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Pharmacy and Clinical Services Management Solution
Request for Information (RFI)

Issued by:

The State of Missouri
Department of Social Services
MO HealthNet Division

Issued on:

August 28, 2020

Responses are requested by:

October 2, 2020

Responses are to be submitted to:

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1.0 INTRODUCTION AND PURPOSE

1.1 Introduction

The Missouri Department of Social Services ("Department") is the designated State Medicaid Agency (SMA), and the MO HealthNet Division (MHD) of the Department is responsible for administering the Missouri Medicaid Program, known as *MO HealthNet*. Medicaid is a federal and state entitlement program that provides funding for medical benefits to low-income individuals who have inadequate or no health insurance coverage. Medicaid guarantees coverage for basic health and long term care (LTC) services based upon income and/or resources.

Missouri utilizes a combination of Fee For Service (FFS) and Managed Care (MC) service delivery models. Approximately two-thirds of the member population (primarily children and healthy adults) are enrolled in MC.

MO HealthNet works with several state agencies to administer the Missouri Medicaid Program. These agencies comprise the Missouri Medicaid Enterprise (MME) and includes the following State Agencies:

- The Family Support Division (FSD) and Children's Division (CD) of the Department are responsible for the Medicaid participant eligibility and enrollment functions.
- The Missouri Medicaid Audit and Compliance (MMAC) Division of the Department is responsible for the Medicaid provider enrollment and program integrity functions.
- The Division of Finance and Administration Services (DFAS) of the Department is responsible for providing administrative support for MHD including Medicaid payment processing and financial reporting.
- The Division of Legal Services (DLS) of the Department is responsible for all the legal services related to the Medicaid program.
- The Information Technology Services Division (ITSD) of the Office of Administration is responsible for the development and operation of systems related to the Medicaid program.
- The Missouri Department of Mental Health (DMH) is responsible for administering Medicaid waiver programs.
- The Missouri Department of Health and Senior Services (DHSS) is responsible for administering Medicaid waiver programs, including Home and Community Based Services.

Created as Title XIX of the Social Security Act in 1965, Medicaid is administered at the federal level by the Centers for Medicare & Medicaid Services (CMS) within the United States Department of Health and Human Services (HHS). CMS establishes and monitors certain requirements concerning funding, eligibility standards, and quality and scope of medical services. States have the flexibility to determine some aspects of their own programs, such as setting provider reimbursement rates and the broadening of the eligibility requirements and benefits offered within certain federal parameters.

The MME Programs are supported by the Medicaid Management Information Systems (MMIS). The MMIS systems automate key business processes including claim and encounter processing, financial management and reporting, payment calculations, third-party liability verification and

collections, drug rebates, prior authorization of services, provider enrollment, member eligibility, member enrollment in health plans, premium collections, care management and coordination, and program integrity.

The MMIS system implementations and operations are funded by the federal government with enhanced funding as defined in 42 CFR Part 433 Subpart C. CMS provides guidance to the States regarding enhanced funding for investments in MMIS solutions through regulation, State Medicaid Director Letters, and presentations. CMS is requiring States to adopt a modular strategy for MMIS replacements breaking the traditional MMIS into smaller, more manageable components that can be more easily replaced ("plug and play") and reused in other States.

1.2 Purpose of Request for Information (RFI)

Missouri is currently considering procurement of a Pharmacy and Clinical Services Management Solution to deliver necessary systems and services to support administration of the MO HealthNet program. This Request for Information (RFI) is issued for the purpose of informing the MME and/or supporting development of a procurement approach for consideration by the MME. The MME is interested in Pharmacy and Clinical Services Management Solutions that would provide some or all of the following items:

- Configurable system(s) that reduces development time for functionality and business process modifications required to support Medicaid Program changes
- Solution(s) supporting multiple payers and benefit packages designed for multiple individual eligibility groups
- Increased automation of Medicaid business processes, including service prior authorization and pre-certification of participant services supporting advancement of business process maturity as defined in the Medicaid Information Technology Architecture (MITA) framework
- Continuation of pharmacy and clinical services, including operation of call centers; development, operation, and support of the Pharmacy and Clinical Services Management System; hosting services; privacy and security management services; professional review services to support prior authorization of participant services; data entry; and project management services, with the majority of these services provided by staff located in Missouri
- A system(s) capable of meeting the needs of the MME for the next decade with a modern, scalable, configurable, and customizable technical architecture based on the Service Oriented Architecture (SOA) principles and compliant with the CMS Medicaid IT Supplement (MITS-11-01-V1.0) Enhanced Funding Requirements: Seven Conditions and Standards
- System components deployed for other SMAs, allowing the MME the opportunity to collaborate with other SMAs on Medicaid Program initiatives and share development costs
- A business rules engine incorporated into the system(s) that allows business users to create, view, modify, and test business rules applied to claims processing and other system functions

- A robust provider web portal, web services, and network connection options that allow Medicaid healthcare service providers to submit and manage pharmaceutical claims and service authorization requests and access necessary participant and provider information in an automated fashion
- Compliance with the X12 and NCPDP transaction standards and the Council for Affordable Quality Healthcare's (CAQH) Committee on Operating Rules for Information Exchange (CORE) Operating Rules governing the exchange of transactions and information to support service provision, claims processing, and payment
- Privacy and security services ensuring compliance with privacy and security laws, regulations, and industry best practices and aggressive management of security risks
- A Pharmacy and Clinical Services Management System(s) supporting the interoperability standards promulgated by the Office of the National Coordinator for Health Information Technology (ONC) and CMS to facilitate the exchange of health information
- A solution supporting case management and coordination of care business functions within the MME
- A solution supporting administration of the Home and Community-Based Services program including management of level of care assessments

The MME anticipates that a Pharmacy and Clinical Services Management Solution that takes advantage of these opportunities will be valuable tools in managing the MME programs, providing services to program participants, and supporting the Medicaid healthcare service providers.

The system(s) included in the solution will be considered part of the MME Medicaid Enterprise Systems (MES) and subject to all requirements for Medicaid Management Information Systems (MMIS) as defined in 42 CFR 433 Subpart C and related regulations.

While meeting time, funding, and resource constraints, the MME is interested in looking at CMS-certifiable MMIS alternatives including the following:

- Commercial Off-the-Shelf (COTS) or federal/state-owned “complete” solutions
- Solutions built from “Best of Breed” business function modules and technical components
- Solutions utilizing services shared with other State Medicaid Agencies

Additionally, a future MMIS component must meet all Medicaid Enterprise Certification Toolkit (MECT) checklist items for the DSS checklist, which can be accessed at the following link: https://www.medicaid.gov/medicaid/data-and-systems/mect/index.html.

The process for procuring, implementing, and operating MMIS systems is lengthy and very complex primarily due to the required coordination between CMS and States, federal and state procurement laws, the complexity of the technology, the complexity of the ever-changing Medicaid Program, and the numerous stakeholders. MHD expects any vendor responding to this RFI is aware of the MMIS procurement and certification requirements and the technical standards as defined by CMS at https://www.medicaid.gov/medicaid/data-systems/index.html.

1.3 Vendor Demonstrations

As a result of the RFI response, the MME may choose to have vendors demonstrate their solutions. The proposed timeframe for these demonstrations is currently during the month of November 2020. Formal invitations will be sent at a later date, once all responses have been received and reviewed. While the MME prefers demos to be in person, due to the ongoing COVID-19 pandemic demos may need to be virtual.

2.0 Background – Current State

Proposed solutions will need to support the information needs of the various programs and populations across the MME. On an annual basis, the current Medicaid Management Information System (MMIS) processes over 95 million claims received from over 800 claims transactions submitters representing an average of over 8,000 providers in each payment cycle. Missouri utilizes a combination of Fee For Service (FFS) and Managed Care (MC) service delivery models. Approximately two-thirds of the member population (primarily children and healthy adults) are enrolled in MC. The remaining one-third of the member population (primarily aged, blind, and disabled) are served through FFS. The pharmacy program is carved out of MC and is entirely FFS. The MMIS solutions must serve the needs of both the FFS and MC service delivery models, but the majority (over 85 percent) of transactions are FFS.

To provide an understanding of program size, a summary of *MO HealthNet* statistics for State Fiscal Year (SFY) 2019 (July 2018 through June 2019) is provided below:

- On average, 875,890 people were enrolled in *MO HealthNet* each month.
- Percentage of enrollees:
  - 61.0% – Children
  - 17.4% – Persons With Disabilities
  - 12.4% – Pregnant Women & Custodial Parents
  - 9.2% – Seniors
- 313,211 claims were processed daily, 99% of which were submitted electronically.
- *MO HealthNet* Expenditures – $7,919.6 M annually.
- Percentage of Expenditures:
  - 47.3% – Persons With Disabilities
  - 25.8% – Children
  - 17.8% – Seniors
  - 9.1% – Pregnant Women & Custodial Parents

The MHD is divided into four primary operational units: Program Operations, Information Systems, Finance, and Medical Services. The Program Operations unit includes Pharmacy Services, Clinical Services, Program Relations, Managed Care, and Waiver Programs. The Information Systems unit includes the MMIS, the Clinical Management Services and System for Pharmacy Claims and Prior Authorizations (CMSP), and the Business Intelligence Solution – Enterprise Data Warehouse (BIS-EDW). The Finance unit includes Financial Services and Reporting, Institutional Reimbursement, Waiver Financing, Rate Setting, Budget, Cost Recovery, Audit Services, Pharmacy Fiscal, and CMS Financial Reporting. The Medical

Services unit includes Program Quality, and Medical Services. All four units report to a Division Director and Deputy Division Director. MHD employs over 200 staff.

The Department of Health and Senior Services (DHSS), Division of Senior and Disability Services (DSDS) operates the Missouri State Plan for Home and Community Based Services (HCBS) in addition to four (4) 1915(c) HCBS Waiver programs. These waivers are administered through the Department of Social Services (DSS), the single State Medicaid Agency (SMA), with DHSS serving as the operational entity. Formal cooperative agreements between the departments outline specific duties related to the administration, operation and oversight functions of the state plan and waivers.

DSDS is responsible for administering the Missouri State Plan, which includes personal care services delivered through an agency-model, self-directed services, and services in a Residential Care Facility/ Assisted Living Facility (RCF/ALF). DSDS also administers four (4) HCBS Waiver programs – Aged and Disabled Waiver (ADW), Adult Day Care Waiver (ADCW), Independent Living Waiver (ILW), and the Structured Family Caregiving Waiver (SFCW). DSDS serves an average of 60,000 unduplicated participants each month across all HCBS offerings.

Key information regarding the Missouri Medicaid Program can be found at http://dss.mo.gov/mhd/general/pages/about.htm.

2.1 Missouri Medicaid Systems

The current Missouri MMIS Fiscal Agent (FA) is Wipro Infocrossing, Inc., who is responsible for the development, operation, and maintenance of the primary Medicaid Management Information System (MMIS), the Decision Support System (DSS), and reporting solutions such as Ad Hoc Reporting and Management and Administrative Reporting Subsystem (MARS). The current Program Integrity (PI) tools used by the MMAC Division include OptumInsight's Surveillance and Utilization Review Subsystem (SURS) and Truven's Fraud and Abuse Detection System (FADS) until the new solution is implemented by IBM, currently planned for late 2020.

In 2001, the MME committed to the development of a supplemental MMIS solution referred to as the Clinical Management and System for Pharmacy Claims and Prior Authorization (CMSP) to automate clinical editing and prior authorization of services provided to Medicaid participants. Subsequently, the CMSP solution was expanded to provide a web portal allowing providers to view Medicaid claims and support pre-certification of services and coordination of care within the Missouri Medicaid Program. The CMSP solution has also been expanded to provide a solution for managing the Missouri Medicaid Electronic Health Record (EHR) Incentive Program. The MHD currently contracts with Conduent for the maintenance, operation, and development of the CMSP in addition to a clinical data mart for CMSP Ad Hoc Reporting.

The Department is currently implementing the Missouri Eligibility Determination and Enrollment System (MEDES) to replace the legacy Medicaid eligibility system. MEDES incorporates the Modified Adjusted Gross Income (MAGI) eligibility standards required by the Affordable Care Act. The Department will eventually migrate all Medicaid eligible populations into MEDES.

The MME currently utilizes a Home and Community Based Services Web Tool that provides case management functionality for participants who have had or are currently receiving Medicaid funded HCBS. The Web Tool is a web portal accessibly by MME staff and contracted providers. MME staff and contracted providers access the Web Tool to complete the case actions necessary to authorize HCBS. Below is the approximate number of users operating in the Web Tool:

Users Type	Number of users
MME Staff	550
Contract Providers	4,000
Total Users (estimate)	4,550

Current Web Tool functionality:

a. The Web Tool supports preliminary Level of Care (LOC) screening (Missouri-specific tool). This screening tool serves as a mechanism to determine preliminary eligibility for HCBS prior to conducting a comprehensive assessment. A Missouri-specific algorithm is attached to this screening tool representative of the LOC evaluation requirements outlined in Missouri 19 CSR 30-81.030;
b. The Web Tool supports a comprehensive LOC assessment utilizing the InterRAI-HC. A Missouri-specific algorithm is attached to this assessment representative of the LOC evaluation requirements referenced above cross-walked to InterRAI-HC questions and responses;
c. The Web Tool offers contract providers an activity queue, alerting them of recent case actions performed by MME staff pertaining to participants authorized for HCBS through their agency;
d. The Web Tool supports the prior authorization of HCBS, including care plan customization and development;
    i. The following types of HCBS may currently be authorized in the Web Tool:
        1. State Plan Personal Care, including personal care – agency, personal care self-directed, and RCF/ALF services; and
        2. Waiver Services: adult day care (ADW, ADCW), chore (ADW), home delivered meals (ADW), homemaker (ADW), respite (ADW), specialized medical equipment (ILW), specialized medical supplies (ILW), financial management services (ILW), and case management (ILW).
e. The Web Tool supports documents, allowing MME users and contract providers to upload documents associated with each HCBS participant's case; and
f. The Web Tool supports case note entry.

2.2 Current MMIS Procurement Status

The MME is working toward the replacement of the existing MMIS modules including the core claims processing system. Thus far, the MME has committed to the following:

- The MME is implementing a Program Integrity Solution to replace the existing Fraud and Abuse Detection System (FADS) and Surveillance and Utilization Review System (SURS) and to add a Program Integrity case management system.
- The MME is implementing a Business Intelligence Solution – Enterprise Data Warehouse (BIS-EDW) to replace the existing MMIS data warehouse and data analytics tools.
- The MME is evaluating options for purchase of a Provider Enrollment Solution to manage the provider enrollment function including the provider screening and monitoring functions.
- The MME is participating in a National Association of State Procurement Officers (NASPO) project to develop a master agreement for Third Party Liability (TPL) services for providing verified TPL leads used in claims processing and for collections on paid claims.
- The MME is procuring an Enrollment Broker and Premium Collections solution and services. The RFP responses are currently being evaluated.
- The MME is participating in a NASPO project to develop a master agreement for a core MMIS claims processing and financial solution. The RFP has closed and responses are being evaluated.
- The MME has released an RFP to procure Health Information Network (HIN) services from HINs serving Missouri providers. The RFP responses have been received and are being evaluated.
- The MME has conducted extensive information gathering sessions to document business requirements related to key Medicaid business functions including claims processing, prior authorization, financial management and reporting, and drug rebate.

3.0 Vision – Future State

The MME envisions services that will support the administration of the MO HealthNet Program. These services include the continuation and consolidation of pharmacy and clinical services, including operation of call centers; development, operation, and support of the Pharmacy and Clinical Services Management System; hosting services; privacy and security management services; professional review services to support prior authorization of participant services; data entry; and project management services, with the majority of these services provided by staff located in Missouri.

The MME envisions an MMIS solution(s) that will provide a comprehensive, scalable, and secure health care information system to support the program management needs of the MME for the next decade and beyond and services to assist with program administration. The Pharmacy & Clinical Services Management Solution system(s) would be a component of the overall MMIS solution. Results of the recently completed Medicaid Information Technology Architecture (MITA) Framework 3.0 State Self-Assessment (SS-A) indicate that MHD is targeting Level 2 and Level 3 MITA maturity for the functions supported by current MMIS solutions. The MME will need a focus on automation, standard data models, standard business rules, and collaboration with data trading partners to meet the target business process maturity levels.

While meeting time, funding, and resource constraints, the MME is interested in looking at CMS-certifiable MMIS solution alternatives including the following:

- Commercial Off-the-Shelf (COTS) or federal/state-owned "complete" solutions
- Solutions built from "Best of Breed" business function modules and technical components
- Solutions utilizing services shared with other State Medicaid Agencies

Additionally, a future MMIS solution(s) must meet all Medicaid Enterprise Certification Toolkit (MECT) checklist items for the DSS checklist, which can be accessed at the following link: https://www.medicaid.gov/medicaid/data-and-systems/mect/index.html

4.0 SUBMISSION REQUIREMENTS

4.1 Response Submission Date, Time, and Format

Interested respondents should submit one (1) electronic copy of their response **by email** as an attachment to the MHD Designated Point of Contact no later than **5:00 PM CDT on October 2, 2020. Please include "RFI Response" in the subject line of the email.**

Responses should be provided in a portable format (Microsoft Word or PDF), formatted using Times New Roman size 11 font, one inch margins, and consecutively numbered pages using a consistent numbering format.

All pages of the response should include the RFI title consistently in either the footer or header of each page. The total response should not exceed the response page limits noted in Table 1 below.

4.2 Response Outline and Page Limit Guidelines

This RFI is issued for the purpose of informing the MME and/or supporting development of a procurement approach for consideration by the MME of a Pharmacy and Clinical Services Management Solution. Responses should be complete when submitted and should clearly describe the respondents' ability to address the overall vision noted in Section 3 and the guidelines and questions specified in Section 4 of this RFI.

Responses should contain the sections identified in Table 1 and include, at a minimum, the information requested in Sections 4.2.1 – 4.2.3. The overall response should not exceed 22 pages and should consider the following page limit guidance.

Table 1: RFI Response Outline and Page Limit Guidance

Section #	Section	Page Limit
1.0	Respondent Identification Cover Page	1
2.0	Organization Summary	2
3.0	Response to RFI Questions	19
	Total	22

4.2.1 Respondent Identification Cover Page

Each respondent will need to include a signed cover page using the format provided in Appendix A to include in their submitted response. A cover page is only required for the organization submitting a response.

4.2.2 Organization Summary

Respondents should provide a brief description of their organization, including the following:

- A general description of the primary business of the organization and its client base
- The organization's areas of specialization
- Any current or recent experience working with state Medicaid agencies
- Size of the organization, including structure
- Vendor support staff qualifications, including experience working with Medicaid systems
- Length of time the organization has been in business, as well as how long the organization has been providing Pharmacy and Clinical Management System and related services

4.2.3 Response to RFI Questions

Please provide a detailed description of your organization's approach to each of the following items, indicating which services your organization is responding to. If your organization is currently not performing the services in one of the sections below please note in the appropriate section.

Please complete the Pharmacy Claims & Drug Rebate tab in the attached Pharmacy and Clinical Services spreadsheet to indicate the following:

1. Indicate whether your organization would be interested in providing the described services.
2. If yes to question 1, please indicate whether your organization would be the primary contractor or be the subcontractor to another organization to provide the described services.

3. If no to question 1, please indicate whether your organization would subcontract another organization to provide the services.
4. If no to question 1 and 3, we would be interested to know if you would expect the described service to be performed by a different type of vendor or a different MMIS component. For example, you may expect the MMIS claims processing system to make the payments to pharmacies and create the remittance advices. Please indicate the MMIS component or type of vendor.
5. If yes on question 1, please indicate if you are currently performing this service for another customer. Please note if the other customer is a State Medicaid Agency.
6. If yes on question 1 or 3, please give a brief description of the product or services.
7. If yes on question 1 or 3, please indicate if the service delivery is automated (e.g. through a web portal or phone app) or manual (e.g. phone call or postal mail). The solution can be both.

Please complete the Audit Services and Call Center Operations tabs in the attached Pharmacy and Clinical Services spreadsheet to indicate the following:

1. Indicate whether your organization would be interested in providing the described services.
2. If yes to question 1, please indicate whether your organization would be the primary contractor or be the subcontractor to another organization to provide the described services.
3. If no to question 1, please indicate whether your organization would subcontract another organization to provide the services.
4. If yes on question 1, please indicate if you are currently performing this service for another customer. Please note if the other customer is a State Medicaid Agency.
5. If yes on question 1 or 3, please give a brief description of the product or services.
6. If yes on question 1 or 3, please indicate if the service delivery is automated (e.g. through a web portal or phone app) or manual (e.g. phone call or postal mail). The solution can be both.

Please complete the Electronic PA System tab in the attached Pharmacy and Clinical Services spreadsheet to indicate the following:

1. Indicate whether your organization has implemented an electronic Prior Authorization (PA) system in the Medicaid Fee-for-Service (FFS) environment. If the answer to this question is no, please proceed to questions 3 and 12.
2. If yes to question 1, please indicate whether your organization is the primary contractor or a subcontractor as part of a larger solution.
3. If no to question 1, please indicate whether your organization would subcontract another organization to provide the system.

4. If yes on question 1, please list the state(s) where your organization implemented an electronic PA system.
5. If yes on question 1, please provide a high-level overview of how long it took to implement the system.
6. If yes on question 1, please indicate if the system has been certified by CMS.
7. If yes on question 1, please indicate if the system allows providers to use a web portal or mobile application to request PAs for services.
8. If yes on question 1, please describe the system functionality available to inquire participant history prior to requesting additional clinical information from the provider.
9. If yes on question 1, please describe the system capabilities as it relates to real time feedback and interaction with the providers during the submission/approval process.
10. If yes on question 1, please indicate whether your system allows for electronic signature or acceptance of the prior authorization.
11. If yes on question 1, please describe the processes available and in use for your system.
12. If yes or no on question 1, please indicate whether your organization provides related professional review services.

If you are collaborating with other organizations to complete your response, please be clear which organization is providing various modules or capabilities of the overall solution in your submitted response.

IMPORTANT NOTE: Your organization is NOT required to provide all of the services described in this RFI in order to submit a response.

Pharmacy Operations

1. Please complete the Pharmacy Claims Processing and Drug Rebate, Audit Services, and Call Center Operations grids as part of your response.
2. The retail pharmacy Point of Sale solution is expected to be operational 24/7 with minimal service disruptions, because a disruption results in MO HealthNet members not receiving their prescriptions. MO HealthNet makes frequent modifications to the member pharmacy benefits, most resulting from planned program changes and some resulting from emerging issues such as budgetary challenges or health emergencies. Please describe your business continuity strategy and the flexibilities your pharmacy system has to accommodate business and program changes to respond to program changes and to emerging issues such as natural disasters or pandemics ranging from regional disasters to national disasters. Please give examples from what you did for other states in response to COVID19.
    a) Business use case – A medication which has an existing clinical edit receives a new FDA approved indication necessitating program changes requiring updates to

allow claims to pay according to the new indication in addition to the old indications.

b) Business use case – Tornado in a region of the state, allow to override early refill in a region of the state instead of statewide.

c) Please give examples from what you did for other states in response to COVID19.

3. Missouri has always been a single state PDL program and pharmacy clinical edits have been customized for the MHD. Does your solution allow for state specific PDL and program specific pharmacy Point of Sale editing?
    a) Business use case – MO HealthNet utilizes both pharmacy and medical claims data in the processing of certain edits. For example, with the drug Humira, we would expect the system to be able to look for a diagnosis (from the point of sale claim and through claims data from the medical claims processor), age criteria, PDL status and a trial of methotrexate prior to approval.
4. Please describe your local support strategy for your State Medicaid clients.
5. Please describe your online portal for current state and plan specific drug formulary for all covered medications, including current and past reimbursement, PA criteria, and PDL status. What functionality is available in your provider portal (billing, RMA, claim lookup, participant history, etc)? What functionality is available in your participant portal (pharmacy history, paperless EOB, etc.)?
6. Does your solution support the NCPDP Formulary layout file?
    a) Business use case - An example is a prescriber is utilizing their EMR and would like to prescribe a medication that is not a preferred agent on the MO HealthNet formulary and requires clinical markers to be approved, how would this information be presented to the prescriber?
7. Does your online portal allow for billing of pharmacy claims?
8. Please describe how your system processes claims for the drug portion of a medical claim that is processed by an outside MMIS vendor. How does this information get processed for clinical editing and drug rebate?
9. Please describe how your system processes and pays claims for compounded medications. How are these claims viewed by state staff in the system? Please describe any limitations on the number of ingredients processed on one claim paid transparently without state staff intervention.
10. Please describe the various methods your pharmacy system can utilize to pay alternative professional dispensing fees on pharmacy claims, please include value based PDF, based on volume, zip code, and any incentive payments and maintaining multiple dispensing fees.
11. What options are available for financial management in the pharmacy system to allow state staff to allocate funds based on funding source for budgeting and federal reporting?
12. Please describe how your solution supports State Pharmacy Assistance Program (SPAP) plans.

13. Please describe how your solution supports unique formularies based on participant benefit package.
14. Please describe how your solution supports real time claim adjustment by state staff.
15. Please describe your system's audit capabilities, including real time fraud, waste and abuse prevention, desk audits and in-person audits.
16. Is your pharmacy system able to process 340B claims by identifying them at the claim level? What pricing methodologies do you have for 340B claims? Does your system process an N1 transaction?
17. What pricing methodologies are available in your system for pharmacy claims payment? Does your system support both a hierarchy and lesser of logic?

Pharmacy Interventions

1. Does your solution access and utilize lab data in the claims adjudication process and or the retrospective DUR process? Please describe your solution capabilities and current implementations.
2. Please describe how machine learning and artificial intelligence is utilized in your pharmacy system.
3. How many pharmacists and clinical staff are dedicated to your other accounts? Does your organization have a central pharmacy clinical research group or does each state have their own resources?
4. MO HealthNet would like to expand pharmacist professional services, please describe how your solution allows pharmacists to bill for these services, including medical billing, point of sale billing, and billing via contractor website. Please include the following specific services in your description: immunizations, injections, MTM, and point of care testing.
    a) Business use case - The administration of healthcare provider administered medications by a pharmacist. Please describe how your system would process the claim and payment for this service.
5. Please describe how your solution utilizes state and/or regional PDMP data in the prospective and retrospective DUR process.
6. Please describe your solution for automated prior authorization of drug claims, including claims from pharmacies and drug claims stripped from medical claims.
    a) Currently providers are required to submit NDCs with the HCPCS code on medical claims. The MMIS strips the NDC and units from the medical and outpatient claim to create a drug claim. The drug claim is then processed through the pharmacy point of sale system and included in the rebate system to allow MHD to invoice manufacturers.
7. Please describe your clinical call center services for prescription authorizations, including front line staff, second level staff, and specialists for reviewing complex regimens including peer to peer reviews, consulting on policy, and appeals hearings.

8. MO HealthNet would like to utilize value based and multi-agency purchasing agreements for purchasing medications. Please describe your experience with these drug purchasing mechanisms.
9. Is your organization a certified Quality Improvement Organization (QIO) or QIO-like entity? If approved as a QIO-like entity, please provide the date of the last certification.

Pharmacy Rebate

1. Please describe how your drug rebate system brings in claims from a pharmacy system, processes and collects drug rebates.
2. What options are available to invoice manufacturers for drug rebate, including federal, supplemental, and State Pharmacy Assistance Programs (SPAP)? How are these rebates allocated to state and federal share based on participant eligibility and specific medication (for example family planning medications)?
3. Describe how your pharmacy system invoices and maintains a unique State Pharmacy Assistance Program (SPAP) with pro-rated units.
4. Please describe how your drug rebate system tracks manufacturer payments, disputes, and interest and processes claim adjustments and recoupments.
5. What is your system's standard service level agreement for claim history retention back to program inception?
6. Please describe your pharmacy system's standard management reports, including data generated for the CMS-64 reporting.
7. Are all open quarters included with each quarterly invoice via all methods of invoice transmission?
8. For manufacturers that participate in multiple rebate programs, does each program have an unique A/R?
9. What options does your rebate system support for inclusion and exclusion of 340B claims and providers?

Prior Authorization & Precertification

1. Please complete the Electronic Prior Authorization System grid as part of your response.
2. Does your system allow a prior-authorization request to enter pending status so a provider can return to supply the rest of the information needed to complete the prior authorization?
3. Does your system allow messaging/pending back to the original requester if more information is required to approve the prior authorization through the portal?
4. Does your system allow providers the ability to upload clinical documentation to support the prior authorization request?
5. Does your system allow the prior authorization to be locked in to a particular service provider after an initial request has been made by an ordering provider? For example, an

ordering provider requests an insulin pump then the DME provider logs in separately, completes the prior authorization and fills the request.

6. Does your system have functionality that enables providers to enter information used to create prior authorizations with the ability to store that information for use in creating future prior authorization requests?
7. Does your system have the ability to perform a real time search of claims history data and/or other data sources to find the data that would support the approval of a prior authorization? Please describe.
8. Are new CMS requirements included at no charge in your system? For example, converting from ICD9 to ICD10 or new HIPAA standards.
9. Does your system use claims history to systematically track billed units against the prior authorized units? How is this information displayed or given to the provider? This includes credited and adjusted claims. Does your system have the ability to integrate with the state's Electronic Visit Verification (EVV) system to track utilized units and compare to billed units and authorized units?
10. Does your system have the ability to track what types of radiology equipment a provider is certified to use, where the equipment is located, and apply this information during adjudication of prior authorization requests?
11. How will the system use evidence-based best practices for treatment and patient care?
    a) Does your system automatically apply nationally accredited criteria to determine the benchmark length of stay based on clinical data supplied by the provider?
    b) Does your system automatically apply nationally accredited criteria to determine the service authorization request based on clinical data supplied by the provider?
12. Does your system allow for state specific modifications to the criteria used to approve prior authorization and inpatient stay requests (certification)?
13. Does your system provide the ability to submit a separate inpatient certification request for a transfer between hospitals during an inpatient stay?
14. Does your system provide a web portal for use by healthcare providers with access to the claims history for program participants, calculation of the medication possession ratio, and explanation of rules applied during claims processing?
15. How does your system generate and send approval and denial letters for prior authorization requests?
16. Does your system generate agreements after the prior authorization request is approved for e-signature or acceptance by the provider and State Medicaid Agency?
17. Describe your process and how your system tracks reconsiderations of review determinations requested by Providers or Beneficiaries for inpatient utilization review.
    a) Include what specialties are available for peer to peer reviews.
18. Describe the specialists and clinical staff available for prior authorization and inpatient certification requests that fall outside the normal approval criteria?

19. Does your system contain a workflow management system to track prior authorization staff productivity and PA status.
20. Describe your products electronic service authorization processing capabilities.
    a) Explain basis for costs and fees.
    b) Is there a limit to the amount of PA volume?
    c) Example of time to process a PA from start to finish.
    d) Does your solution include configurable electronic business rules which would allow MHD to auto approve certain PAs, or is that functionality expected of the receiving (claims processing) system? Please explain.
    e) Does your solution incorporate state defined drug edits?
    f) What report functionality does your product have?
    g) Assumptions, methodologies, and constraints.
21. Describe how our providers would access your solution.
    a) Is a portal available for providers who do not have an Electronic Health Record (EHR), or an ePA enabled EHR?
    b) Will prescribers need to download an app or purchase additional EHR functionality?
    c) Does your product accommodate access through an e-prescribing platform, practice management software, or other stand-alone systems?
22. Please describe how your ePA solution would work with a health information system or prescription processor.
    a) Does your product accommodate access through an e-prescribing platform, practice management software, or other stand-alone systems?
    b) Would you recommend the ePA solution come from the same or different vendor than the e-prescribing payer enablement system? Why or why not?

Home & Community Based Services (HCBS)

Information related to eligibility determination and provider selection is received and made available in the HCBS Web Tool including:

a. Medicaid demographic and eligibility information (date-specific eligibility to include spenddown information and Medicaid eligibility code) from the MMIS system;
b. HCBS provider information specific to the county of residence and the selected service from both the MMIS system and a Home and Community Services Provider Database;
c. Date of Death file, and
d. File data from other MME solutions.

Information sent from the HCBS Web tool includes:

a. Prior Authorizations for the delivery of HCBS (including newly created prior authorizations for delivery and reimbursement of services, changes to an existing prior authorizations and closing of authorizations) sent to the MMIS; and
b. File data to other MME solutions.

1. If you are proposing a solution, would your solution be able to support the aforementioned described functionality through out-of-the-box configuration or customization? Please describe how you would approach providing this functionality and the software solution(s) that would be utilized.
2. HCBS in the MME is rapidly evolving. Would your solution be able to support the addition of new functionality and/or the alteration of existing functionality? Please describe the processes you have in place to add new, or alter existing, functionality in your solution.
3. Would your solution support e-signatures for MME staff and/or contract providers in order to verify acceptance of prior authorizations? Would your solution support e-signatures for other documentation by MME staff, contract providers, or HCBS participants?
4. Will your solution automatically update to comply with requirements set by the Center for Medicare and Medicaid Services (CMS) (e.g. ICD9 to ICD10). If not, what is the process to update your solution to be in compliance with changing federal requirements?
5. The MME is pursuing the development of a Mobile Assessment Application to enable the offline completion of an LOC assessment (InterRAI-HC) for HCBS participants. This application will be primarily utilized on mobile devices (e.g. tablets, mobile phones) in participant homes and communities. The application will send assessment data to the Web Tool to circumvent manual data entry steps and provide real-time eligibility data. Please describe if/how your proposed solution would support the completion of an HCBS assessment via a mobile device, whether in an online and/or offline state. Please also describe any additional functionality your solution offers to support HCBS operations from a remote location.
6. The MME is exploring the addition of Case Mix to HCBS assessments through the use of Resource Utilization Groups (RUGs). These RUGs would be integrated into the HCBS assessment through an algorithm. RUGs would also be used to generate acuity-based plans of care for HCBS participants. Please describe if/how your proposed solution would support this functionality.
7. The MME is exploring the inclusion of workflow functionality into the HCBS solution. Workflow functionality includes the assignment of case management activities (e.g. assessments, care plan changes, provider changes), activity tracking (e.g. tracking pending activities, completed activities), and reporting functionality. Please describe if/how your proposed solution would support this functionality.

8. The MME is pursuing the development of an Electronic Visit Verification (EVV) aggregator. This aggregator will collect HCBS visit from each HCBS provider in order to monitor delivery of services. Please describe if/how your solution can be integrated with this system to display authorized units, billed units, and relevant visit data associated with each participant.
9. Please provide any additional information regarding the potential inclusion of Adult Protective Services (APS) case management and/or Critical Incident Management functionality in your HCBS solution.
10. Please describe any additional functionality included in your HCBS solution not previously mentioned in this document.

Consultation

1. Please explain any payment methodology consulting services you provide including but not limited to:
    a) Recalculating inpatient claims, paid on a per diem basis, in order to determine portion of payment related to healthcare acquired conditions;
    b) Analysis of payment and/or pay for performance methods used by other states and other payers;
    c) Identification and analysis of value purchasing strategies, including analysis of hospital readmissions; and
    d) Analysis of other provider type payment methods such as outpatient, long-term care, FQHC, durable medical equipment, physician fees, etc.

Configuration

1. If your solution(s) is(are) a Commerical Off-The-Shelf Solution (COTS), please describe the change request process for code and configuration changes that impact multiple clients and accounts.
2. If applicable, please describe components of your solution that are deployed in a Software as a Service (SaaS) model where the components are shared across multiple customers. Are these customers State Medicaid Agencies and/or commercial payors?

Interoperability and Health Information Exchange

1. Please describe your solution(s) for supporting State Medicaid Agency implementation and operation of the Application Programming Interfaces (APIs) as required by the CMS Interoperability Rule.
2. Please describe your solution(s) for implementation and operation of a health information exchange platform that meets the health information exchange requirements and standards as established by the ONC and CMS and facilitates the exchange of health

information between state agencies, Health Information Networks, and healthcare service providers.

5.0 PROCEDURE AND INSTRUCTIONS

5.1 RFI Submission

As noted above, the purpose of this RFI is to inform the MHD and/or support development of a procurement approach for consideration by MHD of a Pharmacy and Clinical Management Solution. This RFI does not constitute a solicitation of proposals, a commitment to conduct procurement, an offer to contract, or a prospective contract. The descriptions in this RFI are tentative and may change prior to the procurement of system integration services.

The State of Missouri is not liable for any costs incurred by respondents to produce and submit a response to this RFI for MHD. The MHD will acknowledge the receipt of responses and reserves the right to request any respondent to provide an onsite presentation regarding system integration and/or demonstrate some of their capabilities.

5.2 Designated Point of Contact

The MHD Designated Point of Contact for this RFI is:

Garret Bialczyk
MO HealthNet Division
615 Howerton Court
PO Box 6500
Jefferson City, MO 65102-6500
Phone: (573) 751-7996
Email: Garret.Bialczyk@dss.mo.gov

5.3 Public Information

All submitted responses to this RFI will be subject to Missouri's Sunshine Law and will be shared upon request or will be made publicly available on the State of Missouri website.

More information regarding the Missouri Sunshine Law can be found at http://ago.mo.gov/sunshinelaw/.

5.4 Disclaimers and Disclosure of Proposal Content and Proprietary Information

All information received from respondents becomes the property of the State of Missouri and the Department of Social Services (DSS), MO HealthNet Division (MHD), and Office of Administration- Information Technology Services Division (OA-ITSD). As such, RFI responses can be published in the public domain at the conclusion of the selection process. The State of Missouri does not guarantee protection of any information from public disclosure.

Appendix A – Vendor Response Cover Page

Respondent's Name _____

Respondent's Physical Address _____

City _____ State _____ Zip Code (include 4 digit add on) _____

Respondent's Contact Person _____

Phone Number & Area Code _____ Fax Number & Area Code _____

E-mail Address _____ Website Address _____

_____ _____
Authorized Signature of Respondent Data Signed

_____ _____
Typed Name of Authorized Signatory Title of Authorized Signatory

Appendix B – Acronyms

The following acronyms are used within this document.

Acronym	Definition
BIS-EDW	Business Intelligence Solution – Enterprise Data Warehouse
CD	Children's Division
CMS	Centers for Medicare & Medicaid Services
DFAS	Division of Finance and Administration Services
DHSS	Department of Health and Senior Services
DLS	Division of Legal Services
DMH	Missouri Department of Mental Health
DSS	Decision Support System
FA	Fiscal Agent
FADS	Fraud and Abuse Detection System
FFS	Fee For Services
FSD	Family Support Division
HHS	Health and Human Services
ITSD	Information Technology Services Division
LTC	Long Term Care
MC	Managed Care
MCO	Managed Care Organization
MHD	MO HealthNet Division
MITA	Medicaid Information Technology Architecture
MMAC	Missouri Medicaid Audit and Compliance
MME	Missouri Medicaid Enterprise
MMIS	Medicaid Management Information System
NCPDP	National Council for Prescription Drug Programs
OA-ITSD	Office of Administration- Information Technology Services Division
PDF	Portable Document Format
RFI	Request for Information
RFP	Request for Proposal
SMA	State Medicaid Agency
SPAP	State Pharmacy Assistance Program
SS-A	State Self-Assessment
SSI	Supplemental Security Income
SURS	Surveillance Utilization Review System
TPL	Third Party Liability