FLORIDA DEPARTMENT of management SERVICES
We serve those who serve Florida

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Rick Scott, Governor

Craig J. Nichols, Agency Secretary

ATTACHMENT A - STATEMENT OF WORK

REQUEST FOR PROPOSALS
FOR
INDEPENDENT BENEFIT CONSULTING, ACTUARIAL AND AUDITING SERVICES

DMS-13/14-018

THE STATE OF FLORIDA
DEPARTMENT OF MANAGEMENT SERVICES

Including:

1. Scope of Work

1.1. Independent Benefits Consulting services: Include, but shall not be limited to, the following:

1.1.1. For the Division of State Group Insurance (DSGI):

1.1.1.1. Services will be provided on an as needed basis. The scope and deliverables for each project will be determined and agreed upon by the DSGI and the consultant. Before work commences on any project, the consultant will provide a Statement of Work, which should establish the specific deliverables, costs, payment schedules, start/completion dates, etc. for specific projects. Services include, but shall not be limited to, the following and will be provided at the negotiated ceiling prices, which are incorporated by reference into the Contract. Negotiated prices are "not to exceed" prices and lower pricing may be negotiated by the DSGI under this Contract.

1.1.1.2. Provide the DSGI with legislative support and any requested analyses; review proposed legislation and determine potential program impacts; prepare fiscal impact notes and bill analyses, which is extremely time sensitive work. Subjects and timelines will be specified by the Division.

1.1.1.3. As needed, assist the DSGI with determining financial impacts of plan design, industry and legislative changes; review and develop enrollment, revenue and expense forecast models; assist with forecasting and monitoring enrollment, revenue and expense projections of the self-insured State Employees Health Insurance Trust Fund cash position; and assist with presentations at the Self-Insurance Estimating Conferences upon request.

1.1.1.4. Upon request, provide consulting, advisory and monitoring services to the DSGI for timely implementation of the provisions (requirements) of Federal Patient Protection Affordable Care Act (ACA); determine the financial and actuarial impact of health care reform on the State Employees Health Insurance Trust Fund; and identify cost management strategies and approaches to health care reform initiatives.

1.1.1.5. Provide actuarial services as needed for plan valuation, premium modeling, benefit costing, plan design, risk assessment and fiscal impact analysis.

1.1.1.6. Perform special projects, special studies and special evaluations as needed within the timeline specified by the DSGI.

1.1.1.7. Be readily available to consult or advise the DSGI by phone, letter, email or in person and to conduct presentations as requested.

1.1.1.8. Assist with the development and implementation of an educational and outreach strategy that informs members of the available benefit choices and services offered by the program; create and disseminate various educational materials, brochures, flyers (hard copy and online learning kits) as well as opportunities for training members on the benefit plan (web based training sessions and local meeting facility).

1.1.1.9. Advise the DSGI of the actuarial significance of proposed changes regarding:
a. Benefit levels
b. Contributions
c. Actuarial funding methods, assumptions, and techniques
d. Investment policy
e. Administrative procedures

1.1.1.10. Assist the DSGI in the preparation or review of legislation, including fiscal notes and bill analyses which is extremely time sensitive work.

1.1.2. For the Division of Retirement (Retirement):

1.1.2.1. Perform special projects, special studies and special evaluations as needed within timelines specified by Retirement.

1.1.2.2. Assist with the development and implementation of an educational and outreach strategy that informs members of the available benefit choices and services offered by the program; create and disseminate various educational materials, brochures, flyers (hard copy and online learning kits) as well as opportunities for training members on the benefit plan (web based training sessions and local meeting facility).

1.1.2.3. Review the administration of state-administered retirement systems and optional retirement programs, including an appraisal of any problems arising in the administration of such systems and recommendations to correct said problems.

1.1.2.4. Advise Retirement with respect to the requirements and actuarial significance of federal laws that impact the Retirement's programs.

1.1.2.5. Perform reviews of actuarial valuations and impact statements submitted by local government pension plans.

1.1.2.6. Perform calculations of the actuarial accrued liability and present value costs for membership transfers. Create and update calculators to perform the majority of these requests from members.

1.1.2.7. Perform the actuarial accrued liability calculations for upgraded service credit. Create and update a calculator to perform the majority of these requests from members.

1.1.2.8. Prepare and update other calculators and projection models as specified by Retirement.

1.1.2.9. Hourly rates for consulting services and special studies as the basis for project costs are covered by a purchase order or a letter of authorization for special studies and other services as quoted on the attached Price Sheet. Special studies may be paid by other than an hourly rate basis through a fixed rate or fixed price memorandum of agreement acceptable to both parties.

1.2. Auditing Services: Include, but shall not be limited to, the following:

1.2.1. For the DSGI Only

1.2.1.1. Medical Claims Audits – Service Provider (SP) and Third Party Administrator

Each audit will include an electronic review of 100% of claims processed during the audit period. The electronic review shall include, but not be limited to the following:

a. Identification of potential duplicate payments
b. Validation of claimants eligibility
c. Accuracy of member cost-sharing amounts
d. Review of outlier charges
e. Review of excluded benefits
f. Identification of potential billing errors and anomalies

Based on the results of the electronic audit tests, focused samples shall be selected targeting potential problematic areas. The size of the focused sample will be determined based on the results of electronic audit tests. An onsite manual review of the focus samples will be performed at the Provider's facilities. The purpose of the focused manual review is to:

a. Evaluate claim issues identified in the electronic analysis
b. Identify potential claim payment errors to be reviewed by the SP or TPA
c. Verify that claims are being paid in accordance with contractual requirements, provider contracts and reimbursement arrangement
d. Assess accuracy of benefits and coverage provisions
e. Measure claim processing turnaround time and financial information, payment(s) and procedural accuracy
f. Identify potential medical and payment policy issues
g. Calculate estimated error in paid claims and associated root cause or trend analysis

In addition to the focus sample review, the following target samples will be reviewed manually at the Provider's facilities:

a. Out of pocket accumulators (10 claims)
b. Services rendered out of State (10 claims exceeding $10,000)
a. Emergency Room Co-Pays (10 claims)
b. Provider Network Discounts (6 institutional, 4 physician)
c. Medicare Coordination of Benefits (10 claims exceeding $25,000)

1.2.1.2. Operational Assessment

The consultant shall conduct a review of the overall administrative operations of the SPs and TPA relative to their performance of the State's requirements. The administrative review is intended to identify opportunities to improve the efficiency and quality of the SPs and TPA operation, and measure SPs' and TPA's compliance with contractual performance standards and compare to industry standards and best practices.

The assessment should include, but shall not be limited to, the following:

1.2.1.3. Fraud and abuse - validate procedures and system edits, proactively search for potential fraud and abuse and verify compliance with reporting requirements

1.2.1.4. HIPAA compliance – verify adherence to leading industry practices in the development, implementation and application of administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the protected health information that the SP or TPA creates, receives, maintains or transmits

1.2.1.5. Self-reported performance standards and guarantees – verify the accuracy of self-reported quarterly and annual performance guarantees, including the methodology and supporting documentation used to calculate the reported performance guarantees

1.2.1.6. Customer Service – validate compliance with contractual requirements pertaining to call center operations and claims operations and assess adequacy of training programs

1.2.1.7. Claims processing – evaluate examiner training and performance monitoring and assess adequacy of procedures used to identify root causes of resource issues impacting accuracy of claim determinations

1.2.1.8. Internal audits – validate adherence to internal audit requirements and assess adequacy of response to audit findings

Audit follow up procedures may be necessary if required by the DSGI to obtain assurances about purported client resolution and implementation and are assumed to be included in the proposed cost of the audit.

Each review shall begin by July 1 and shall be completed by October 31, each year.

A separate report shall be issued for each SP and TPA audited, for a total of five medical claims audit reports.

1.2.2. Annual Pharmacy Benefits Manager (PBM) Performance and Compliance Audit – Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) Plans

The purpose of the audit is to annually determine whether the PBM has implemented the HMO and PPO plan designs accurately to deliver proper administration of drug categories within the cost structure of the contract; validate the pricing commitment and evaluate the performance of the PBM, including performance guarantees.

1.2.2.1. An onsite visit will be conducted and samples of Rx claims will be selected as follows:

a. Electronic Claims Audit – validation and review of 100% of all retail and mail order pharmacy claims paid during the audit period to measure and report accuracy in benefit determinations and compliance with established administrative procedures, contractual requirements and benefit design for the Rx Plan
b. Mail-Order Claims for Manual Review – random sample of mail-order claims
c. Paper Claims for Manual Review – random sample of paper claims

1.2.2.2. The audit shall include, but shall not be limited to, the following:

a. Dispensing Accuracy
b. Financial Accuracy

c. Pricing Accuracy*
d. Discount Guarantees*
e. Rebate Guarantees*
f. Eligibility of Recipients
g. Adherence to benefit design
h. Contract Terms and Conditions
i. Duplicate Claims
j. Mail Order Facility
k. Centers for Medicare & Medicaid Services (CMS) Retiree Drug Subsidy (RDS) Cost Reporting**

*Consultant shall use the pricing data source used by the PBM to validate drug availability and pricing.

**CMS-RDS Cost Reporting shall include validating the accuracy of claims data used to determine the RDS subsidy due to the DSGI.

1.2.2.3. The audit shall include a validation of the following performance guarantees:

a. Electronic Claims
b. Mail-Order
c. Retail Paper Claims Processing Time
d. Mail-Order Claims Processing Time
e. Retail Claims Processing Accuracy
f. Mail-Order Claims Processing Accuracy
g. Other recommended reviews as needed

Audit follow up procedures shall be necessary if required by the DSGI to ensure corrective actions and resolutions have been fully and properly implemented and are assumed to be included in the proposed cost of the audit.

Each project shall begin by July 1 and shall be completed by October 31 of each year.

1.2.3. Annual CMS RDS Audit (PPO and HMO)

The annual audit is to provide assurance that reported costs were incurred by eligible Medicare participants enrolled in the State Employees' PPO Plans and HMO; prescription drugs were incurred by eligible Medicare members enrolled in the State Employees' PPO Plan and HMO Plan and eligible under the Medicare Part D program; and the subsidy amounts were calculated in accordance with the CMS guidelines and requirements. The Cost Reports involved in these audits, which are submitted to CMS-RDS by PBM, on behalf of the State of Florida, are for costs incurred during the Plan year.

a. Engagement meeting conducted via conference call
b. The entire population of incidents will be reviewed to determine whether reported costs were incurred by eligible Medicare participants enrolled in the State Employees' PPO Plans and the State Employees' HMO Plans
c. The entire population of prescription drugs incurred and paid during the audit period will be reviewed to determine whether the prescription drugs incurred by eligible Medicare members enrolled in the State Employees' PPO Plans and the State Employees' HMO Plans were eligible under the Medicare Part D program

d. The entire population of incidents will be reviewed to determine whether the subsidy amounts were calculated in accordance with the CMS guidelines and requirements
e. Comparison of population included in the RDS Cost Report against CMS Covered Retiree List (CRL)

This project shall begin by October 1 and shall be completed by December 31 each year.

1.3. Actuarial Services: Services include, but shall not be limited to, the following:

1.3.1. For the DSGI

1.3.1.1. Full Government Accounting Standards Board (GASB 43 and 45 Actuarial Valuation Study

The primary purpose of the full actuarial valuation study is to provide the Annual Require Contribution (ARC) calculations and estimate the cost and liabilities of the current Program plan, including future changes adopted by GASB, for compliance with GASB 43 and 45 accounting rules for postemployment benefits other than pensions Other Personnel Employer Benefits (OPEB) for the fiscal year. The actuarial valuation shall include a forecast of results for 30 years. All GASB 43 and 45 technical bulletins must be taken into consideration. Actuarial valuations shall be performed in accordance with accepted actuarial practices as set forth by the American Academy of Actuaries (AAA).

1.3.1.2. Update GASB 43 and 45 Actuarial Valuation Study

The update as of July 1 is to estimate the Program's annual required contribution and annual OPEB cost by employer for the fiscal year and a 30 year forecast of results. All GASB 43 and 45 technical bulletins must be taken into consideration. The update will also estimate the net OPEB obligation as of June 30 of the fiscal year. The update should include:

a. Actual and anticipated PPO cost increases as compared to assumed cost increases;
b. Actual and anticipated HMO premium increases as compared to assumed premium increases;
c. Actual and anticipated increases in PPO and HMO monthly retiree contributions as compared to assumed retiree contribution increases and;
d. Estimated costs of legislated benefit changes. Actuarial reports shall be accompanied by a signed statement certifying representations contained therein.

1.3.1.3. RDS Actuarial Attestation – PPO Plans and Self-Funded HMO Plans

The purpose of the actuarial attestation is to evaluate the State Employees' Health Insurance Program to determine whether the prescription drug benefits offered under the PPO and HMO plans are actuarially equivalent (creditable coverage), to determine whether the Program is eligible for RDS and to comply with the RDS application requirements. This actuarial determination measures whether the expected amount of paid claims under the entity's prescription drug coverage is at least as much as the expected amount of paid claims

under the standard Medicare prescription drug benefit. The actuary must be a member of the AAA to attest to the Medicare Part D equivalence of the Plan Sponsor's Applications' Benefit Options and analysis must conform to CMS guidelines established for the RDS program for plans applying for the Plan Year. All actuarial projects in this RFP shall begin July 1 of each year and shall be completed prior to the CMS RDS application deadline.

1.3.2. For Retirement:

1.3.2.1. Create calculators as requested.

a. Create calculators to reflect the cost of purchases at the actuarial accrued liability, the present value of the accumulated benefit obligation, actuarial accrued liability for upgraded service credit and other calculators as requested based on the most recent valuation.

1.3.2.2. Prepare actuarial valuations as directed by Retirement.

a. Prepare or review actuarial valuations of local government retirement plans or for employees not covered by the FRS.

1.4. Additional Service Requirements for the DSGI and Retirement

1.4.1. All project lead actuaries assigned to the projects and approved by the Department shall be enrolled actuaries as defined in section 112.625(3), F.S., and shall be members of the American Academy of Actuaries or the Society of Actuaries in good standing who are responsible for overseeing other assigned staff and the final work product.

2. Contractor Deliverables

2.1. Consulting Services

The following project deliverables are to be provided for consulting services, upon request:

2.1.1. Legislative Support and Analyses
Be available as needed to the Department for analysis preparation and presentation to legislative staff

2.1.2. State Employees Health Insurance Trust Fund

a. Assistance determining financial impacts of plan design, industry and legislative changes
b. Reviewing and developing enrollment, revenue and expense forecast models
c. Assistance forecasting and monitoring enrollment, revenue and expense projections
d. Assisting with presentations at the Self-Insurance Estimating Conferences upon request
e. Availability for consulting and advisory services as needed

2.1.3. Federal Patient Protection Affordable Care Act (ACA)

a. Available for consultation and assistance for the DSGI implementation
b. Advise the DSGI on plan optimization strategies
c. Assess the feasibility of implementation and risks and costs of compliance

2.1.4. Other projects as needed by the Department
All deliverables will be presented by the consultant to the Division requesting services in a meaningful and acceptable manner (i.e., to the satisfaction of the Division Director and Bureau Chief). Based on circumstances, adjustment to the time allowed for each deliverable may be made when requested by the consultant if permission is authorized in writing by the Division contact.

2.2. Actuarial Services

Project deliverables will be more specifically spelled out in the purchase order or letter of authorization, but shall not be limited to, the following:

2.2.1. Legislative Support and Analyses
Be available as needed to the Divisions for analysis preparation and presentation to legislative staff

2.2.2. Full GASB requirements for an Actuarial Valuation Study, July 1 through June 30. The update to the Actuarial Valuation Report shall include the following components:

a. Summary of Principle Results
b. Liabilities and Costs, including implicit rate subsidy and the impact on OPEB liability
c. GASB Disclosure and Reporting Information for Pension and OPEB Statements (for Comprehensive Annual Financial Report (CAFR) compliance)
d. Development of Claim Costs
e. Summary of Benefits
f. Summary of Data
g. Actuarial Assumptions and Methods
h. Additional tables can be added to the report if considered to add value to the report
i. Actuarial reports shall be accompanied by a signed statement certifying representations contained therein

2.2.3. Update GASB 43 and 45 Actuarial Valuation Study
The update to the Actuarial Valuation Report shall include the following components:

a. Summary of Principle Results
b. Liabilities and Costs, including implicit rate subsidy and the impact on OPEB liability
c. GASB Disclosure and Reporting Information (for Comprehensive Annual Financial Report (CAFR) compliance)
d. Development of Claim Costs
e. Summary of Benefits
f. Summary of Data
g. Actuarial Assumptions and Methods
h. Additional tables can be added to the report if considered to add value to the report
i. Actuarial reports shall be accompanied by a signed statement certifying representations contained therein

2.2.4. Annual Retiree Drug Subsidy (RDS) Actuarial Attestation – Preferred Provider Organization (PPO) Plans and Self-Funded Health Maintenance Organization (HMO) Plans

2.2.5. Legislative Support and Analyses
2.2.6. Other projects as needed by the Department
2.2.7. The Actuarial Attestation Report shall include, but will not to be limited to, the following:
a. Actuarial Equivalence and Creditable Coverage (Net and Gross Tests)
b. Participant Data
c. Summary of Plan Provisions
d. Total Rates and Retiree Contributions
e. Actuarial Assumptions and Methods
f. Actuarial reports shall be accompanied by a signed statement certifying representations contained therein

All deliverables will be presented by the consultant to the DSGI in a meaningful and acceptable manner (i.e., to the satisfaction of the Division Director and Bureau Chief of Finance for the DSGI). Based on circumstances, adjustment to the time allowed for each deliverable may be made when requested by the consultant if permission is authorized in writing by the DSGI Bureau Chief of Finance.

2.3. Auditing Services

2.3.1. Project deliverables for the annual medical claims audits include the following:

2.3.1.1. Kick-off meeting with SPs and TPA
2.3.1.2. Identification of data requirements
2.3.1.3. Coordination of onsite review between the DSGI, consultant and SPs and TPA.
2.3.1.4. Draft report for each SP and TPA, combining results of both the audit review and operational assessment. A separate report shall be provided for each SP and TPA.
2.3.1.5. A review and evaluation of the adequacy of SP and TPA responses to the draft report.
2.3.1.6. A final audit report including the following aspects of the scope of the project:
a. Executive Summary
b. Key findings and observations of all components of the audit
c. Results of the electronic audit tests of 100% of claims processed
d. Results of focused claims samples, including error rates
e. Results of duplicate electronic analysis of 100% of claims processed
f. Results of out of pocket claims calculations
g. Results of out of State claims processing
h. Results of provider network discount calculations
i. Results of processing Medicare coordination of benefits claims
j. Results of HIPAA compliance
k. Results of accuracy of the reported performance guarantees and appropriateness of the methodology for calculating the performance guarantees
l. Overall assessment of the subrogation process
m. Overall assessment of the handling and resolution of fraud/abusive activities
n. Overall assessment of customer service and claims processing

o. Description and explanation of identified deficiencies and opportunities of improvement, including any processes not adhering to contractual or industry standards and best practices
p. Recommendations of specific corrective action plans to improve deficiencies, implement processes adhering to industry standards and best practices and enhance service and reduce costs

2.3.1.7. Audit follow up procedures may be necessary if required by the DSGI to ensure corrective actions have been fully and properly implemented and are assumed to be included in the proposed cost of the audit

2.3.2. Project deliverables for the annual PBM audit include the following:

2.3.2.1. Kick-off meeting with SPs and TPA
2.3.2.2. Identification of data requirement
2.3.2.3. Coordination of onsite review between the DSGI, consultant and PBM
2.3.2.4. Develop and submit a draft report that includes all requirements and aspects of the scope of this project
2.3.2.5. Review and evaluate adequacy of PBM response to the draft report
2.3.2.6. Prepare final audit report of all aspects of the scope of this project, including:
a. Executive Summary
b. Key findings and observations of all components of the audit
c. Matrix summarizing all key findings and observations by Plan Year
d. Results of duplicate electronic analysis of Rx claims processed.
e. Results of standard operating procedures
f. Comparisons between ratios resulting from the audit, industry benchmarks, and State's performance guarantees
g. Description and explanation of identified deficiencies and opportunities of improvement, including any processes not adhering to contractual or industry standards and best practices
h. Audit follow procedures shall be necessary if required by the DSGI to ensure corrective actions have been fully and properly implemented and are assumed to be included in the proposed cost of the audit

2.3.3. Project deliverables for the annual RDS audits include the following:

2.3.3.1. Kick-off meeting with SPs and TPA
2.3.3.2. Identification of data requirements
2.3.3.3. Draft report for each SP and TPA, combining results of both the audit review and operational assessment. A separate report shall be provided for each SP and TPA
2.3.3.4. A review and evaluation of the adequacy of SP and TPA responses to the draft report
2.3.3.5. A final audit report including the following:
a. Executive Summary
b. Key findings and observations of the audit
c. Results of member eligibility review
d. Results of prescription drug eligibility review
e. Results from the review of the calculation of subsidy amounts

This statement is applicable to all requirements and deliverables set forth in the Contract: Whenever any date prescribed herein falls on a Saturday, Sunday, or legal holiday, the action required on that date shall be required on the next business day.

3. Contract Completion

The Contractor shall satisfy all of the above criteria for each project identified by the purchase order no later than the expiration date of the Contract, as extended or renewed or, where applicable, the expiration of date any purchase order(s) off the Contract.

4. Assumptions and Methodologies

4.1. The following assumptions are an inherent aspect of the scope of the project. As such, should any of these assumptions, approaches and methodologies change, the applicable timelines and cost associated with this project may need to be revisited.

4.2. Consultant shall inform the state of the proposed assumptions, approaches and methodologies to be used to conduct the audits and operational assessments.

4.3. Timely feedback to relevant and reasonable requests for information made by the consultant;

4.4. All requests to participate in any meetings or presentations, to provide a response to any questions, perform further analysis as it relates to work performed by the consultant, will come from the requesting Division's Contract Manager.

5. Reporting Requirements

For each project, the Contractor shall provide at least the following:

5.1. Summary of principle results, findings and recommendations
5.2. Assumptions, approach and methodologies
5.3. Draft and final reports
5.4. Relevant schedules
5.5. Electronic copy of the report and five (5) hard copy reports (binders)

6. Data Requests

For Independent Benefit consulting services, the Contractor and the appropriate Department contact shall mutually agree to a schedule for the completion of any requested projects. The schedule shall include timeframes, interim presentations and final reports. Agreed upon coordination shall include, but not be limited to briefing sessions, legislative testimony, presentations, draft reports and report formatting.

For each actuarial and auditing services project, the Contractor shall discuss the data requirements with the appropriate Department contact and provide a list of agreed upon data requirements to the respective SPs and TPA. The Consultant shall provide the name of a contact person responsible for communication for the project. The Consultant must have the ability to exchange data in a secured method.

7. Financial Consequences for Nonperformance

7.1. Withholding Payment

In addition to the specific consequences explained in this Statement of Work, the State reserves the right to withhold payment or implement other appropriate remedies, such as contract termination or nonrenewal, when the Contractor has failed to perform/comply with provisions of this Contract. These consequences for non-performance shall not be considered penalties.

7.2. ~~Specific Consequences~~Liquidated Damages

The services provided under this Contract are part of an important state function and as such the services must be provided in a timely manner. Any payment as set forth in the contract or pursuant to written approval for a project assumes the services required under this Contract are fully performed in a timely manner. If the services are not fully performed in a timely manner, the Department will be entitled to liquidated~~specified~~ damages, as set forth below, to be applied against the Contractor's invoice. The ~~credits~~ liquidated damages are a reasonable approximation of the damage resulting from an untimely performance or nonperformance. The Parties are stipulating to the damages because the actual loss of value will not be readily ascertainable and will be difficult to prove. These damages are not intended to be a penalty; the Department may waive the damages in a particular case if the Department determines in its discretion that the damages are not warranted. These damages shall be in addition to and shall not constitute a waiver of, the Department's right to pursue any remedies or other damages under this Contract. The damages are as follows:

	1st day past deadline	2nd day past deadline	Each additional day past deadline
*Untimely report(s) or deliverable(s)	$1500	$1000	$500
	Per occurrence		
*Failure to Comply with Other Applicable Requirements	$500		

***NOTE**: Upon written request by the Contractor, and at the Division's sole discretion, it may grant a written extension to a deadline. If the Division grants such an extension of a deadline, the counting of days untimely will begin from the deadline named by the Division in the extension.

8. Subcontractors

The Contractor shall use only those subcontractors as contained in Form 8 - Subcontracting, of the Contractor's response to the solicitation. Should the Contractor need to subcontract any services to the subcontractor not identified in the Contractor's proposal to the solicitation, the Contractor shall submit a written request, (see section 3.6 of the request for proposal) to the DMS Contract Manager.

9. Additions/Deletions

Additions or Deletions to the Deliverables that are not otherwise specified will be handled via an amendment to the statement of work or an updated statement of work in accordance with the purchase order.

10. Transition Plan

In connection with any termination or expiration of this Contract, the Contractor agrees to work with the Department to ensure an orderly and efficient transition from the Contractor to another vendor or to the Department. During this transition period, the Contractor will transfer all necessary records, files and documents.