as may be necessary to correct any deficiencies, problems, failures, incompatibilities, and/or errors identified during UAT.

2.8.7.5 Agree that Bidder will provide a separate User Acceptance Testing environment for the entire UAT period as well as the operations period of the contract.

2.8.7.6 Describe Bidder's approach to supporting UAT. Include availability of UAT environment, preparation of test data, response to discrepancies and resolution of problems.

2.8.7.7 Describe the support that will be provided to HCA for creation of test cases that cover all system functions, processes, and interfaces.

2.8.7.8 Describe the Bidder's approach for supporting HCA staff in the analysis of test results.

2.8.7.9 Describe the process and timelines for correcting discrepancies and ensuring corrected code is thoroughly tested and migrated to the UAT environment for re-testing.

2.8.7.10 Agree that the Bidder will perform regression testing during UAT. Further, agree that the Bidder will coordinate with HCA on timing of regression tests.

2.8.7.11 Describe Bidder's approach to developing the Deliverables required for this DDI stage. List the responsibilities for HCA, MMIS vendor and Bidder staff during this stage.

2.8.7.12 Describe Bidder's approach to coordinating the responsibilities of HCA and the current MMIS vendor with those of the Bidder to ensure overall project success.

2.8.8 **Approach to Implementation/Cutover**

Respond to the following:

2.8.8.1 Agree that the Bidder must produce, at a minimum, the following deliverables in this stage:

Deliverable Name	Description
Disaster Recovery Plan	A plan for resuming operations in the event there are significant adverse conditions that disrupt service. See Technical Requirement 3.1.7.
Solution Implementation/Cutover Plan	A document reflecting the final requirements and implementation approach for the solution. Must include Cutover Schedule, plan for final data conversion and a contingency back-out plan.
Certification of Operational Readiness	A formal review with key stakeholders to ensure the system/application completed its implementation processes according to the Operational Readiness Plan and that it is ready for turnover to the Operations & Maintenance team and operational release into the Production environment. Must include Bidder's statement of readiness to perform production operations.

2.8.8.2 Describe any recommended changes or additions to the deliverables listed in the table above. State "Not applicable" if Bidder does not have any such recommendations.

2.8.8.3 Describe Bidder's approach for minimizing interruption to Pharmacy claims processing during implementation/cut-over to the new solution.

2.8.8.4 Describe contents of the Solution Implementation/Cutover Plan to include the items above and other items the Bidder feels are necessary.

2.8.8.5 Agree that final go-live of the Bidder's solution will be dependent on formal acceptance of Certification of Operational Readiness Deliverable by HCA.

2.8.8.6 Agree to support HCA as needed in Operational Readiness review activities that may be required in order to obtain approval from the Washington State Office of the Chief Information Officer.

2.8.8.7 Describe Bidder's approach to developing the Deliverables required for this DDI stage. List the responsibilities of HCA, MMIS Vendor and Bidder staff during this stage.

2.8.8.8 Describe Bidder's approach to coordinating the responsibilities of HCA and the current MMIS vendor with those of the Bidder to ensure overall project success.

2.8.9 **Approach to Final Certification**

Respond to the following:

2.8.9.1 Agree that the Bidder must produce, at a minimum, the following deliverables in this stage:

Deliverable Name	Description
Certification Artifacts - production screenshots, reports and data for final Certification Review with CMS.	A collection of data, documents, and information provided as evidence for CMS' final certification review. Evidence includes but is not limited to samples of production data, substantive and representative sets of reports (including performance) and any other information or data in order to validate business outcomes and applicable metrics related to Outcome Based Certification needs.

2.8.9.2 Describe any recommended changes or additions to the deliverables listed in the table above. State "Not applicable" if Bidder does not have any such recommendations.

2.8.9.3 Agree that Bidder will deliver a Pharmacy POS solution that will meet or exceed all CMS certification requirements.

2.8.9.4 Include a proposed timeline for preparation of certification materials and presentation of the materials to the HCA Project Manager.

2.8.9.5 Describe Bidder's approach to coordinating the responsibilities of HCA and the MMIS vendor with those of the Bidder to ensure overall project success.

2.9 OPERATIONS AND MAINTENANCE (MR & MS)

The prompts within this section consists of both MR and MS Requirements. Only the "Agree" prompts are MR.

With cutover of live operations to the new POS, the former system will be taken out of service and operations and maintenance of the new system will begin. When the new POS solution is in place, HCA will continue with this Facilities Management operations model, where state staff performs the majority of operations as identified in Section 1.4, *Operations and Maintenance Model*. The successful Bidder will provide the system maintenance and operations described in this RFP for the life of the contract.

2.9.1 **Organization and Staffing**

Respond to the following:

2.9.1.1 Provide a project organization chart identifying by position and roles/responsibilities of the Bidder's staff (down to at least the lead level), including subcontractors, responsible for carrying out the operations and maintenance of the POS after implementation.

2.9.1.2 Agree that the Account Director and Operations Manager will be considered as Key Staff designees during the Operations and Maintenance period and that HCA has the right to approve initial selection and any subsequent change to these personnel during the term of the contract.

2.9.2 **Operations and Maintenance**

The ASB must perform operations and maintenance throughout the life of the contract and in accordance with the fixed price O&M bid including cloud hosting operations and updates, patches and repairs to Pharmacy POS solution in the production, test and all other Washington accessible environments as well as troubleshooting with HCA, correction (including development, testing, training and implementation) of any deficiency or problem with the solution.

Respond to the following:

2.9.2.1 Describe the Bidder's approach to systems operations and maintenance.

2.9.2.2 Describe Bidder's approach to maintaining and enhancing its Pharmacy POS product to ensure it continues to comply with industry standards and CMS regulations.

2.9.2.3 Describe how changes and enhancements to the Bidder's Pharmacy POS solution would be introduced to HCA and agree that Bidder will comply with the operational requirements in Section 4.11.

2.9.2.4 Describe Bidder's approach for promoting approved changes into User Acceptance Testing and from User Acceptance Testing to production environment.

2.9.2.5 Describe Bidder's process for dealing with emergency fixes. Include how Bidder's fix will be tested and promoted through testing environments to production.

2.9.2.6 Agree that Bidder will respond to HCA on non-emergency troubleshooting requests within 3 days of discovery.

2.9.2.7 Agree that the tasks identified above will be included as part of the proposed fixed price for operations and maintenance as identified in Attachment 10, *Response Form for Section 5, Cost Proposal*.

2.9.3 **Contract Administration**

Respond to the following:

2.9.3.1 Describe the Bidder's approach for monitoring and reporting performance of the system during operations. Include metrics that will be tracked, frequency of reporting and access methods to data.

2.9.3.2 Describe the Bidder's approach for transitioning to another entity at the end of the contract period. Further, agree that the Bidder will cooperate completely with HCA and the subsequent entity including, but not limited to, a transition plan that includes data conversion, parallel testing, and system cutover activities.

2.9.3.3 Agree that the Bidder will continue to follow all project management processes established in Section 2.4 throughout the operations phase or the Bidder must propose alternate processes.

2.9.3.4 Agree that the Bidder will establish a problem resolution process including a help desk that satisfies requirements in Section 4.11.

2.9.3.5 Agree that the Bidder will develop an Annual Business Plan. The Plan should include the following elements; an road/map or outline of major activities planned for the coming year, business improvement objectives and outcomes for the coming year, methodology for performing activities and meeting objectives, methods for measuring customer service performance, methods for identifying where customer

services performance is inadequate, approach for developing and implementing corrective actions.

2.9.3.6 Agree that the Bidder will develop a monthly report for HCA to describe compliance to the Annual Business Plan and update on any corrective action plans.

2.9.3.7 Agree that Bidder will walk-through performance reports at the request of HCA.

END OF SECTION 2

SECTION 3. TECHNICAL PROPOSAL

The prompts within this section consists only of MS Requirements, and each requirement will be scored.

Bidders must respond to the requirements below in accordance with Section 7.6.3, Proposal Format Instructions, which includes instructions on filling out each cell within the requirements tables within this Section 3.

3.1 OVERVIEW

HCA's technology requirements are driven by a set of guiding principles for enterprise architecture that are designed to maximize value for HCA and the clients, providers and communities it serves. These principles include the following:

Cloud-based solutions that:

- Allow HCA to dynamically expand and contract capacity quickly to respond to business needs, such as handling peak capacity periods.
- Reduce cost by not owning hardware and infrastructure.
- Better manage robust security across applications.

SaaS/COTS solutions are preferred over custom-built and/or custom-components in order to:

- Share and leverage best practices that have been developed across the industry and more quickly respond to industry changes.
- More effectively plan, track and monitor development, administration and operations costs.
- Limit code development as much as possible to configuration.
- Implement new features on shorter and predictable implementation cycles.

Maintain loose coupling between systems based on natural system boundaries to:

- Dramatically reduce integration costs through the use of open Application Program Interfaces (APIs).
- Minimize cost and disruption in the event a major component of the system has to be replaced.

HCA requires the ASB meet or exceed Federal certification and performance standards by meeting the conditions defined in 42 C.F.R. 433.112(b) and those principles established under the Medicaid Information Technology Architecture (MITA) initiative and framework. This includes the goals and technical principles that promote rules engines, where possible, to extend the system's configuration abilities to be managed by the business community. All conditions must be met in order for HCA to remain eligible for Federal Financial Participation (FFP) funding. HCA requires that the ASB establish and maintain a performance record of high availability.

HCA requires the ASB meet or exceed HIPAA security, privacy and transaction standards, accessibility standards established under section 508 of the Rehabilitation Act or standards that provide greater accessibility for individuals with disabilities and compliance with Federal civil rights laws; standards adopted by the Secretary under section 1104 of the Affordable Care Act (ACA); and standards and protocols adopted by the Secretary under section 1561 of the ACA.

In addition to Federal requirement compliance, the ASB's system must comply with all applicable State of Washington Office of the Chief Information Officer (OCIO) standard and security requirements including a cyber-security design review. The OCIO sets information technology (IT) policy and direction for the State of Washington and the State CIO is a member of the Governor's Executive Cabinet and

advisor to the Governor. The ASB will be required to participate in a yearly disaster recovery exercise with HCA in which results will be made available to the State Auditor's Office (SAO).

REQUIREMENTS TABLE ON THE FOLLOWING PAGE

3.1.1 **General**					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
3.1.1.1	Describe your product's technical offering and include any ranges of high availability and business continuity options available. Describe any unique, innovative or additional features available in your offering and the advantages they bring to HCA.				
Response:					
3.1.1.2	Describe your product's architecture design. Include your current and target architecture and design principles and degree to which your current product meets those principles. List your use of included technologies and versions and include when your product last had a significant upgrade as well as your product roadmap for future technology enhancements.				
Response:					
3.1.1.3	The Bidder must maintain all Third-Party Software products at either their most current version or no more than one version back. Describe your ability to meet this requirement.				
Response:					
3.1.1.4	Identify, if any, the third-party providers, organizations or other organizational resources other than your company that you intend to use to support these technology requirements. Indicate the nature and overall content of the contractual agreement that you plan to have with this external resource. Indicate the viability of the proposed resource(s) in terms of the following: market position, ability to meet requirements, alignment with industry standards and practices, industry implementation track record and Bidder implementation track record.				
Response:					

3.1.1 **General**					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
3.1.1.5	The Bidder must collaborate with HCA and the MMIS contractor to develop and/or update conceptual and logical data models. Describe your ability to meet this requirement.				
Response:					

END OF SECTION 3.1.1

3.1.2 **Standards**					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
3.1.2.1	Describe how the Bidder's solution complies with applicable Washington State Office of the Chief Information Officer (OCIO) standards. Please respond specifically to the link and standard below and attach any evidence of compliance. https://ocio.wa.gov/policy/securing-information-technology-assets Security 141.10				
Response:					
3.1.2.2	Describe how Bidder would ensure that any components installed on State workstations, now and in the future, must be compatible with HCA currently supported software versions of, and future updates and patches for, the Microsoft Operating System, Microsoft Office Suite, and all modern internet browsers.				
Response:					
3.1.2.3	The Bidder's solution must comply with all applicable current and future Center for Medicare and Medicaid Services (CMS) certification requirements. Attach any evidence of previous certification from other implementations.				
Response:					
3.1.2.4	Describe how the Bidder's solution complies with all NIST standards for cloud computing. Relevant links are listed below. Attach any evidence of compliance and/or certification. https://www.nist.gov/itl/nist-cloud-computing-related-publications https://www.nist.gov/news-events/news/2018/02/nist-releases-evaluation-cloud-computing-services-based-nist-sp-800-145 https://csrc.nist.gov/publications/detail/sp/500-299/draft https://bigdatawg.nist.gov/_uploadfiles/M0008_v1_7256814129.pdf				
Response:					

3.1.2 **Standards**					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
3.1.2.5	Describe how the Bidder's solution complies with all applicable Section 508 of the Rehabilitation Act of 1973 standards and attach your response to the checklist referenced in the link below. https://www.hhs.gov/web/section-508/index.html https://www.hhs.gov/web/section-508/accessibility-checklists/index.html				
Response:					
3.1.2.6	The Bidder must provide HCA an annual report from its external auditor on effectiveness of internal controls. The report must be provided at go-live and annually thereafter. The report must be compliant with the American Institute of Certified Public Accountings (AICPA) Statement on Standards for Attestation Engagement (SSAE) No. 18, Reporting on Controls at a Service Organization, Service Organization Control (SOC) 1, SOC 2, and Type 2 Report. Describe your ability to meet this requirement.				
Response:					
3.1.2.7	Describe how the Bidder's solution complies with any applicable Americans with Disabilities Act (ADA) standards. Attach any evidence of compliance.				
Response:					
3.1.2.8	The Bidder's solution must inform a user of applicable privacy policy and terms of service prior to granting access. Describe your ability to meet this requirement.				
Response:					

END OF SECTION 3.1.2

3.1.3 **Security**					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
3.1.3.1	Describe how the Bidder's solution's security integrates with the State's access and identity management tools and Active Directory authentication system for HCA users through single sign on as described in OCIO 141.10. Solutions which use Domain trusts will not be acceptable.				
Response:					
3.1.3.2	Describe how the Bidder's solution will deliver services through the state's identity access management infrastructure that provides single sign on to all modules/functions within the system enabled in the user's security profile.				
Response:					
3.1.3.3	The Bidder's solution must provide secure access to vendors and Providers working outside the State's firewall in compliance with OCIO 141.10 policy via Secure Access Washington (SAW). Describe your ability to meet this requirement.				
Response:					
3.1.3.4	Describe how Bidder's solution security will dynamically control and administer role-based user access for all users, including the ability for users to have more than one role. Include a description of how role hierarchy is addressed in Bidder's solution.				
Response:					

3.1.3 **Security**					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
3.1.3.5	The Bidder must participate in the Office of Cyber Security (OCS) design review process and successfully pass the review using the Office of Chief Information Officer (OCIO) 141.10 standard and OCS vendor design review checklist. A copy of the OCS checklist is included herein as Attachment 5, *OCS Design Review Checklist*. The Bidder must complete Checklist B of this Attachment 5 and return the completed version in their response for this requirement. The Bidder is also required to add in Notes within Checklist B to indicate current and future ability to maintain compliance with the Checklist B items. Bidder understands that a full design review including the ability to successfully pass the review will still be required if selected as the ASB. This design review will also include any third-party providers that will support the technology requirements.				
Response:					
3.1.3.6	The Bidder's solution, data, and all facilities and services provided to Washington State will be located within the United States. Data cannot be moved offshore. Describe your ability to meet this requirement.				
Response:					

END OF SECTION 3.1.3

3.1.4 **System Auditing**					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
3.1.4.1	The Bidder's solution must ensure that all system events are written to a system event log. Describe your ability to meet this requirement.				
Response:					

END OF SECTION 3.1.4

3.1.5 **Database**					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
3.1.5.1	The Bidder's solution must maintain historical records (e.g., a log file) of table updates and data logged including but is not limited to, user ID, data before change, change data and date/time stamp. Describe your ability to meet this requirement including the ability to provide the information to HCA when requested.				
Response:					

END OF SECTION 3.1.5

3.1.6 **Back-Up and Recovery**					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
3.1.6.1	Describe the Bidder's system's process for complete backup and recovery of all database tables and system files.				
Response:					
3.1.6.2	Describe the Bidder's solution's ability for point-in-time recovery of data to the last completed transaction.				
Response:					
3.1.6.3	The Bidder's system must allow for continued use of the system during backups. Describe your ability to meet this requirement.				
Response:					

END OF SECTION 3.1.6

3.1.7 **Disaster Recover and Business Continuity**					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
3.1.7.1	Describe your proposed disaster recovery and business continuity plan. Describe the testing methodology and frequency for recovery.				
Response:					
3.1.7.2	The ASB must perform an annual disaster recovery test demonstrating the efficacy of their Disaster Recovery Plan. Describe your ability to meet this requirement.				
Response:					

END OF SECTION 3.1.7

3.1.8 **Test Environments**					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
3.1.8.1	Describe how the Bidder controls the software promotion process through the testing approval process using an automatic management and version control tool. Identify the tools used for software promotion, testing, and version control.				
Response:					
3.1.8.2	Ability to provide a User Acceptance Test environment that mirrors the production environment of the POS solution.				
Response:					
3.1.8.3	Ability to use claims data necessary to meet the testing objectives.				
Response:					
3.1.8.4	Ability to maintain regression test case packets to support regression test methods.				
Response:					
3.1.8.5	Ability to compare regression testing results and automatically identify variations from expected results.				
Response:					

END OF SECTION 3.1.8

3.1.9 **Interfaces**					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
3.1.9.1	Describe your product's application programming interface (API) architecture for the exchange of data between your system and others.				
Response:					
3.1.9.2	Describe how the Bidder's solution will support the required interfaces to and from the MMIS and other partner systems as outlined in Attachment 6, *Interfaces*.				
Response:					
3.1.9.3	Ability to produce load reports that monitor and report performance of all electronic data exchange into and out of the POS.				
Response:					
3.1.9.4	Describe how you identify and respond to load issues and make modifications to the POS to meet demand.				
Response:					
3.1.9.5	Bidder's solution must be able to receive Prior Authorizations (PA) as a faxed or scanned form and import the contents of the PA to the POS system. Describe your ability to meet this requirement.				
Response:					
3.1.9.6	Bidder's solution is compatible with a modern IVR system and can return a Prior Authorization status update. Describe your ability to meet this requirement.				
Response:					

END OF SECTION 3.1.9

3.1.10 **Health Insurance Portability and Accountability Act**					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
3.1.10.1	The Bidder solution must comply with all HIPAA current and future rules as they become final or amendments to final rules. Describe your ability to meet this requirement.				
Response:					
3.1.10.2	Describe in detail how the proposed solution uses current and supports future encryption/decryption standards for sensitive HIPAA Level 1-4 data, (e.g. Social Security Number, address, medical information), both at rest stored in the database and in transit.				
Response:					
3.1.10.3	Describe how the Bidder's solution provides masking of personally identifiable information (PII), HIPAA, or other state category 3 and above data within development, test, and live environments unless authorized to view such data.				
Response:					
3.1.10.4	Ability to test the transmission of electronic claims for new providers or providers who have changes in provider software or billing agency to ensure HIPAA and Companion Guide (CG) compliance. Testing must be completed through a complete payment cycle prior to authorizing live submissions.				
Response:					

END OF SECTION 3.1.10

END OF SECTION 3

SECTION 4. FUNCTIONAL PROPOSAL

The prompts within this section consists only of MS Requirements, and each requirement will be scored.

Bidders must respond to the requirements below in accordance with Section 7.6.3, Proposal Format Instructions, which includes instructions on filling out each cell within the requirements tables within this Section 4.

4.1 ELIGIBILITY & PHARMACY BENEFIT PLANS

The POS system must have the ability to integrate with the MMIS (ProviderOne) system to receive real-time and accurate information regarding client eligibility, insurance, and demographic information on individuals eligible for HCA programs in the State of Washington. This data is required to support all eligibility determination and claims processing functions and to provide accurate reporting and analysis functions.

It is HCA's desire to leverage upgraded technology and provide consistent and real-time information from ProviderOne to the new POS. HCA requires the ability to configure Pharmacy Benefit Plans in the POS using a broad set of characteristics from client demographics, eligibility, claim characteristic, provider characteristics and groups of procedures, diagnoses and drugs. Assignment of clients to Pharmacy Benefit Plans is maintained in the POS. Although not currently implemented, HCA needs the ability to configure a Copay within a benefit plan based on a broad range of criteria.

REQUIREMENTS TABLE ON THE FOLLOWING PAGE

4.1.1 **General** (**2-Page Limit** for Response to Section 4.1.1.1; **1-Page Limit** per Response to Sections 4.1.1.2 – 4.1.1.14)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.1.1.1	Describe your product's Eligibility and Pharmacy Benefit Plan offering and include any unique, innovative or additional features available and the advantages they bring to HCA.				
Response:					
4.1.1.2	Ability to receive client data from the MMIS in real time including, but not limited to: client demographics, Managed Care Organization (MCO) information, Third Party Liability (TPL) information, client diagnoses, and restrictions (a.k.a. lock-in).				
Response:					
4.1.1.3	Ability to use the client ID from the MMIS as the client ID in POS.				
Response:					
4.1.1.4	Ability to maintain and associate multiple client IDs and link those IDs for the same client.				
Response:					
4.1.1.5	Ability to view, define and configure (create and modify) pharmacy benefit plans using a broad range of characteristics from client demographics, eligibility, claim characteristics, provider characteristics, ranges or groups of procedures, diagnoses, or National Drug Codes (NDC).				
Response:					
4.1.1.6	Ability to view, define and configure pharmacy benefit plans to identify clients as Indian Health Service (IHS) eligible American Indian (AI)/Alaska Native (AN) clients.				
Response:					

4.1.1 **General** (**2-Page Limit** for Response to Section 4.1.1.1; **1-Page Limit** per Response to Sections 4.1.1.2 – 4.1.1.14)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.1.1.7	Ability to identify client restrictions that originate in the MMIS and define pharmacy benefit plans that restrict all benefits to a specific provider (prescriber) and/or specific pharmacy location.				
Response:					
4.1.1.8	Ability to modify client restriction data in the POS, including effective/end dates, assigned provider (prescriber) and assigned pharmacy directly in POS to support claims processing.				
Response:					
4.1.1.9	Ability to view current and historical claims data and the client's corresponding eligibility data that applied at the time of claim adjudication.				
Response:					
4.1.1.10	Ability to define and configure single or tiered copay in pharmacy benefit plans on a broad range of criteria that include, but are not limited to, client demographics, drug, drug class, price ranges.				
Response:					
4.1.1.11	Ability to accumulate client cost share (e.g. deductible, maximum out of pocket costs, or copay accumulator).				
Response:					
4.1.1.12	The ability to search current and historical client data using a combination of single, partial, and multiple filters. Examples: MMIS client ID, last name + date of birth, range of from-to eligibility dates, last name + Recipient Aid Category (RAC) + county.				
Response:					

4.1.1 **General** (**2-Page Limit** for Response to Section 4.1.1.1; **1-Page Limit** per Response to Sections 4.1.1.2 – 4.1.1.14)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.1.1.13	Ability to upload files to mass update current client information.				
Response:					
4.1.1.14	Ability to feed client data with POS information back to the MMIS on at least a weekly basis.				
Response:					

END OF SECTION 4.1

4.2 PROVIDER

The Washington State MMIS is the system of record for all Provider types including Prescriber and Pharmacy Providers. The MMIS includes providers who practice in multiple provider locations and may have more than one Drug Enforcement Administration (DEA) number in the MMIS for the same National Provider Indicator (NPI). The MMIS manages enrollment and credentialing of these Providers and currently feeds Provider data to the POS on a nightly basis. HCA's desire is to leverage upgraded technology and provide consistent and real-time Provider information from the MMIS to the new POS.

HCA requires the ability to manage additional data about Prescribers and Pharmacies in the POS, including the ability to configure groups and assign Providers to multiple groups/networks. Some examples of providers groups that need to be managed in the POS are:

- Endorsing providers - Washington State contracts with the Center for Evidence-Based Policy (Oregon EPC), Oregon Health and Science University (OHSU) and classifies providers as "Endorsing" when there is agreement to automatically interchange any non-preferred drug with a preferred drug in that therapeutic class. The endorsing provider information is received from OHSU on a weekly basis and loaded into the POS.
- Managed Care Organizations (MCO) - Washington's MMIS also treats Managed Care Organizations (MCO) as a type of provider.

REQUIREMENTS TABLE ON THE FOLLOWING PAGE

4.2.1 **General** (**2-Page Limit** for Response to Section 4.2.1.1; **1-Page Limit** per Response to Sections 4.2.1.2 – 4.2.1.11)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.2.1.1	Describe your product's Provider offering and include any unique, innovative or additional features available and the advantages they bring to HCA.				
Response:					
4.2.1.2	Describe any additional source files or services your product uses to acquire or validate provider data.				
Response:					
4.2.1.3	Ability to receive provider (prescriber and pharmacy) data from the MMIS in real time.				
Response:					
4.2.1.4	Ability to view and use all provider records if there are multiple Drug Enforcement Agency (DEA) numbers associated with the same National Provider Identification number (NPI) to support claims processing functions.				
Response:					
4.2.1.5	Ability to maintain and associate multiple MMIS provider IDs, such as NPI, for the same provider.				
Response:					
4.2.1.6	Ability to maintain and store current and historical provider data, such as type, specialty, taxonomy, Employer Identification Number (EIN), license information, and other data to support claims processing.				
4.2.1.7	Ability to use effective start and end dates that support provider eligibility (e.g., sanctions, inactive or 340b status) to support claims processing and drug rebate.				

4.2.1 **General** (**2-Page Limit** for Response to Section 4.2.1.1; **1-Page Limit** per Response to Sections 4.2.1.2 – 4.2.1.11)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
Response:					
4.2.1.8	Ability to reactivate inactive providers, either manually or automatically.				
Response:					
4.2.1.9	Ability to define, configure and group the providers, based on provider attributes for both prescribers and pharmacies, to facilitate claims processing and reporting, including but not limited to, provider types, specialties, taxonomy, pharmacy dispensing tier, pharmacy unit dose enrolled status, endorsing provider (practitioner and dental), tribal indicator, and 340B indicator. A provider (both prescribers and pharmacies) may belong to more than one group/network.				
Response:					
4.2.1.10	Ability to import data, as often as weekly, for endorsing providers from an external source file.				
Response:					
4.2.1.11	Ability to define and configure IHS and tribal pharmacies as eligible to receive the encounter-based rate for services provided to their IHS-eligible AI/AN clients only, while allowing standard rates for services to all other clients.				
Response:					

END OF SECTION 4.2

4.3 DRUG REFERENCE FILE

The POS drug reference file functions must allow HCA staff the ability to add, update or overwrite elements of the drug reference data to accommodate HCA-required changes for its current and future pharmacy programs. This includes the ability to quickly add or change indicators and rules over time in response to legislative changes to the WA Pharmacy program.

Detailed drug and pricing information is currently obtained weekly from Medi-Span and First Data Bank and are loaded into POS for use during claims adjudication. HCA desires the ability to obtain drug reference information from both Medi-Span and First Databank as well as product and pricing information from the Centers for Medicare and Medicaid (CMS) Drug Data Reporting (DDR) system to fully manage the pharmacy and drug rebate programs.

REQUIREMENTS TABLE ON THE FOLLOWING PAGE

4.3.1 **General** (**2-Page Limit** for Response to Section 4.3.1.1; **1-Page Limit** per Response to Sections 4.3.1.2 – 4.3.1.4)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.3.1.1	Describe your product's Drug Reference File offering, including the ability to add, update or overwrite elements (e.g. change the multi-source code indicator from a "M" to a "Y") and include any unique, innovative or additional features available and the advantages they bring to HCA.				
Response:					
4.3.1.2	The ability to use the weekly drug reference information from both Medi-Span and First Databank files, as directed by HCA, to support pricing and drug rebate. The vendor solution must also import the CMS Drug Data Reporting (DDR) drug rebate file and reconcile with the drug file according to HCA department policies.				
Response:					
4.3.1.3	Ability to maintain a history of inactive and obsolete NDC's from the drug reference file.				
Response:					
4.3.1.4	Ability to generate a report of changes made on the Drug Reference file, including but not limited to date of change, time, change made and user ID as specified by HCA.				
Response:					

END OF SECTION 4.3

4.4 EDITS/BUSINESS RULES

The POS system must be capable of allowing HCA state staff the ability to add, change and remove adjudication rules, configure edits and customize transmission messages. Washington State HCA staff have significant experience in defining, managing and configuring the current POS. A rules engine or similar functionality is a key element of the new POS solution to allow state staff to perform on-going program and policy updates themselves rather than rely on the Bidder to complete this work. In addition, State staff configuration through a rules engine feature or via screen should be an easy process and one that can be accomplished by HCA program staff if needed.

The following requirements describe the different types of edits and categories of information HCA expects to be able to use to configure edits or rules for POS claims and encounter adjudication.

REQUIREMENTS TABLE ON THE FOLLOWING PAGE

4.4.1 **General** (**2-Page Limit** for Response to Section 4.4.1.1; **1-Page Limit** per Response to Sections 4.4.1.2 – 4.4.1.26)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.4.1.1	Describe your product's ability to allow HCA to configure edits and customized messages (such as through a rules engine), and continue to make changes based on future program additions. Include any unique, innovative or additional features available and the advantages they bring to HCA.				
Response:					
4.4.1.2	Ability to define and configure and maintain edit dispositions based on criteria specified by HCA.				
Response:					
4.4.1.3	Ability to define and configure an unlimited number of edits and business rules for POS claim rejection that can be tied to standard NCPDP Drug Utilization Review (DUR) reject codes for claim denial and/or ProDUR.				
Response:					
4.4.1.4	Ability to define and add additional text to accompany standard NCPDP DUR reject codes and their messages.				
Response:					
Note: The statement below applies to requirements 4.4.1.5-4.4.1.26. The Bidder's claims processing system must have functionality to provide unique editing and claims/encounter processing adjudication rules as specified and configured by HCA for each of the individual programs and data characteristics, including, but not limited to:					
4.4.1.5	Client and/or Pharmacy Benefit Plan Restrictions – ability to define and configure benefit plan restrictions that apply to a given Client including but not limited to: benefit restrictions on a lock-in or other monitoring programs, living arrangements (e.g. ambulatory vs long-term care settings), managed care status, Medicare status, Third Party Liability and eligibility for other HCA programs.				
Response:					

4.4.1 **General** (**2-Page Limit** for Response to Section 4.4.1.1; **1-Page Limit** per Response to Sections 4.4.1.2 – 4.4.1.26)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.4.1.6	Prescriber Validation – ability to define and configure edits to validate the prescriber on the claim as eligible based on real-time information from the provider subsystem in the MMIS. This includes drugs written by a dentist and endorsing providers.				
Response:					
4.4.1.7	Sanctioned Providers – ability to define and configure edits to validate and deny payment for sanctioned providers (e.g. prescribers or pharmacies) as designated by the state or federal government.				
Response:					
4.4.1.8	Out of State (OOS) Providers – ability to define and configure edits and process claims for OOS providers that meet HCA's reimbursement criteria.				
Response:					
4.4.1.9	Authorized Prescribers – ability to define and configure edits and limit payment for specific drugs, classes, or specific HCA programs to authorized prescribers as designated by HCA.				
Response:					
4.4.1.10	Reference File – ability to define and configure edits to apply HCA-specific payment criteria based on Medi-Span, FDB and other reference files as designated by HCA.				
Response:					
4.4.1.11	Co-Payments – ability to define and configure edits to apply different co-payment amounts as specified by HCA including but not limited to, different benefit plans, client attributes and drug products.				
Response:					

4.4.1 **General** (**2-Page Limit** for Response to Section 4.4.1.1; **1-Page Limit** per Response to Sections 4.4.1.2 – 4.4.1.26)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.4.1.12	Prior Authorizations (PA) – ability to define and configure edits for drugs requiring PA or bypass PA requirements when pre-defined criteria have been met based on HCA policy. HCA intends to automate PAs as much as possible based on multiple criteria including pharmacy and medical claims history information.				
Response:					
4.4.1.13	Diagnosis-Specific – ability to define and configure edits for drugs requiring submission of specific diagnosis codes.				
Response:					
4.4.1.14	Age-Specific – ability to define and configure edits for drugs requiring client age restrictions.				
Response:					
4.4.1.15	Managed Care – ability to define and configure edits for a number of HCA defined policies, including but not limited to, client enrollment in a managed care program, adding new MC programs to a benefit plan and determining if a particular drug is a carve-out of the capitated rate and eligible for FFS.				
Response:					
4.4.1.16	Compounded Drugs – ability to define and configure edits for compound drug claims as designated by HCA.				
Response:					
4.4.1.17	Preferred Drug List and Other Formulary – ability to define and configure edits for preferred, non-preferred, and non-covered drugs at the Generic Product Identifier (GPI) or drug class level to different client's benefit plans.				
Response:					

4.4.1 **General** (**2-Page Limit** for Response to Section 4.4.1.1; **1-Page Limit** per Response to Sections 4.4.1.2 – 4.4.1.26)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.4.1.18	Quantity, Days' Supply, Limits, and Frequency of Service – ability to define and configure edits for claims to assure that the quantity of services, supply, limit and frequency is consistent with HCA's policies to include using pharmacy and medical claims history information.				
Response:					
4.4.1.19	Proposed Less-Than-Effective Drugs – ability to define and configure edits on drugs that the federal government has identified as proposed less than effective under the Therapeutic Equivalency Code (TEC) program or other CMS qualifying designation.				
Response:					
4.4.1.20	Other CMS-Restricted Drugs – ability to define and configure edits for any drug that CMS has identified as restricted.				
Response:					
4.4.1.21	Approved Manufacturers – ability to define and configure edits to reject claims for drugs from manufacturers who are not participating in the Medicaid drug rebate program.				
Response:					
4.4.1.22	340B Providers – ability to define and configure edits based on valid submitted values (e.g. NPI, submission clarification code) for use in claims adjudication and processing.				
Response:					
4.4.1.23	Morphine Milligram Equivalent – ability to define and configure edits for the MME of opioids as specified by HCA.				
Response:					

4.4.1 **General** (**2-Page Limit** for Response to Section 4.4.1.1; **1-Page Limit** per Response to Sections 4.4.1.2 – 4.4.1.26)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.4.1.24	Managed Care Encounter Processing – ability to define and configure a unique set of edits and edit dispositions to managed care encounter records as specified by HCA.				
Response:					
4.4.1.25	Pharmacy Tribal Encounter Reimbursement – ability to define, configure and use a unique set of edits to validate IHS eligible American Indian/Alaskan Native (AI/AN) Clients and IHS or Tribal Pharmacies and their eligibility for an encounter-based reimbursement rate.				
Response:					
4.4.1.26	Pricing & Reimbursement – ability to define, configure and use specific pricing edits as defined by HCA, including but not limited to identifying upper and lower limits and differences between billed charge and price of the product.				
Response:					

END OF SECTION 4.4

4.5 PRIOR AUTHORIZATION

Pharmacy prior authorization (PA) requests are submitted to the Health Care Authority by a Pharmacy when a POS claim has rejected and a PA is needed to fill the prescription. Pharmacy staff and prescribers can request authorization by faxing a state-designed paper request form, via phone call or in rare cases mailing in the request to HCA. Although the new POS solution must continue to support these legacy methods, HCA is looking to enhance current operational procedures by reducing paper requests and allow both pharmacies and/or prescribers to submit a PA request via an on-line secure portal. The portal would also allow providers to monitor the PA request, submit or attach additional information as required and retrieve applicable correspondence related to the PA request.

HCA also desires robust PA workflow management processes including dashboard-type functionality that is accessible to state staff. State supervisory staff need an efficient way to assign work, ensure state staff are completing requests within approved timelines and monitor staff performance. State staff need the ability to understand their workload and be alerted when deadlines are approaching.

HCA intends to leverage updated technology within newer POS PA components to allow state staff to configure the criteria to automate PA approvals wherever possible. This is turn will reduce staff workload and the manual processing needed of many PA requests. Currently, HCA uses a process referred to as Expedited Authorization to automate approval of many of the PA requests. Expedited Authorization approval is achieved when a pharmacy submits a pre-defined PA number on the claim that attests to certain client conditions. It is the desire of HCA to eliminate the need for Expedited Authorizations and find additional ways to achieve the same outcomes. It is also HCA's desire to automate PA denials if specific information is not received within HCA-defined timelines.

Prior Authorization processing results in correspondence that is either printed locally and faxed or printed centrally and mailed using existing State print facilities. PA requests may also be faxed back to the prescriber when more information is needed. Although these processes will continue to need to be supported, HCA is looking to maximize the on-line portal usage for correspondence retrieval to reduce paper printing and mailing costs as well as minimize the amount of faxing that state staff are currently required to perform. Correspondence template functionality in the new system must support the nine languages currently required by HCA. The nine supported languages include the following: English, Chinese, Cambodian-Khmer, Korean, Laotian, Russian, Somali, Spanish and Vietnamese.

The POS needs the ability to send Prior Authorization data back to the MMIS for use in analytics to the data warehouse.

REQUIREMENTS TABLE ON THE FOLLOWING PAGE

4.5.1 **General** (**2-Page Limit** for Response to Section 4.5.1.1; **1-Page Limit** per Response to Sections 4.5.1.2 – 4.5.1.8)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.5.1.1	Describe your product's Prior Authorization offering and include any unique, innovative or additional features available and the advantages they bring to HCA.				
Response:					
4.5.1.2	Ability to assign and use a unique Prior Authorization number which can be associated with claims.				
Response:					
4.5.1.3	Ability to use Prior Authorization (PA) effective dates for processing claims against that PA.				
Response:					
4.5.1.4	Ability to update data fields in an existing Prior Authorization (PA) (e.g. update the end date to extend the PA) regardless of whether a claim has been processed against that PA.				
Response:					
4.5.1.5	Ability for Providers (through an online portal) and HCA staff to add date-specific free form comments to the Prior Authorization (PA). HCA staff and pharmacists need the ability to add an unlimited amount of comments.				
Response:					
4.5.1.6	Ability for a very select number of HCA staff, controlled by user profile, to delete comments on a PA record for situations such as when data was applied to the wrong client.				
Response:					
4.5.1.7	Ability to define and configure and capture the source (input method) of the Prior Authorization, including but not limited to fax, phone, portal, mail.				

4.5.1 **General** (**2-Page Limit** for Response to Section 4.5.1.1; **1-Page Limit** per Response to Sections 4.5.1.2 – 4.5.1.8)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
Response:					
4.5.1.8	Ability to capture prior authorization data from a faxed-in request and automatically generate a prior authorization record that is available in the workflow and processes according to state-specific rules.				
Response:					

END OF SECTION 4.5.1

4.5.2 **Workflow and Prior Authorization Status** (**1-Page Limit** per Response to Sections 4.5.2.1 – 4.5.2.5)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.5.2.1	Ability to define and configure Prior Authorization categories for workflow assignment and track, manage, monitor, and report all workflow changes, including time spent in each stage and cumulative overall time to complete the PA.				
Response:					
4.5.2.2	Ability to capture and retain the date of the Prior Authorization determination or decision.				
Response:					
4.5.2.3	Ability to change workflow assignments and route Prior Authorizations. Access to this ability to be limited to a set of users.				
Response:					
4.5.2.4	Ability to automatically update the status of a Prior Authorization record when additional required PA data has been received from the provider.				
Response:					
4.5.2.5	Ability to define and configure automated changes to the status of a Prior Authorization based on a configurable list of rules, including, but not limited to, passage of time intervals which govern required action.				
Response:					

END OF SECTION 4.5.2

4.5.3 **Exception Processing** (**1-Page Limit** per Response to Sections 4.5.3.1 – 4.5.3.9)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.5.3.1	Ability to use a Prior Authorization to adjust the price a pharmacy will be paid on a claim-by-claim basis.				
Response:					
4.5.3.2	Ability to define and configure PA criteria to support automatic approval of PA requests that meet that criteria, including but not limited to automatic generation of a PA for clients with chronic conditions based on continued eligibility for a program.				
Response:					
4.5.3.3	Ability to define and configure Prior Authorization limitations controlling the dispensing of products with effective date ranges, including but not limited to, total units per year with a monthly limit, dollar limit, age group limit and combinations of elements.				
Response:					
4.5.3.4	Ability to identify a Prior Authorization request for which an Administrative review/appeal has been filed, and track the comments and outcome.				
Response:					
4.5.3.5	Ability to select a rejected claim and generate a new Prior Authorization from it, prepopulating PA data from the rejected claim.				
Response:					
4.5.3.6	Ability for authorized state personnel to use a denied PA, update with newly acquired information and create a new PA request for processing.				
Response:					
4.5.3.7	Ability to define and configure criteria for override codes that will bypass any Prior Authorizations or limitations for exceptional cases.				

4.5.3 **Exception Processing** (**1-Page Limit** per Response to Sections 4.5.3.1 – 4.5.3.9)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
Response:					
4.5.3.8	Ability to define and configure criteria associated with a system-assigned PA or override number (Pre-selected PA number).				
Response:					
4.5.3.9	Ability to process claims when a service that meets the predefined criteria and is paid by submitting a preselected PA or override number.				
Response:					

END OF SECTION 4.5.3

4.5.4 **Correspondence** HCA requires functionality from the Bidder that will allow the creation and storage of PA templates within the new solution provided. The Bidder will not be required to mail out the correspondence but instead generate and provide a data file to the State printing facility. (**2-Page Limit** for Response to Section 4.5.4.1); **1-Page Limit** per Response to Sections 4.5.4.2 – 4.5.4.7)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.5.4.1	Describe your product's Correspondence offering and include any unique, innovative or additional features available and the advantages/benefits they bring to HCA.				
Response:					
4.5.4.2	Ability to define, create, configure, and store templates for correspondence to prescribers, pharmacies and clients in at least nine languages supported by HCA.				
Response:					
4.5.4.3	Ability to automatically generate and print Prior Authorization approval, pending or denial correspondence to clients, pharmacies and prescribers.				
Response:					
4.5.4.4	Ability to send a data file to the State printing facility for printing and mailing of PA correspondence.				
Response:					
4.5.4.5	Ability to upload and associate Prior Authorization supporting documents received via mail, fax, or portal to a PA record.				
Response:					
4.5.4.6	Ability for state staff to attach documents or forms to correspondence prior to faxing or mailing.				
Response:					

4.5.4 **Correspondence** HCA requires functionality from the Bidder that will allow the creation and storage of PA templates within the new solution provided. The Bidder will not be required to mail out the correspondence but instead generate and provide a data file to the State printing facility. (**2-Page Limit** for Response to Section 4.5.4.1); **1-Page Limit** per Response to Sections 4.5.4.2 – 4.5.4.7)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.5.4.7	Ability to search, sort, and filter all documents, images, and attachments associated with a Prior Authorization.				
Response:					

END OF SECTION 4.5.4

4.5.5 **Dashboard Functionality** (**2-Page Limit** for Response to Section 4.5.5.1)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.5.5.1	Ability to provide a performance dashboard, accessible by state staff and customizable by user, that is updated in real time for viewing and monitoring the end-to-end processing of PA requests. This includes, but is not limited to, the ability to capture the receipt, status changes in workflow, user name, and elapsed time in process.				
Response:					

END OF SECTION 4.5.5

4.5.6 **Web-based Prior Authorization Portal** (**2-Page Limit** for Response to Section 4.5.6.1 and 4.5.6.2)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.5.6.1	Ability for providers (pharmacies and/or prescribers) to access a secure web-based portal to enter in Prior Authorization requests, add/upload supporting documentation, view correspondence, view status of request and receive notifications.				
Response:					
4.5.6.2	Describe any additional features available with your product's web-based Portal offering including, but not limited to, the ability resurrect a denied request and resubmit, or to perform editing (e.g. client eligibility) while a provider is entering a request.				
Response:					

END OF SECTION 4.5.6 & END OF SECTION 4.5

4.6 CLAIMS AND ENCOUNTERS

The POS claims processing system must be able to receive and process real-time electronic claims for adjudication and immediately notify the provider of the claim disposition. The state of Washington does not accept paper claims.

The POS claims processing system must accept, and process claims in the current National Council for Prescription Drug Program (NCPDP) format and have the ability to support future formats without additional cost to HCA. The POS claims processing system must also support both provider and state staff claims adjustments. The POS system must be fully Accredited Standards Committee (ASC) X12 compliant and receive and maintain Centers for Medicare and Medicaid (CMS) federal certification.

In addition, the POS claims processing system must able to accept and process these additional transactions noted below and apply state-specific rules per HCA direction. These claims and encounters are initially accepted through the MMIS:

- Medical Fee for Service (FFS) claims that include a National Drug Code (NDC) are sent to the POS for adjudication and inclusion in claims history and drug rebate.
- MCO pharmacy encounters are accepted in the POS for adjudication and inclusion in claims history and drug rebate.
- MCO medical encounters that include an NDC are sent to the POS for adjudication and inclusion in claims history and drug rebate.

Encounters can be received daily and are central to HCA's ability to fulfill a variety of federal reporting requirements including rate setting and utilization management activities.

HCA requires the ability to set up all pricing rules in the POS, including the ability to price compound drugs at the ingredient level and establish the pharmacy actual acquisition cost (AAC) based upon the available prices in the drug file. POS will need functionality that allows for a reimbursement algorithm based on the lowest of the available rates using the following price points:

- National average drug acquisition cost (NADAC)
- Maximum allowable cost (MAC)
- Federal Upper Limit (FUL)
- Automated maximum allowable cost (AMAC)
- Provider's usual and customary charge to the Non-Medicaid population
- AAC for drugs purchased under section 340B of the Public Health Services (PHS) Act and dispensed to medical assistance clients

As part of the weekly payment processing cycle, the POS system will be required to send claims/encounters and adjudication results to the MMIS. All payments, including the remittance advice (RA), to POS providers will continue to be made from the MMIS. The results of payment processing will be sent back to the POS, including warrant, RA information, Transaction Control Number (TCN) and account code details.

The POS system will also be required to send claims and encounters to the Drug Rebate component to support rebate invoicing processes.

REQUIREMENTS TABLE ON THE FOLLOWING PAGE

4.6.1 **General** (**2-Page Limit** for Response to Section 4.6.1.1; **1-Page Limit** per Response to Sections 4.6.1.2 – 4.6.1.13)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.6.1.1	Describe your product's Claims and Encounter processing offering and include any unique, innovative or additional features available and the advantages they bring to HCA.				
Response:					
4.6.1.2	Ability to accept electronic claims data in the current HIPAA-adopted NCPDP format for both Fee for Service (FFS) claims and Managed Care Organization (MCO) encounters. This includes the ability to support additional or updated NCPDP formats within the contract period.				
Response:					
4.6.1.3	Ability to establish and maintain control procedures to ensure that all electronic claims and encounters are processed appropriately, including a full reconciliation of all records submitted, the number of submitted records not imported into POS, and a description of the error(s) for those records not imported.				
Response:					
4.6.1.4	Ability to capture all data submitted in NCPDP format as part of the claim/encounter record regardless of whether it is used for processing the claim.				
Response:					
4.6.1.5	Ability to accept batch files in the NCPDP format.				
Response:					
4.6.1.6	Ability to accept and process medical claims and encounters with NDC’s from the MMIS.				
Response:					

4.6.1 **General** (**2-Page Limit** for Response to Section 4.6.1.1; **1-Page Limit** per Response to Sections 4.6.1.2 – 4.6.1.13)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.6.1.7	Ability to process claims denied by the MCO as encounter records and include capturing the denial reason.				
Response:					
4.6.1.8	Ability to distinguish encounter records from FFS claims and apply unique edits to validate the data, including but not limited to, provider or recipient on file. Encounters that fail the user defined edits will receive a disposition of "Rejected."				
Response:					
4.6.1.9	Ability to differentiate the source of FFS claims and Encounter data: for example, FFS claims from pharmacies, MCO NCPDP encounters, medical FFS claims with NDC's and MCO encounters with NDC's from the MMIS.				
Response:					
4.6.1.10	Ability to capture the MMIS TCN for medical claims with NDC's that are sent to the POS for processing and maintain this transaction number as the primary transaction number in the POS.				
Response:					
4.6.1.11	Ability to use multiple sets of drug coverage limitations when the client falls into more than one pharmacy benefit category, and apply a benefit coverage hierarchy to facilitate claim processing. For example, a client on Medicare that also resides in a skilled nursing facility and has coverage for both.				
Response:					
4.6.1.12	Ability to capture all PA's submitted on the claim and all PA's used to adjudicate the claim at the time of claims processing. This includes allowing state staff to easily view the PA's from the claim record.				
Response:					

4.6.1 **General** (**2-Page Limit** for Response to Section 4.6.1.1; **1-Page Limit** per Response to Sections 4.6.1.2 – 4.6.1.13)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.6.1.13	Ability to associate TPL-recovered dollars without adjusting the claim(s).				
Response:					

END OF SECTION 4.6.1

4.6.2 **Pricing** (**1-Page Limit** per Response to Sections 4.6.2.1 – 4.6.2.12)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.6.2.1	Ability to evaluate the results of pricing algorithms to determine which of several methods apply to a specific NDC and use the method which yields the lowest net cost.				
Response:					
4.6.2.2	Ability to apply pricing rules and determine the price for a medical claim/encounter with a National Drug Code (NDC) received from the MMIS.				
Response:					
4.6.2.3	Ability to maintain a history of rates and their respective effective dates for up to 10 years.				
Response:					
4.6.2.4	Ability to define, configure, and use date effective pricing rules for claims and encounters which support automatic selection of the appropriate price for the claim line item on a compound. Pricing rules to be applied to individual ingredient lines of the compound claim.				
Response:					
4.6.2.5	Ability to override the rate of a claim and either select an alternate pricing method or manually enter a new price.				
Response:					
4.6.2.6	Ability to price a claim based on the combination of a Prior Authorization (PA) code and a drug product code.				
Response:					
4.6.2.7	Ability to price a claim based on the presence of another product(s) in claims history for the client.				

4.6.2 **Pricing** (**1-Page Limit** per Response to Sections 4.6.2.1 – 4.6.2.12)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
Response:					
4.6.2.8	Ability to retain both the selected pricing method and the resulting price for claims as well as encounters, regardless of whether the claim/encounter is paid or denied.				
Response:					
4.6.2.9	Ability to define and use provider-specific rates for dispensing fees.				
Response:					
4.6.2.10	Ability to price claims based on provider characteristics.				
Response:					
4.6.2.11	Ability to apply state-defined co-payments at the time of adjudication.				
Response:					
4.6.2.12	Ability to price and reimburse qualified tribal pharmacies at an encounter-based rate for services provided to IHS-eligible qualified tribal members.				
Response:					

END OF SECTION 4.6.2

4.6.3 **Payment Details/Results** (**1-Page Limit** per Response to Sections 4.6.3.1 – 4.6.3.2:					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.6.3.1	Ability to extract FFS claim and encounter data processing results and send to the MMIS via a daily interface.				
Response:					
4.6.3.2	Ability to receive payment results from the MMIS and associate to each paid POS claim the warrant number, warrant amount, TCN, AFRS account coding, and remittance advice information.				
Response:					

END OF SECTION 4.6.3

4.6.4 **Adjustments/Mass Adjustments** (**1-Page Limit** per Response to Sections 4.6.4.1 – 4.6.4.3)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.6.4.1	Ability to process different claim and encounter adjustments, including but not limited to, provider or state initiated and mass adjustments.				
Response:					
4.6.4.2	Ability to identify the type and source of any adjustment performed.				
Response:					
4.6.4.3	Ability to define criteria for a mass adjustment for state users to evaluate and modify the results prior to final submission by state staff.				
Response:					

END OF SECTION 4.6.4 & END OF SECTION 4.6

4.7 COORDINATION OF BENEFITS / THIRD-PARTY LIABILITY

The POS system must have the ability to validate claims to determine whether there is a liable third party that must be billed prior to billing HCA, which is the payer of last resort. Third party liability (TPL) information, combined with client information is transferred to the POS from the MMIS and must be used to ensure all other payment opportunities are exhausted. The POS system must have the functionality to report TPL plan information to the billing providers when another payer is primary or available as well as capture any TPL information submitted on the claims.

The POS system must also maintain Medicare Plan indicators to identify Medicare eligibility and applicable drugs covered under that plan and process claims accordingly. Obtaining maximum cost avoidance and reimbursement for clients covered by third parties is an important objective of HCA.

REQUIREMENTS TABLE ON THE FOLLOWING PAGE

4.7.1 **General** (**2-Page Limit** for Response to Section 4.7.1.1; **1-Page Limit** per Response to Sections 4.7.1.2 – 4.7.1.8)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.7.1.1	Describe your product's Coordination of Benefits/Third Party Liability (COB/TPL) offering and include any unique, innovative or additional features available and the advantages they bring to HCA.				
Response:					
4.7.1.2	Ability to view and access Third Party Liability (TPL) insurance information received from the MMIS to support accurate coordination of benefits processing.				
Response:					
4.7.1.3	Ability to return TPL plan information to billing providers when another payer is primary (or available).				
Response:					
4.7.1.4	Ability to view and access Medicare Part B, C and D plan information received from the MMIS to support accurate coordination of benefit processing.				
Response:					
4.7.1.5	Ability to process Medicare Part B cross-over claims.				
Response:					
4.7.1.6	Ability to manually update Third Party Liability (TPL) information in POS if needed to support coordination of benefit processing.				
Response:					
4.7.1.7	Ability to identify, track and report all cost avoided amounts due to third party liability (TPL) coverage when a claim is denied due to TPL, or when a primary insurance payment impacts the Medicaid reimbursement amount.				
Response:					

4.7.1 **General** (**2-Page Limit** for Response to Section 4.7.1.1; **1-Page Limit** per Response to Sections 4.7.1.2 – 4.7.1.8)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.7.1.8	Ability to capture the primary payer's TPL information, including co-payments, submitted on claims and apply during the time of claims processing.				
Response:					

END OF SECTION 4.7

4.8 DRUG REBATE

The Medicaid Drug Rebate Program (MDRP) is a federal program authorized by Section 1927 of the Social Security Act. The program requires drug manufacturers to participate in a rebate program with state Medicaid agencies in exchange for coverage of most of their drugs.

HCA staff fully manage the federal Drug Rebate Program in Washington. This includes support and management of invoicing for Supplemental and value-based rebates. Drug rebate processing is currently accomplished both in the drug rebate component of the legacy POS system and the MMIS. The legacy drug rebate component contains a set of programs and procedures that support quarterly drug rebate invoicing. The MMIS is considered the system of record for the processing of manufacturer invoice payments. Payments and other accounts receivable functions will continue to be recorded in the MMIS as that system directly interfaces with Washington's financial system.

It is the intent of HCA to procure a flexible system that can support electronic invoicing and a means for manufacturers to access their individual invoice data electronically. The system must also have the ability to allow staff to manage all drug rebate programs including; updating labeler information, real-time access to claims level detail to support invoicing disputes/resolution and the ability to perform ad-hoc queries for information within the drug rebate component.

REQUIREMENTS TABLE ON THE FOLLOWING PAGE

4.8.1 **General** (**2-Page Limit** for Response to Section 4.8.1.1)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.8.1.1	Describe your product's Drug Rebate offering and include any unique, innovative or additional features available and the advantages they bring to HCA.				
Response:					

END OF SECTION 4.8.1

4.8.2 **State Configuration/Usage** (**1-Page Limit** per Response to Sections 4.8.2.1 – 4.8.2.9)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.8.2.1	Ability to import and maintain the CMS Quarterly Unit Rebate Amount file, Unit Rebate Offset Amount file and Labeler file.				
Response:					
4.8.2.2	Ability to separately configure and identify traditional rebates from supplemental or value-based rebates as defined by contract.				
Response:					
4.8.2.3	Ability to create a conversion factor to address Unit of Measure changes for invoicing and rebate purposes.				
Response:					
4.8.2.4	Ability to update labeler information in the drug rebate system.				
Response:					
4.8.2.5	Ability to identify claims/encounters which are eligible for drug rebate and exclude those that are ineligible for drug rebate.				
Response:					
4.8.2.6	Ability for medical claims/encounters which contain NDCs to be included in the drug rebate process.				
Response:					
4.8.2.7	Ability for drug rebate staff to access all invoice claim level detail online.				
Response:					
4.8.2.8	Ability to maintain 10 years of drug rebate data.				

4.8.2 **State Configuration/Usage** (**1-Page Limit** per Response to Sections 4.8.2.1 – 4.8.2.9)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
Response:					
4.8.2.9	Ability to perform ad hoc queries of drug rebate information using a wide variety of search criteria.				
Response:					

END OF SECTION 4.8.2

4.8.3 **Drug Rebate Invoicing** (**1-Page Limit** per Response to Sections 4.8.3.1 – 4.8.3.7)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.8.3.1	Ability to produce electronic invoices for eligible Fee for Service (FFS) claims, Managed Care Organization (MCO) encounters, Supplemental and Value-Based Rebate agreements and claims for Physician Administered drugs.				
Response:					
4.8.3.2	Ability to produce invoices in a printable fashion such as pdf or excel.				
Response:					
4.8.3.3	Ability to calculate invoices for supplemental and value-based rebate agreements, separate from federal rebates.				
Response:					
4.8.3.4	Ability to calculate unit conversions between NDC and HCPCS units on the claim to support claim processing functions.				
Response:					
4.8.3.5	Ability to adjust claim/encounter units in the drug rebate solution solely for invoicing purposes.				
Response:					
4.8.3.6	Ability to conduct trial runs of all invoices as many times as needed to confirm the data is correct prior to closing the rebate quarter, and sorted by, but not limited to, labeler, contract, and program. This includes the ability to flag and correct claims before invoices are finalized.				
Response:					
4.8.3.7	Ability to send invoice and claim level data to the MMIS necessary for the drug rebate accounts receivable process.				

4.8.3 **Drug Rebate Invoicing** (**1-Page Limit** per Response to Sections 4.8.3.1 – 4.8.3.7)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
Response:					

END OF SECTION 4.8.3

4.8.4 **Adjustments and Disputes** (**1-Page Limit** per Response to Sections 4.8.4.1 – 4.8.4.4)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.8.4.1	Ability to produce invoices that reference changes made to claim information reported on previously produced invoices. These prior period corrections must reflect original invoice quarter.				
Response:					
4.8.4.2	Ability for any claim/encounters adjustments in MMIS or POS to be reflected in drug rebate claim details.				
Response:					
4.8.4.3	Ability to associate the claims with NDC level detail related to a manufacturer's dispute and assign a dispute category.				
Response:					
4.8.4.4	Please describe how your solution processes manufacturer’s adjustments to unit rebate amounts and considers the information for future invoices.				
Response:					

END OF SECTION 4.8.4

4.8.5 **Manufacturer Portal** (**2-Page Limit** for Response to Section 4.8.5.1)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.8.5.1	Ability to provide a secure web portal that allows manufacturers at a minimum to update their labeler information, access claim level detail specific to their invoices, and view any correspondence.				
Response:					

END OF SECTION 4.8.5 & END OF SECTION 4.8

4.9 OPERATIONAL REPORTING

The POS solution must provide a comprehensive suite of operational reports in full support of HCA programs. HCA considers operational reports to be those reports directly connected to the on-line transaction processing (OLTP) data files and whose purpose is to support OLTP functions within the modular POS solution. Examples of these reports include prior authorization and workflow management, post-adjudication claims/encounter utilization and expenditure results, and drug rebate pre- and post-invoicing support.

The POS solution must feed detailed information regarding clients, providers, prior authorization, claims/encounters, Preferred Drug List (PDL) configuration and drug rebate information to the MMIS daily so that each week an extract, transfer and load (ETL) process moves this data to the data warehouse. HCA state staff will perform analytic and compliance reporting using the data warehouse repositories. This includes CMS-64 and T-MSIS reporting, retroactive drug utilization reporting and provider fraud, waste and abuse investigations.

It is HCA's intent to leverage to the extent possible, the operational reports contained within the Bidder's suite and modify as needed to meet HCA's needs. HCA desires a flexible reporting system that can easily accommodate changes to existing reports as well as the creation of new reports to support HCA program updates. All reports should be delivered in formats that are acceptable to HCA.

HCA is also interested in any reporting tools that may be available for state staff use. The desired emphasis is for users to have most of the information they need available to them through screens, operational reports, online dashboards and portals. However, if the tool is part of combined features of the Bidder's offering, HCA would like to understand what is available and how state staff would access the tool.

REQUIREMENTS TABLE ON THE FOLLOWING PAGE

4.9.1 **General** (**2-Page Limit** for Response to Section 4.9.1.1 and 4.9.1.2; **1-Page Limit** per Response to Sections 4.9.1.3 – 4.9.1.13)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.9.1.1	Describe your product's Pharmacy operational reporting offering and suite of reports and include any unique, innovative or additional features available and the advantages they bring to HCA. Include any information regarding reporting tools or ad hoc capabilities that may also be included in your offering.				
Response:					
4.9.1.2	Describe your product's Drug Rebate operational reporting offering and suite of reports and include any unique, innovative or additional features available and the advantages they bring to HCA.				
Response:					
4.9.1.3	Ability to export all report results in multiple formats, including but not limited to Excel, Microsoft Word (.docx) and CSV so that state staff can manipulate the data.				
Response:					
4.9.1.4	Ability to produce reports that reflect PA workflow management and overall processing timeframes, including but not limited to, receipt, source, count, status, time at each stage, overall aging and processing time.				
Response:					
4.9.1.5	Ability to report on PA's and drug utilization for a specific period of time, including but not limited to, specific drug requested, prescriber, number of requests, approvals and denials.				
Response:					
4.9.1.6	Ability to report workflow productivity details for each staff member processing PA requests, including but not limited to, overall count processed each day and processing status results (e.g. number of approved, denied, pended, cancelled).				
Response:					

4.9.1 **General** (**2-Page Limit** for Response to Section 4.9.1.1 and 4.9.1.2; **1-Page Limit** per Response to Sections 4.9.1.3 – 4.9.1.13)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.9.1.7	Ability to report on claims and encounter processing results on an ad hoc basis that includes the specific DUR edit(s) applied, amount paid, captured and rejected percentages, override information, pricing information including co-payment amounts.				
Response:					
4.9.1.8	Ability to report all adjustments made to Unit Rebate Amounts (URAs) for all NDCs for a select period of time.				
Response:					
4.9.1.9	Ability to produce reports that support drug rebate pre and post invoicing processes, including but not limited to: - Labeler and associated invoices for selected quarter(s). - An individual Invoice and all claims data for that invoice. - Identify whether claims exist where the supplemental utilization value is 0 or negative. - Identify NDCs which are being used but are not being invoiced.				
Response:					
4.9.1.10	Ability to report on 340B providers showing submitted costs versus the NADAC for a specific drug.				
Response:					
4.9.1.11	Ability to report on supplemental rebate products and the contracted supplemental rate.				
Response:					

4.9.1 **General** (**2-Page Limit** for Response to Section 4.9.1.1 and 4.9.1.2; **1-Page Limit** per Response to Sections 4.9.1.3 – 4.9.1.13)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.9.1.12	Ability to produce post-adjudication utilization and expenditure reports, including but not limited to: -Preferred and Non-preferred drug utilization -Specialty Drug vs Traditional drug utilization -Prescriber patterns -Pharmacy dispensing patterns (e.g. use of DAW codes, or DUR overrides). -Top fifty drugs by total expenditure and total claims				
Response:					
4.9.1.13	Ability to report configuration updates made by HCA staff, including before and after values of updates.				
Response:					

END OF SECTION 4.9

4.10 USER AND SYSTEM DOCUMENTATION

HCA requires the ASB to provide user and system documentation that includes:

- POS user manuals and tutorials
- POS system documentation
- A complete data dictionary

The POS user manuals and tutorials must be online assets that ensure internal and external stakeholders know how to use the system to perform job functions. The user documentation must be provided in electronic form and be available in its final form during user acceptance testing and remain current throughout operations. User groups include HCA staff for all POS functions and subsystems, pharmacy and prescribers for all provider-facing functions, such as a Prior Authorization Portal and Manufacturers for manufacturer-facing functions, such as a Manufacturers' portal.

The POS system documentation provides HCA with the functional specifications of how the system functions in order for HCA to conduct proper User Acceptance Testing (UAT) and ensure the system is operating as designed. System documentation includes the technical specification for all electronic interfaces sufficient for development of the sending or receiving system to integrate with the POS. System documentation must be available in its final form prior to UAT and kept current with each subsequent release in operations prior to UAT.

The ASB must provide a complete data dictionary that includes field-level definitions for all data elements in the POS in clear business language that describes the meaning of the data, including any valid values, ranges and other business rules.

REQUIREMENTS TABLE ON THE FOLLOWING PAGE

4.10.1 **General** (**2-Page Limit** for Response to Section 4.10.1.1 – 4.10.1.4; **1-Page Limit** per Response to Sections 4.10.1.5 – 4.10.1.9)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.10.1.1	Describe your product's User documentation offering including any online manuals and/or user tutorials. Include any unique, innovative or additional features available and the advantages they bring to HCA.				
Response:					
4.10.1.2	Describe your product's System documentation offering including functional specifications and interface technical specifications. Include any unique, innovative or additional features available and the advantages they bring to HCA.				
Response:					
4.10.1.3	Describe your product's Data Dictionary offering. Include any unique, innovative or additional features available and the advantages they bring to HCA.				
Response:					
4.10.1.4	Describe your product's Online Help features. Include any unique, innovative or additional features available and the advantages they bring to HCA. Include information regarding how the help feature is continually updated.				
Response:					
4.10.1.5	User and system documentation must be kept current and available in time for user acceptance testing as all upgrades and new releases are applied to the POS during operations. Describe your ability to meet this requirement.				
Response:					
4.10.1.6	All user and system documentation must be provided to the state through a shared secure repository that is available to both Bidder and HCA staff. Describe your ability to meet this requirement.				
Response:					

4.10.1 **General** (**2-Page Limit** for Response to Section 4.10.1.1 – 4.10.1.4; **1-Page Limit** per Response to Sections 4.10.1.5 – 4.10.1.9)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.10.1.7	The Bidder must provide online user manuals, tutorial and/or other tools to ensure all user groups are fully trained in how to use the system. User groups include HCA staff, Pharmacies, Prescribers and Manufacturers. Describe your ability to meet this requirement.				
Response:					
4.10.1.8	The Bidder must provide an electronic searchable data dictionary that defines all data elements in the POS solution in clear business language. Describe your ability to meet this requirement.				
Response:					
4.10.1.9	The data dictionary must be kept current and available in time for user acceptance testing as all upgrades and new releases are applied to the POS during operations. Describe your ability to meet this requirement.				
Response:					

END OF SECTION 4.10

4.11 OPERATIONS

The ASB will be responsible for the performance and operation of the POS solution, ensuring all system functions are efficient, reliable and accurate. The Bidder is required to have established operational procedures and provide qualified personnel throughout the life of the contract. The Bidder will provide all software, facilities and supplies necessary to support the production and operation of the POS, as well as, meet the requirements and performance standards described in this RFP. The Bidder's POS solution must comply and remain in full compliance with all HIPAA standards and CMS certification requirements.

The Bidder will be responsible for system, application and network performance of the portions of the solution defined as Bidder's responsibility. The Bidder will provide a problem-resolution tracking system and participate in issue identification, escalation, prioritization and resolution. The Bidder will be required to report on performance metrics.

The Bidder must comply with all applicable federal and state data retention rules as described in these requirements for all program information, data, and correspondence that is received and produced through the POS solution.

REQUIREMENTS TABLE ON THE FOLLOWING PAGE

4.11.1 **General** (**2-Page Limit** for Response to Section 4.11.1.1; **1-Page Limit** per Response to Sections 4.11.1.2-4.11.2.5))					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.11.1.1	Describe your proposed Operations offering, including any unique, innovative or additional features available and the advantages they bring to HCA. Include any information regarding the suite of performance reports that may be available for monitoring the system.				
Response:					
4.11.1.2	The Bidder must comply with all state and federal audit requests and provide any necessary data, information and/or reports as directed by HCA. Describe your ability to meet this requirement.				
Response:					
4.11.1.3	The Bidder must provide HCA with responses and Corrective Action Plans (CAP) for any performance or service level agreement (SLA) audit review findings, and must ensure all subcontractors, if applicable, also comply. In addition, the Bidder must provide monthly status updates for each CAP until the CAP is complete and the finding is remediated. Describe your ability to meet this requirement.				
Response:					
4.11.1.4	The Bidder must participate in, support all requests for demonstrations, documentation and reports, and achieve federal certification of their solution in accordance with the Outcomes Based Certification approach defined by CMS. Describe your ability to meet this requirement.				
Response:					
4.11.1.5	The Bidder must maintain federal certification of their solution by complying with all ongoing evaluation and reporting requirements as directed by HCA and CMS. Describe your ability to meet this requirement.				
Response:					

END OF SECTION 4.11.1

4.11.2 **Performance** (**1-Page Limit** per Response to Sections 4.11.2.1 – 4.11.2.7)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.11.2.1	The Bidder must monitor and report actual response times and other performance measures to the State in both graphic and tabular/text depiction. Describe your ability to meet this requirement.				
Response:					
4.11.2.2	The monthly average time to fully adjudicate each electronic POS claim must not exceed three seconds. Describe your ability to meet this requirement.				
Response:					
4.11.2.3	All components of the POS solution must be available 99.5% of the time 24 hours per day, 7 days a week on a monthly basis, excluding any negotiated and approved downtime. Describe your ability to meet this requirement.				
Response:					
4.11.2.4	The daily average screen response time for all components of the POS solution must not exceed four seconds within business hours (M-F, 6:00 A.M.-7:00 P.M. Pacific Time). Describe your ability to meet this requirement.				
Response:					
4.11.2.5	Describe your ability to satisfy response time requirements for at least 300 concurrent internal state users.				
Response:					
4.11.2.6	Describe your ability to process 250,000 claims/encounters per day.				
Response:					
4.11.2.7	The Bidder must be able to produce a periodic 508 compliance test report as directed by HCA. Describe your ability to meet this requirement.				

4.11.2 **Performance** (**1-Page Limit** per Response to Sections 4.11.2.1 – 4.11.2.7)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
Response:					

END OF SECTION 4.11.2

4.11.3 **Problem Resolution** (**1-Page Limit** per Response to Sections 4.11.3.1 – 4.11.3.7)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.11.3.1	The Bidder will provide procedures for problem resolution and exception handling that will be approved by HCA. Describe your ability to meet this requirement.				
Response:					
4.11.3.2	The Bidder must provide a problem-resolution tracking system available to HCA for reporting. Describe your ability to meet this requirement.				
Response:					
4.11.3.3	The Bidder must provide an initial response to all unplanned outages within 30 minutes of the incident and continue the response every hour until resolved. Describe your ability to meet this requirement.				
Response:					
4.11.3.4	The Bidder will provide a single point of contact for all problem resolution for the POS solution. Describe your ability to meet this requirement.				
Response:					
4.11.3.5	The Bidder must provide and maintain a system change request repository for use by HCA and Bidder staff. Describe your ability to meet this requirement.				
Response:					
4.11.3.6	The Bidder must deliver a change request response (Firm Offer) within 20 business days of receipt of a HCA Change Request, unless otherwise agreed. Describe your ability to meet this requirement.				
Response:					
4.11.3.7	The Bidder must provide a process for HCA to obtain a high-level estimate of a requested enhancement(s) to the system. This is especially critical during the WA legislative season when estimates are required within 2-3 days. Describe your ability to meet this requirement.				

END OF SECTION 4.11.3

4.11.4 **User Acceptance Testing Support** (1**-Page Limit** for Response to Section 4.11.4.1)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.11.4.1	The UAT environment requires periodic refresh from Production to maintain HCA's ability to perform User Acceptance Testing throughout the Operations phase. Describe your ability to meet this requirement.				
Response:					

END OF SECTION 4.11.4

4.11.5 **Data Retention** (**2-Page Limit** for Response to Section 4.11.5.1; **1-Page Limit** per Response to Sections 4.11.5.2 – 4.11.5.5)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
4.11.5.1	Describe your product's proposed Data Retention offering, including any unique, innovative or additional features available and the advantages they bring to HCA.				
Response:					
4.11.5.2	Ability to configure the retention rules for each data set including having the ability to define the retention periods per State and Federal schedules.				
Response:					
4.11.5.3	Ability to retain up to 4 years of claims history on-line, to include adjustments and all supporting transaction information.				
Response:					
4.11.5.4	Ability to retain Client and Provider information indefinitely in the POS solution.				
Response:					
4.11.5.5	Ability to retain PA determinations on-line for up to 10 years.				
Response:					

END OF SECTION 4

SECTION 5. COST PROPOSAL

The prompts within this section consists of MS Requirements.

The maximum proposed bid for this contract must be $35.9 million or less to be considered responsive to this RFP. The evaluation process is designed to award this procurement not necessarily to the Bidder of least cost, but rather to the Bidder whose proposal best meets the requirements of this RFP. However, Bidders are encouraged to submit proposals that are consistent with state government efforts to conserve state resources.

HCA will retain a holdback of 10% of the charges for each Deliverable that has received Acceptance. HCA will pay the holdback within 30 days following receipt of the invoice that follows HCA's receipt of federal Certification from CMS.

5.1 IDENTIFICATION OF COSTS

HCA seeks a "fixed-price-not-to-exceed" contract for fulfilling the requirements of this RFP. Therefore, the cost proposal must reflect all costs which are associated with meeting the requirements and services listed in the RFP, and which are offered by the Bidder as part of the Bidder's proposal.

Identify all costs in U.S. dollars including all applicable taxes and expenses to be charged for performing the services necessary to accomplish the objectives of the contract. The Bidder is to submit a fully detailed budget including staff costs and any expenses necessary to accomplish the tasks and to produce the deliverables under the contract. Bidders are required to collect and pay Washington state sales and use taxes, as applicable. HCA will not be responsible for erroneous, hidden, non-disclosed, or underestimated costs.

Prices quoted must remain fixed for the duration of the contract executed as a result of this RFP. See Section 1.10 for the term of the contract and extension options. Bidder **must complete** Attachment 10, *Response Form for Section 5, Cost Proposal* to respond to this SECTION 5. Bidder's cost proposal will be scored based on 4 amounts: **(1)** Total DDI Cost, **(2)** Blended DDI Hourly Rate, **(3)** Operations and Maintenance Fixed Price, and **(4)** Blended O&M Hourly Rate. Bidder's response must adhere to the following:

1. Total DDI Cost must not exceed $5.5 million
    - Total DDI costs include (1) the fixed price for meeting all solution functionality requirements, and (2) an additional amount representing 10% of the proposed fixed price that is set aside for change requests for system enhancements.
    - Total cost for all deliverables completed by June 30, 2022 must not exceed $2 million.
2. Blended DDI Hourly Rate
    - This is the singular hourly rate that will be used for system enhancements during DDI (See Section 2.4.10).
3. Operations and Maintenance Fixed Price must not exceed $30.4 million
    - Costs must not exceed $3.4 million for O&M year 1.
    - Costs must not exceed $4.5 million per year for O&M years 2-7.
    - Following DDI completion, Bidder must provide a 3-month warranty period free of all Operations and Maintenance costs. The amounts stated immediately above include this no-cost warranty period.
4. Blended O&M Hourly Rate
    - This is the singular hourly rate that will be used for system enhancements during O&M (See Section 2.4.10).

END OF SECTION 5

SECTION 6. REQUIRED MISCELLANEOUS FORMS

The prompts within this section consists of both MR and MS Requirements.

Section 6.1 will be evaluated on a pass/fail basis. Bidder **must complete** Attachment 11, *Certifications and Assurances* to respond to Section 6.1.

Section 6.2, Bidder will receive either 0 or 200 points based on its certification statement in Attachment 12, *Executive Order 18-03*. Bidder **must complete** Attachment 12, *Executive Order 18-03* to respond to Section 6.2.

Section 6.3 will be evaluated on a pass/fail basis. Bidder **must complete** Attachment 13, *Diverse Business Inclusion Plan* to respond to Section 6.3.

Section 6.4 will be evaluated on a pass/fail basis. Bidder **must complete** Attachment 14, *Wage Theft Prevention* to respond to Section 6.4.

6.1 CERTIFICATIONS AND ASSURANCES (MR)

Attachment 11, *Certifications and Assurances* must be signed and dated by a person authorized to legally bind the Bidder to a contractual relationship, e.g., the President or Executive Director if a corporation, the managing partner if a partnership, or the proprietor if a sole proprietorship.

6.2 EXECUTIVE ORDER 18-03 (MS)

Pursuant to RCW 39.26.160(3) and consistent with Executive Order 18-03 – Supporting Workers' Rights to Effectively Address Workplace Violations (dated June 12, 2018), HCA will evaluate bids for best value and provide a bid preference in the amount of 200 points to any Bidder who certifies, pursuant to the certification attached as Attachment 12, *Executive Order 18-03,* that their firm **does not** require its employees, as a condition of employment, to sign or agree to mandatory individual arbitration clauses or class or collective action waiver. Bidders that do require their employees, as a condition of employment, to sign or agree to mandatory individual arbitration clauses or class or collective action waiver will not be disqualified evaluation of this RFP; however, they will receive 0 points for this section.

6.3 DIVERSE BUSINESS INCLUSION PLAN (MR)

In accordance with legislative findings and policies set forth in RCW 39.19, the state of Washington encourages participation in all contracts by firms certified by the Office of Minority and Women's Business Enterprises (OMWBE), set forth in RCW 43.60A.200 for firms certified by the Washington State Department of Veterans Affairs, and set forth in RCW 39.26.005 for firms that are Washington Small Businesses.

Participation may be either on a direct basis or on a subcontractor basis. However, no preference on the basis of participation is included in the evaluation of Diverse Business Inclusion Plans submitted, and no minimum level of minority- and women-owned business enterprise, Washington Small Business, or Washington State certified Veteran Business participation is required as a condition for receiving an award. Any affirmative action requirements set forth in any federal governmental regulations included or referenced in the contract documents will apply. Complete Attachment 13, *Diverse Business Inclusion Plan* to respond to this section.

6.4 WAGE THEFT PREVENTION (MR)

Attachment 14, *Wage Theft Prevention* must be completed, signed and dated by a person authorized to legally bind the Bidder to a contractual relationship, e.g., the President or Executive Director if a corporation, the managing partner if a partnership, or the proprietor if a sole proprietorship.

END OF SECTION 6

SECTION 7. GENERAL INFORMATION FOR BIDDERS

7.1 RFP COORDINATOR

The RFP Coordinator is the sole point of contact in HCA for this procurement. All communication between the Bidder and HCA upon release of this RFP must be with the RFP Coordinator, as follows:

Name	Jack Kent
E-Mail Address	HCAProcurements@hca.wa.gov
Phone Number	(360) 725-1931

Due to the current remote working conditions, HCA will not be accepting physical mail for this RFP; all communication and document submissions should be routed through e-mail (preferable) and telephone. Any other communication will be considered unofficial and non-binding on HCA. Bidders are to rely on written statements issued by the RFP Coordinator. Communication directed to parties other than the RFP Coordinator may result in disqualification of the Bidder.

7.2 ESTIMATED SCHEDULE OF PROCUREMENT ACTIVITIES

Issue Request for Proposals	01/26/2021
Questions Due	02/12/2021 @ 5 p.m. PST
Answers Posted	03/12/2021
Submit Letter of Intent to Propose	04/05/2021
Proposals Due	04/12/2021 @ 12 p.m. PST
Evaluate Written Proposals	04/13/2021-5/13/2021
Conduct Oral Interviews/Demos with Finalists	05/17/2021-5/25/2021
Announce “Apparent Successful Bidder” and send notification via e-mail to unsuccessful Bidders	05/28/2021
Hold Debriefing Conferences (if requested)	06/04/2021-6/08/2021
Negotiate Contract	06/01/2021-07/15/2021
Begin Contract Work	09/17/2021

HCA reserves the right in its sole discretion to revise the above schedule.

7.3 QUESTIONS AND ANSWERS

Bidders are encouraged to submit written questions concerning the RFP to the RFP Coordinator by February 12, 2021. HCA will provide answers to the Bidder questions on March 12, 2021 via amendment to the RFP that will be posted on WEBS.

HCA cannot commit to providing formal answers to questions received after the date noted above in Section 7.2.

7.4 REVISIONS TO THE RFP

If HCA determines in its sole discretion that it is necessary to revise any part of this RFP, then HCA will provide addenda via e-mail to all individuals who have made the RFP Coordinator aware of their interest. Addenda will also be published on Washington’s Electronic Bid System (WEBS), at https://fortress.wa.gov/ga/webs/. For this purpose, the published questions and answers and any other pertinent information will be provided as an addendum to the RFP and will be placed on the website.

HCA also reserves the right to cancel or to reissue the RFP in whole or in part, prior to execution of a contract.

7.5 LETTER OF INTENT TO PROPOSE

To be eligible to submit a Proposal, a **Bidder must submit** a Letter of Intent to Propose. The Letter of Intent to Propose must be emailed to the RFP Coordinator, listed in Section 7.1, and must be received by the RFP Coordinator no later than the date and time stated in the Procurement Schedule, Section 7.2.

The subject line of the email **must include** the following: RFP No. 2020HCA28 – Letter of Intent to Propose – [Bidder entity's name].

The Letter of Intent to Propose **must be** attached to the email as a separate document in PDF.

Information in the Letter of Intent to Propose **must be** placed in the following order:

- Bidder's Organization Name;
- Bidder's authorized representative for this RFP (who must be named the authorized representative identified in the Bidder's Proposal);
- Title of authorized representative;
- Address, telephone number, and email address;
- Statement of intent to propose; and
- A statement of how the Bidder meets all of the minimum requirements specified in Section 1.11 of this RFP.

HCA may use the Letters of Intent to Propose as a pre-screening to determine whether minimum qualifications are met.

7.6 SUBMISSION OF PROPOSALS

7.6.1 Electronic Proposals

The proposal must be received by the RFP Coordinator no later than the Proposal Due deadline in Section 7.2, Estimated Schedule of Procurement. Bidder's proposal must be submitted in separate documents: one document for each of the five scored sections (sections 2-6), and one document that combines all responses into a single document. The Bidder References, Key Staff References, and Résumé Forms should be attached as three separate additional documents.

Proposals must be submitted electronically as an attachment to an e-mail to the RFP Coordinator at the e-mail address listed in Section 7. Attachments to e-mail should be in PDF, except for Section 2.4.12.1, which should be attached as a Microsoft Project file. Zipped files cannot be received by HCA and cannot be used for submission of proposals. The Attachment 11, *Certifications and Assurances* form must have a scanned signature of the individual within the organization authorized to bind the Bidder to the offer. HCA does not assume responsibility for problems with Bidder's e-mail. If HCA e-mail is not working, appropriate allowances will be made.

Proposals may not be transmitted using facsimile transmission or physical mail.

Bidders should allow sufficient time to ensure timely receipt of the proposal by the RFP Coordinator. Late proposals will not be accepted and will be automatically disqualified from further consideration, unless HCA e-mail is found to be at fault. All proposals and any accompanying documentation become the property of HCA and will not be returned.

7.6.2 Mandatory and Mandatory Scored Requirements

Requirements in RFP Sections 2, 3, 4, 5 and 6 are categorized as follows:

- **Mandatory Requirements (MR)** – Denotes a requirement that is mandatory, but is not scored numerically; instead, MR prompts are evaluated on a pass/fail basis. Bidders must demonstrate compliance with MR requirements, otherwise the Bidder's proposal will be deemed as non-responsive and the Bidder's proposal will be disqualified from the evaluation process. Bidders should include the cost of meeting MR requirements in their proposed fixed price (see Section 5.1, *Cost Proposal* for pricing instructions).

- **Mandatory Scored (MS)** – Denotes a requirement that is required and scored. Bidders must demonstrate compliance with MS requirements, if not the Bidder's proposal may be deemed as non-responsive and the Bidder's proposal may be disqualified from the evaluation process. Bidders should include the cost of meeting MS requirements in their proposed fixed price (see Section 5.1, *Cost Proposal* for pricing instructions).

7.6.3 **Proposal Format Instructions**

Bidder proposals must respond to all requirements identified in RFP Sections 2, 3, 4, 5 and 6.

- **Management Proposal** (Section 2): Bidders must respond using Attachment 7, *Response Form for Section 2, Management Proposal*. The Bidder's response must clearly state how each requirement is met. Bidders must also use Attachments 2, 3, and 4 to respond to the Bidder References, Résumé, and Key Staff References sections of the Management Proposal, respectively.
- **Technical Proposal** (Section 3): Bidders must respond using Attachment 8, *Response Form for Section 3, Technical Proposal*, which uses the table format provided in RFP Section 3 (see Table 1 below). Multiple requirements in this Section 3 request the Bidder to attach documentation. All requested attachments in this Section 3 should be combined into one PDF file, with matching section/requirement numbers listed, and attached separately in e-mail to Bidder's proposal submission.
- **Functional Proposal** (Section 4): Bidders must respond using Attachment 9, *Response Form for Section 4, Functional Proposal*, which uses the table format provided in RFP Section 4 (see Table 1 below).
- **Cost Proposal** (Section 5): Bidder must respond using Attachment 10, *Response Form for Section 5, Cost Proposal*.
- **Required Miscellaneous Forms** (Section 6): Bidder must complete and include as separate attachments to their proposal submission the following attachments: Attachment 11, *Certifications and Assurances*, Attachment 12, *Executive Order 18-03*, Attachment 13, *Diverse Business Inclusion Plan,* and Attachment 14*, Wage Theft Prevention*.

7.6.3.1 **Table 1: Sample Requirements Table**

Requirement Category/Title (Page limit information)					
Req. #	**Requirement**	(1) Comply	(a) Core	(b) Custom	(c) 3rd Party
x.x.x.x	Sample Requirement Text				
Response: Bidder's Response goes here.					

For each requirement identified in Sections 3 and 4, complete the provided tables' information as follows:

(1) **Comply**: Insert an "X" if the Bidder's offering complies with the requirement and leave **blank** if the Bidder's offering does not comply with the requirement. Bidder must also indicate how it will comply, where a, b and c **are not** mutually exclusive.

a. **Core**: Insert an "X" if the Bidder currently provides this requirement through their offering of a POS installed in another state or non-state entity and/or can be transferred from another state or non-state entity "as-is" or with little modification for Washington State.

b. **Custom**: Insert an "X" if the Bidder proposes to meet this requirement through custom development or through moderate or extensive modification to the system and leave blank if the Bidder does not require custom development or moderate/extensive modifications to meet this requirement.
Note: indicate "custom" for those features that require substantial or "from the ground up" development efforts, including moderate or extensive modifications to a transfer system.

c. **3rd Party**: Insert an "X" if the Bidder proposes to meet this requirement through a relationship with another party (e.g., a sub-contractor, or other 3rd party) and leave blank if the Bidder does not plan to form a relationship with another firm to meet this requirement.

Response: Insert a complete description of the Bidder's approach to meeting this requirement. Insert the response directly in the table, using as much space as needed within the page limits outlined. (e.g., Bidders are highly encouraged to explain responses in sufficient detail to meet the requirement and not provide single-line responses).

7.7 PROPRIETARY INFORMATION / PUBLIC DISCLOSURE

Proposals submitted in response to this RFP will become the property of HCA. All proposals received will remain confidential until the Apparent Successful Bidder is announced; thereafter, the proposals will be deemed public records as defined in chapter 42.56 of the Revised Code of Washington (RCW).

Any information in the proposal that the Bidder desires to claim as proprietary and exempt from disclosure under chapter 42.56 RCW, or other state or federal law that provides for the nondisclosure of a document, must be clearly designated. The information must be clearly identified and the particular exemption from disclosure upon which the Bidder is making the claim must be cited. Each page containing the information claimed to be exempt from disclosure must be clearly identified by the words "Proprietary Information" printed on the lower right hand corner of the page. Marking the entire proposal exempt from disclosure or as Proprietary Information will not be honored.

If a public records request is made for the information that the Bidder has marked as "Proprietary Information," HCA will notify the Bidder of the request and of the date that the records will be released to the requester unless the Bidder obtains a court order enjoining that disclosure. If the Bidder fails to obtain the court order enjoining disclosure, HCA will release the requested information on the date specified. If a Bidder obtains a court order from a court of competent jurisdiction enjoining disclosure pursuant to chapter 42.56 RCW, or other state or federal law that provides for nondisclosure, HCA will maintain the confidentiality of the Bidder's information per the court order.

A charge will be made for copying and shipping, as outlined in RCW 42.56. No fee will be charged for inspection of contract files, but 24 hours' notice to the RFP Coordinator is required. All requests for information should be directed to the RFP Coordinator.

The submission of any public records request to HCA pertaining in any way to this RFP will not affect the procurement schedule, as outlined in Section 2.2, unless HCA, in its sole discretion, determines that altering the schedule would be in HCA's best interests.

7.8 ACCEPTANCE PERIOD

Proposals must provide 180 calendar days for acceptance by HCA from the due date for receipt of proposals.

7.9 MOST FAVORABLE TERMS

HCA reserves the right to make an award without further discussion of the proposal submitted. Therefore, the proposal should be submitted initially on the most favorable terms which the Bidder can propose. HCA reserve the right to contact a Bidder for clarification of its proposal.

HCA also reserves the right to use a Best and Final Offer (BAFO) before awarding any contract to further assist in determining the ASB(s).

The ASB should be prepared to accept this RFP for incorporation into a contract resulting from this RFP. The contract resulting from this RFP will incorporate some, or all, of the Bidder's proposal. The proposal will become a part of the official procurement file on this matter without obligation to HCA.

7.10 COSTS TO PROPOSE

HCA will not be liable for any costs incurred by the Bidder in preparation of a proposal submitted in response to this RFP, in conduct of a presentation, or any other activities related in any way to this RFP.

7.11 RECEIPT OF INSUFFICIENT NUMBER OF PROPOSALS

If HCA receives only one responsive proposal as a result of this RFP, HCA reserves the right to either: 1) directly negotiate and contract with the Bidder; or 2) not award any contract at all. HCA may continue to have the bidder complete the entire RFP. HCA is under no obligation to tell the Bidder if it is the only Bidder.

7.12 NO OBLIGATION TO CONTRACT

This RFP does not obligate HCA to enter into any contract for services specified herein.

7.13 REJECTION OF PROPOSALS

HCA reserves the right, at its sole discretion, to reject any and all proposals received without penalty and not to issue any contract as a result of this RFP.

7.14 COMMITMENT OF FUNDS

The Director of HCA or his/her delegate is the only individual who may legally commit HCA to the expenditures of funds for a contract resulting from this RFP. No cost chargeable to the proposed contract may be incurred before receipt of a fully executed contract.

7.15 ELECTRONIC PAYMENT

The state of Washington utilizes electronic payment in its transactions. The ASB must register with the Statewide Payee Desk at https://ofm.wa.gov/it-systems/statewide-vendorpayee-services/receiving-payment-state in order to receive payment for services performed under an awarded contract.

7.16 INSURANCE COVERAGE

As a requirement of the resultant contract, the ASB is to furnish HCA with a certificate(s) of insurance executed by a duly authorized representative of each insurer, showing compliance with the insurance requirements set forth below.

The ASB must, at its own expense, obtain and keep in force insurance coverage which will be maintained in full force and effect during the term of the contract. The ASB must furnish evidence in the form of a Certificate of Insurance that insurance will be provided, and a copy must be forwarded to HCA within 15 days of the contract effective date.

7.16.1 **Liability Insurance**

7.16.1.1 Commercial General Liability Insurance: ASB will maintain commercial general liability (CGL) insurance and, if necessary, commercial umbrella insurance, with a limit of not less than $1,000,000 per each occurrence. If CGL insurance contains aggregate limits, the General Aggregate limit must be at least twice the "each occurrence" limit. CGL insurance must have products-completed operations aggregate limit of at least two times the "each occurrence" limit. CGL insurance must be written on ISO occurrence from CG 00 01 (or a substitute form providing equivalent coverage). All insurance must cover liability assumed under an insured

contract (including the tort liability of another assumed in a business contract), and contain separation of insureds (cross liability) condition.

7.16.1.2 Additionally, the ASB is responsible for ensuring that any subcontractors provide adequate insurance coverage for the activities arising out of subcontracts.

7.16.1.3 Business Auto Policy: As applicable, the ASB will maintain business auto liability and, if necessary, commercial umbrella liability insurance with a limit not less than $1,000,000 per accident. Such insurance must cover liability arising out of "Any Auto." Business auto coverage must be written on ISO form CA 00 01, 1990 or later edition, or substitute liability form providing equivalent coverage.

7.16.2 **Employers Liability ("Stop Gap") Insurance**

7.16.2.1 The ASB will buy employers liability insurance and, if necessary, commercial umbrella liability insurance with limits not less than $1,000,000 each accident for bodily injury by accident or $1,000,000 each employee for bodily injury by disease.

7.16.3 **Cyber-Liability Insurance / Privacy Breach Coverage**

For the purposes of this section the following definitions apply:

Breach – means the unauthorized acquisition, access, use, or disclosure of Data shared under any resulting Contract that compromises the security, confidentiality, or integrity of the Data.

Confidential Information – is information that is exempt from disclosure to public or other unauthorized persons under 42.56 RCW or other federal or state laws. Confidential Information includes, but is not limited to, Personal Information and Protected Health Information.

Data – means information that is disclosed or exchanged between HCA and Apparent Successful Bidder. Data includes Confidential Information.

Personal Information – means information identifiable to any person, including but not limited to, information that relates to a person's name, health, finances, education, business, use, or receipt of governmental services or other activities, addresses, telephone numbers, social security numbers, driver's license numbers, credit card numbers, any other identifying numbers, and any financial identifiers.

Protected Health Information (PHI) – means information that relates to the provision of health care to an individual, the past, present, or future physical or mental health or condition of an individual, the past, present, or future payment for provision of health care to an individual. PHI includes demographic information that identifies the individual or about which there is reasonable basis to believe, can be used to identify the individual. PHI is information transmitted, maintained, or stored in any form or medium. PHI does not include education records covered by the Family Educational Right and Privacy Act, as amended.

7.16.3.1 For the term of any resulting Contract and three (3) years following its termination or expiration, ASB must maintain insurance to cover costs incurred in connection with a security incident, privacy Breach, or potential compromise of Data, including:

a. Computer forensics assistance to assess the impact of a Data Breach, determine root cause, and help determine whether and the extent to which notification must be provided to comply with Breach notification laws;

b. Notification and call center services for individuals affected by a security incident, or privacy Breach;

c. Breach resolution and mitigation services for individuals affected by a security incident or privacy Breach, including fraud prevention, credit monitoring, and identity theft assistance; and

d. Regulatory defense, fines, and penalties from any claim in the form of a regulatory proceeding resulting from a violation of any applicable privacy or security law(s) or regulation(s).

7.16.4 **Additional Provisions**

Above insurance policy must include the following provisions:

7.16.4.1 Additional Insured. The state of Washington, HCA, its elected and appointed officials, agents and employees must be named as an additional insured on all general liability, excess, umbrella and property insurance policies. All insurance provided in compliance with this contract must be primary as to any other insurance or self-insurance programs afforded to or maintained by the state.

7.16.4.2 Cancellation. State of Washington, HCA, must be provided written notice before cancellation or non-renewal of any insurance referred to therein, in accord with the following specifications. Insurers subject to 48.18 RCW (Admitted and Regulation by the Insurance Commissioner): The insurer must give the state 45 days advance notice of cancellation or non-renewal. If cancellation is due to non-payment of premium, the state must be given ten days advance notice of cancellation. Insurers subject to 48.15 RCW (Surplus lines): The state must be given 20 days advance notice of cancellation. If cancellation is due to non-payment of premium, the state must be given ten days advance notice of cancellation.

7.16.4.3 Identification. Policy must reference the state's contract number and the Health Care Authority.

7.16.4.4 Insurance Carrier Rating. All insurance and bonds should be issued by companies admitted to do business within the state of Washington and have a rating of A-, Class VII or better in the most recently published edition of Best's Reports. Any exception must be reviewed and approved by the Health Care Authority Risk Manager, or the Risk Manager for the state of Washington, before the contract is accepted or work may begin. If an insurer is not admitted, all insurance policies and procedures for issuing the insurance policies must comply with chapter 48.15 RCW and 284-15 WAC.

7.16.4.5 Excess Coverage. By requiring insurance herein, the state does not represent that coverage and limits will be adequate to protect ASB, and such coverage and limits will not limit ASB's liability under the indemnities and reimbursements granted to the state in this Contract.

7.16.5 **Workers' Compensation Coverage**

The ASB will at all times comply with all applicable workers' compensation, occupational disease, and occupational health and safety laws, statutes, and regulations to the full extent applicable. The state will not be held responsive in any way for claims filed by the ASB or their employees for services performed under the terms of this contract.

END OF SECTION 7

SECTION 8. EVALUATION AND SELECTION

Responsive Proposals will be evaluated strictly in accordance with the requirements stated in this RFP and any addenda issued. The evaluation of proposals will be accomplished by evaluation teams, to be designated by HCA, which will determine the ranking of the proposals. Evaluations will only be based upon information provided in the Bidder's Proposal.

All proposals received by the stated deadline, Section 7.2, Estimated Schedule of Procurement Activities, will be reviewed by the RFP Coordinator to ensure that the Proposals contain all of the required information requested in the RFP. Only responsive Proposals that meet the requirements will be evaluated by the evaluation team. Any Bidder who does not meet the stated qualifications or any Proposal that does not contain all of the required information will be rejected as non-responsive.

The RFP Coordinator may, at his or her sole discretion, contact the Bidder for clarification of any portion of the Bidder's Proposal. Bidders should take every precaution to ensure that all answers are clear, complete, and directly address the specific requirement.

Responsive Proposals will be reviewed and scored by an evaluation team using a weighted scoring system, Section 8.2, Evaluation Weighting and Scoring. Proposals will be evaluated strictly in accordance with the requirements set forth in this RFP and any addenda issued.

HCA, at its sole discretion, may elect to select the top-scoring firms as finalists for an oral presentation.

8.1 EVALUATION TEAMS

The evaluation of the proposals will be conducted by the below groups of State staff:

- Administrative Team;
- Management Evaluation Team;
- Technical Evaluation Team;
- Functional Evaluation Team; and
- Oral Presentation Evaluation Team.

The POS Replacement Project Team will provide staff to assist each evaluation team to distribute proposal materials and perform the Assessment of Compliance for the management, technical, functional and cost proposals. These staff will act as advisors to the evaluation teams and facilitate the proposal review meetings. The RFP Coordinator will schedule demonstrations and oral presentations, and coordinate the final review and approval of the Bidder selection.

The evaluations will progress independently of each other, without cross-dissemination of evaluation results (except when a proposal is rejected as non-responsive). Certain individuals may serve on more than one team. In such cases, they will not share any team scores with members of another team.

8.1.1 Administrative Team

The RFP Coordinator will conduct an administrative review of the proposal to ensure all mandatory prompts were completed (see Section 8.2.2). The RFP Coordinator will also score Section 5, Cost Proposal and Section 6, Miscellaneous Forms.

8.1.2 Management Evaluation Team

To leverage the expertise within HCA, the Management Evaluation Team will consist of staff skilled in program and project management from various divisions within HCA.

This team will conduct the evaluation of management proposals against the requirements outlined in Section 2 of the RFP. This team will also be responsible for performing and documenting reference checks for the Key Staff and Bidder organization. The reference checks will be performed prior to final proposal scoring.

8.1.3 Technical and Functional Evaluation Teams

To leverage the expertise within HCA, the Technical Evaluation Team will consist of skilled technical managers and staff from various organizations within HCA. The Functional Evaluation Team will consist of subject area experts from various divisions within HCA.

These teams will conduct the evaluation of technical and functional proposals against requirements outlined in Section 3 and 4 of the RFP.

8.1.4 Oral Presentation Evaluation Team

The Oral Presentation Evaluation Team will consist of members from the Management, Functional and Technical Evaluation Teams. The Oral Presentation Evaluation Team will evaluate the Bidder's performance during oral presentations by assessing criteria in each of the four areas below:

- Engagement Team Members, their Qualifications and a demonstration of their ability to work together as a cohesive team;
- Approach to Project Management;
- Understanding of the RFP and HCA Requirements; and
- Understanding of HCA.

8.2 EVALUATION PROCESS

8.2.1 Overview

The evaluation process is split into two stages and is organized into the following steps:

Stage 1

- Step 1 - Assessment of Compliance (see Section 8.2.2)
- Step 2 - Evaluation and Scoring of Management Proposals
- Step 3 - Evaluation and Scoring of Technical Proposals
- Step 4 - Evaluation and Scoring of Functional Proposals
- Step 5 - Scoring of Cost Proposals
- Step 6 - Scoring of Incentive Points (see Section 6.2)

Stage 2

- Step 7 - Selection of Finalists
- Step 8 - Evaluation and Scoring of Bidder Demonstrations and Oral Presentations
- Step 9 - Recommended Bidder Selection

Evaluations conducted in steps 2 through 5 and 7 through 8 will be scored. The distribution of points for each evaluation step are provided in the table below.

Bidder Proposal Scoring Point Distribution

Stage 1		
Evaluation Step	**Points allowed**	**% of total points**
Management Proposal	2,400	24
Technical Proposal	2,000	20
Functional Proposal	2,400	24
Cost Proposal	1,000	10
Executive Order 18-03	200	2
Stage 2		
Bidder Demonstrations	1,500	15
Oral Presentations	500	5
Total Points	**10,000**	**100**

The remainder of this section summarizes each of the evaluation steps and the responsibilities of the evaluators.

8.2.2 **Assessment of Compliance**

Prior to release of the management, technical and functional proposals to the evaluation team members, all proposals will be assessed for compliance with minimum qualifications and mandatory requirements (MR) as specified in Sections 2, 3 and 4 of the RFP. The RFP Coordinator will be responsible for the compliance assessment. Only proposals meeting these qualifications will be further evaluated.

The mandatory requirements are not assigned a point score. The RFP Coordinator will record PASS or FAIL for each requirement.

Any proposal that receives a FAIL score on any mandatory requirement or for some reason, cannot be evaluated, will be deemed non-responsive. Any proposal that is non-responsive may be rejected by HCA. The RFP Coordinator in consultation with the POS Replacement Project Co-Sponsors will determine whether a proposal will be rejected as non-responsive or if HCA will request corrective action or clarification from the Bidder.

Corrections to proposal material may be requested, in writing, with a limited time period for their receipt to ensure timely evaluation of the full proposal or to allow for its rejection for noncompliance. A correction requested from one Bidder does not establish a right or opportunity for any other Bidder to submit questions or clarifications. Corrections must be limited to only those requested by the RFP Coordinator.

All Bidders whose proposals meet minimum qualifications will then proceed through the proposal evaluation and scoring steps. The evaluation and scoring of the Management, Technical and Functional Proposals outlined below will focus on Mandatory Scored Requirements (MS).

8.2.3 **Scoring Criteria for Management, Technical, and Functional Proposals**

Raw Score	Description	Discussion
0	**No value**	The Bidder has omitted any discussion of this requirement or the information provided is of no value.
1-3	**Poor**	The Bidder has not fully established the capability to perform the requirement, has marginally described its approach, or has simply restated the requirement.
4-6	**Average**	The Bidder has an acceptable capability or solution to meet this criterion and has described its approach in sufficient detail to be considered "as meeting minimum requirements".
7-9	**Above Average**	The Bidder has demonstrated an above-average capability, approach, or solution and has provided a complete description of the capability, approach, or solution to the requirement. The Bidder has included any additional features available to HCA within the base product that are not listed in the requirements.
10	**Excellent**	The Bidder has provided a unique, innovative, detailed, efficient approach or established, by references and presentation of material, far superior capability in this area. The Bidder has included any additional features available to HCA within the base product that are not listed in the requirements.

Raw scores in each of the Management, Technical and Functional Proposals will be added together (Management, Technical and Functional Proposals will each receive its own score). The total raw score for each Proposal category will be normalized arriving at the final Management, Technical and Functional Proposal scores by using the following formula (scores will be rounded to 2 decimal places):

$$y = \left(\frac{n}{x}\right) z$$

y = final Management/Technical/Functional Proposal score for Bidder n
n = total Management/Technical/Functional Proposal raw score for Bidder n
x = highest total Management/Technical/Functional Proposal raw score for all qualified Bidders
z = maximum points allowed: 2400, 2000, and 2400 points respectively.

8.2.4 **Scoring of Cost Proposals**

Upon completion of the Management, Technical and Functional evaluations, the RFP Coordinator will score the Cost proposals. If a Bidder's proposal has been considered non-responsive through any of the prior evaluations, the Bidder's Cost Proposal will not be scored.

The Cost Proposals will be assessed to determine whether they meet all compliance requirements including the submission of all required forms and statements. The RFP Coordinator will complete a compliance checklist to indicate whether the Bidder provided all required forms and statements and all required signatures are provided. Any proposal omitting any of the required forms or statements shall be deemed non-responsive and may be rejected by HCA.

All sections of the Cost Proposal will be evaluated and scored. The Cost Proposal providing the lowest overall price for a specific section will receive the maximum point score for that section. All other proposals will receive fewer points based upon the following formula:

$$y = \left(\frac{x}{z}\right) a$$

y = Bidder's score for Cost Proposal subsection
x = Lowest Bidder's price for Cost Proposal subsection
z = Bidder's price for Cost Proposal subsection
a = Points available for that subsection

Total points available for each of the subsections are as follows:

- Total DDI Cost = 400 points
- Blended DDI Hourly Rate = 100 points
- O&M Fixed Price = 400 points
- Blended O&M Hourly Rate = 100 points

Scores for all subsections within the Cost Proposal will be summed arriving at a total score for the Cost Proposal. The total score will be normalized arriving at the final Cost Proposal score by using the following formula:

$$y = \left(\frac{n}{x}\right) 1{,}000$$

y = Final Cost Proposal score for Bidder
n = Total weighted Cost Proposal score for Bidder
x = Highest total weighted Cost Proposal score for all qualified Bidders

8.2.5 **Selection of Finalists**

Scores for the Management, Technical, and Functional Proposals will be added to each Bidder's scores for Cost Proposals and incentive points gained in Section 6.2 to arrive at a total Stage 1 score for each Bidder. Finalists will be selected based upon total Stage 1 scores, and will be asked to participate in Stage 2 Demonstrations and Oral Presentations.

HCA will select the top 2 highest scoring Stage 1 Bidders to participate in Stage 2. **However**, if the 3rd highest scoring Stage 1 Bidder is within 5% of the 2nd highest scoring Stage 1 Bidder, then HCA will also invite that 3rd place Bidder to participate in Stage 2. Bidders not selected as finalists will be notified by HCA by email.

8.2.6 **Evaluation and Scoring of Bidder Demonstrations**

Bidder demonstrations are part of the functional requirements evaluation, but will be scored separately in Stage 2. The purpose of this step is to assess how well the Bidder meets functional requirements through scripted demonstrations. Bidders selected as finalists as described in Section 8.2.4 will be invited to demonstrate their system.

The Bidder Demonstration Evaluation Team will consist of members from the Management, Functional and Technical Evaluation Teams.

Each scenario will be scored by evaluators on a scale of 0-10 using the criteria outlined below:

Bidder Demonstration Scoring Criteria

Score	Description	Discussion
0	**No value**	The Bidder has omitted any discussion of this requirement or the information provided is of no value.
1-3	**Poor**	The Bidder has not fully demonstrated the capability to perform the requirement, has marginally described its approach, or has simply restated the requirement.
4-6	**Average**	The Bidder has demonstrated an acceptable capability or solution to meet this criterion and has described its approach in sufficient detail to be considered "as meeting minimum requirements".
7-9	**Above Average**	The Bidder has demonstrated an above-average capability, approach, or solution and has provided a complete description of the capability, approach, or solution to the requirement. The Bidder has demonstrated any additional features available to HCA (and related to the scenario) within the base product that are not listed in the requirements.
10	**Excellent**	The Bidder has demonstrated an innovative, detailed, efficient approach or established, by presentation of material, far superior capability in this area. The Bidder has demonstrated any additional features available to HCA (and related to the scenario) within the base product that are not listed in the requirements.

Discussions between evaluators will influence the final score assigned to each scenario. Scenario scores are summed to arrive at a total Bidder demonstration score. More information on the number of scenarios and the details of those scenarios will be made available to the Finalists after Stage 1.

The total demonstration score will be normalized arriving at the final demonstration score by using the following formula:

$$\boldsymbol{y = \left(\frac{n}{x}\right) 1,500}$$

y = final demonstration score for Bidder
n = total demonstration score for Bidder
x = highest total demonstration score for all Finalists

8.2.7 **Evaluation and Scoring of Oral Presentations**

The purpose of this step is to allow the Bidders to present their proposals through oral presentations. The following areas will be addressed by each Bidder during the presentation:

- Engagement Team Members and their Qualifications
- Approach to Project Management
- Understanding of the RFP and HCA Requirements
- Understanding of HCA

Within each area, criteria are defined and will be scored by evaluators on a scale of 0-10 using the criteria outlined below:

Oral Presentation Scoring Criteria

Score	Description	Discussion
0	**No value**	The Bidder has failed to present information to demonstrate that the criteria can be met and the information provided is of no value.
1-3	**Poor**	The Bidder has addressed the criteria but not in a manner that is sufficient to demonstrate the capability to meet the requirement.
4-6	**Average**	The Bidder has an acceptable capability or solution to meet this criterion and has described its approach in sufficient detail to be considered "as meeting minimum requirements".
7-9	**Above Average**	The Bidder has demonstrated an above-average capability, approach, or solution and has provided a complete description of the capability, approach, or solution to satisfy the criterion.
10	**Excellent**	The Bidder has provided an innovative, detailed, efficient approach or established, by references and presentation of material, far superior capability in this area.

Discussions between evaluators will influence the final score assigned to a criterion within an area. Scores for each area will be summed to arrive at the total oral presentation score. More information about content and requirements of the oral presentation will be made available to the Finalists after Stage 1.

The total oral presentation score from the evaluators will be normalized arriving at the final score by using the following formula:

$$y = \left(\frac{n}{x}\right) 500$$

y = final presentation score for Bidder
n = total presentation score for Bidder
x = highest total presentation score for all Finalists

8.3 BIDDER SELECTION

Bidder selection begins after evaluation and scoring are complete for the Stage 1 Management, Technical, Functional and Cost proposals and Miscellaneous Required Forms in Section 6, as well as the Stage 2 Demonstrations and Oral Presentations. The scores are combined to produce the final scoring and ranking of Bidders.

HCA at its sole discretion may elect to take the highest 2 to 3 Bidders into a Best and Final Offer evaluation.

8.3.1 Best and Final Offer

Upon completion of the Bidders' oral presentations and demonstrations, the RFP Coordinator may issue to the Bidders a request for Best and Final Offers. This request may include specific instructions as to the content and form of the Best and Final Offer and an invitation to submit a revised proposal.

The State reserves the right to select the Apparent Successful Bidder without requesting a Best and Final Offer. Therefore, Bidders should submit their proposal on the most favorable terms the Bidder can offer.

8.3.2 Selection of Apparent Successful Bidder (ASB)

There will be 1 Apparent Successful Bidder identified to be eligible to provide the solution specified in the RFP and subsequent Bidder proposal. The Apparent Successful Bidder must meet the minimum qualifications and all the Mandatory Requirements (MR) of this RFP. HCA management will make the final determination as to which Bidder will be officially selected and announced as the Apparent Successful Bidder under this solicitation. In so doing, HCA management will be guided but

not bound by the scores awarded by the evaluators. HCA management will determine which proposals evaluated will best meet the needs of HCA.

HCA reserves the right to reject any or all bids for any reason deemed by HCA to be in HCA's interest, including but not limited to:

- Unacceptable cost;
- Poor quality of proposal; or
- Lack of, or poor quality of, competition.

8.3.3 **Announcement of Apparent Successful Bidder**

Once HCA has determined the Apparent Successful Bidder, all Bidders will be notified by email. The date of the announcement of the Apparent Successful Bidder will be the date the announcement email is sent.

8.3.4 **Debriefing Conferences**

Any Bidder who has submitted a Proposal and been notified it was not selected for contract award may request a debriefing. The request for a debriefing conference must be received by the RFP Coordinator no later than 5:00 p.m., local time, in Olympia, Washington, within **3 business days** after the Unsuccessful Bidder Notification is e-mailed to the Bidder. The debriefing will be held in accordance with the solicitation schedule above in Section 7.2.

Discussion at the debriefing conference will be limited to the following:

8.3.5 Evaluation and scoring of the Bidder's Proposal;

8.3.6 Critique of the Proposal based on the evaluation; and

8.3.7 Review of the Bidder's final score in comparison with other final scores without identifying the other Bidders.

Topics a Bidder could have raised as part of the complaint process (Section 8.4.1) cannot be discussed as part of the debriefing conference, even if the Bidder did not submit a complaint.

Comparisons between proposals, or evaluations of the other proposals will not be allowed. Debriefing conferences may be conducted in person or on the telephone and will be scheduled for a maximum of 30 minutes.

8.4 COMPLIANT AND PROTEST PROCEDURES

8.4.1 **Complaints**

Bidders may submit a complaint to HCA based on any of the following:

- The RFP unnecessarily restricts competition;
- The RFP evaluation or scoring process is unfair or unclear; or
- The RFP requirements are inadequate or insufficient to prepare a response.

A complaint must be submitted to HCA prior to five business days before the bid response deadline. The complaint must:

- Be in writing;
- Be sent to the RFP Coordinator in a timely manner;
- Clearly articulate the basis for the complaint; and
- Include a proposed remedy.

The RFP Coordinator will respond to the complaint in writing. The response to the complaint and any changes to the RFP will be posted on WEBS. The Director of HCA will be notified of all

complaints and will be provided a copy of HCA's response. A Bidder or potential Bidder cannot raise during a bid protest any issue that the Bidder or potential Bidder raised in a complaint. HCA's action or inaction in response to a complaint will be final. There will be no appeal process.

8.4.2 **Protest Process**

A bid protest may be made only by Bidders who submitted a response to this RFP and who have participated in a debriefing conference. Upon completing the debriefing conference, the Bidder is allowed five business days to file a protest with the RFP Coordinator. Protests must be received by the RFP Coordinator no later than 4:30 p.m., local time, in Olympia, Washington on the fifth business day following the debriefing. Protests may be submitted by e-mail or by mail.

Bidders protesting this RFP must follow the procedures described below. Protests that do not follow these procedures will not be considered. This protest procedure constitutes the sole administrative remedy available to Bidders under this RFP.

All protests must be in writing, addressed to the RFP Coordinator, and signed by the protesting party or an authorized agent. The protest must state (1) the RFP number, (2) the grounds for the protest with specific facts, (3) complete statements of the action(s) being protested, and (4) the relief or corrective action being requested.

Only protests alleging an issue of fact concerning the following subjects will be considered:

- A matter of bias, discrimination, or conflict of interest on the part of an evaluator;
- Errors in computing the score; or
- Non-compliance with procedures described in the RFP or HCA requirements.

Protests based on anything other than those items listed above will not be considered. Protests will be rejected as without merit to the extent they address issues such as: (1) an evaluator's professional judgment on the quality of a Proposal; or (2) HCA's assessment of its own needs or requirements.

Upon receipt of a protest, HCA will undertake a protest review. The HCA Director, or an HCA employee delegated by the HCA Director who was not involved in the RFP, will consider the record and all available facts. If the HCA Director delegates the protest review to an HCA employee, the Director nonetheless reserves the right to make the final agency decision on the protest. The HCA Director or his or her designee will have the right to seek additional information from sources he or she deems appropriate in order to fully consider the protest.

If HCA determines in its sole discretion that a protest from one Bidder may affect the interests of another Bidder, then HCA may invite such Bidder to submit its views and any relevant information on the protest to the RFP Coordinator. In such a situation, the protest materials submitted by each Bidder will be made available to all other Bidders upon request.

The final determination of the protest will:

- Find the protest lacking in merit and uphold HCA's action; or
- Find only technical or harmless errors in HCA's acquisition process and determine HCA to be in substantial compliance and reject the protest; or
- Find merit in the protest and provide options to the HCA Director, which may include:

    a. Correct the errors and re-evaluate all Proposals; or
    b. Issue a new solicitation document and begin a new process; or
    c. Make other findings and determine other courses of action as appropriate.
    d. Make other findings and determine other courses of action as appropriate.

If the protest is not successful, HCA will enter into a contract with the ASB(s), assuming the parties reach agreement on the contract's terms.

8.5 CONTRACT PROCESS

8.5.1 Contract Negotiation

Immediately following the announcement of the ASB, contract negotiations will begin. HCA reserves the right to cancel the award and award the contract to the next ranked Bidder if either of the following occurs:

8.5.1.1 Substantive progress in negotiating a contract is not achieved within 20 business days of announcing the ASB.

8.5.1.2 The ASB fails to sign the successfully negotiated contract within 5 business days of delivery to the ASB.

8.5.2 Contract Award and Execution

HCA reserves the right to make an award without further discussion of the Apparent Successful Bidder's submitted proposal. Therefore, the proposal should be initially submitted on the most favorable terms the Bidder can offer.

The Apparent Successful Bidder should be prepared to accept this RFP for incorporation into a contract resulting from this RFP. Contract negotiation, if held, will provide for the incorporation of the Bidder's proposal to this RFP.

8.5.3 Proposal Part of Contract

This RFP and the ASB's proposal will become part of the contract. Additionally, HCA may choose to verify any or all Bidder's representations that appear in the proposal. Failure of the Bidder to produce results promised in the proposal, in demonstrations, or in actual use may result in elimination of the Bidder from the evaluation process or in contract cancellation or termination.

8.5.4 Sample Contract

The ASB will be expected to enter into a contract that is substantially the same as the sample contract included herein as Attachment 15, *Sample Contract*. That sample contract includes the service level agreement terms included herein as Attachment 16, *Performance Standards*. The ASB will also be expected to enter into a Data Share Agreement and/or Business Associate Agreement that is substantially the same as the sample DSA/BAA included herein as Attachment 17, *Data Share Agreement/Business Associate Agreement*.

HCA will not accept any draft contracts prepared by any Bidder. The Bidder may submit exceptions as allowed in Attachment 11, *Certifications and Assurances*. HCA will review requested exceptions and accept or reject the same at its sole discretion.

If, after the announcement of the ASB, and after a reasonable period of time, the ASB and HCA cannot reach agreement on acceptable terms for the Contract, the HCA may cancel the selection and Award the Contract to the next most qualified Bidder.

8.5.5 Negotiating is Acceptable

The foregoing should not be interpreted to prohibit either party from proposing additional contract terms and conditions during the negotiation of the final contract.

END OF SECTION 8

SECTION 9. RFP ATTACHMENTS

- Attachment 1 – *Definitions (page 1)*
- Attachment *2* – *Bidder References Form* (2.5.2.1)
- Attachment 3 – *Résumé Form (2.6.2.1)*
- Attachment 4 – *Key Staff References Form (2.6.2.2)*
- Attachment 5 – OCS Design Review Checklist (3.1.3.5)
- Attachment 6 – *Interfaces (3.1.9.2)*
- Attachment 7 – *Response Form for Section 2, Management Proposal*
- Attachment 8 – *Response Form for Section 3, Technical Proposal*
- Attachment 9 – *Response Form for Section 4, Functional Proposal*
- Attachment 10 – *Response Form for Section 5, Cost Proposal (2.9.2.7 and 5.1)*
- Attachment 11 – Certifications and Assurances (6.1)
- Attachment 12 – Executive Order 18-03 (6.2)
- Attachment 13 – *Diverse Business Inclusion Plan (6.3)*
- Attachment 14 – *Wage Theft Prevention (6.4)*
- Attachment 15 – *Sample Contract (8.5.4)*
- Attachment 16 – *Performance Standards (8.5.4)*
- Attachment 17 - *Sample Data Share Agreement/Business Associate Agreement (8.5.4)*