



Medicaid Management Information Systems (MMIS) Request for Information (RFI)

Issued by:

The State of Missouri
Department of Social Services
MO HealthNet Division

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Responses are requested by:

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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.

The Missouri Medicaid Enterprise (MME) is composed of 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.

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. To reduce the risks inherent in implementations of modular MMIS solutions provided by multiple vendors, CMS recommends the States utilize third-party System Integrators to provide oversight, management, integration, and technology services to support the implementation of modular MMIS solutions.



1.2 Purpose of Request for Information (RFI)

Missouri is currently planning for procurement for its Medicaid Management Information System (MMIS) and its Fiscal Agent services. This Request for Information (RFI) is issued for the purpose of obtaining information to support development of a procurement approach for consideration by MHD in preparing one or more Requests for Proposal (RFPs) to be awarded in one or more distinct contracts. MHD is seeking information regarding available MMIS solutions that are configurable and would provide a comprehensive, scalable, and secure health care information system to support the program management needs of the Missouri Medicaid Enterprise (MME) for the next decade and beyond, and Fiscal Agent (FA) services to assist with program administration. The MME is interested in MMIS solutions and FA services that would provide some or all of the following opportunities:

- Configurable MMIS solution(s) that reduces development time for functionality and business process modifications required to support Medicaid Program changes
- MMIS solution(s) supporting multiple payers and benefit packages designed for multiple individual eligibility groups
- Reduced overall cost of the MMIS operations and Fiscal Agent services
- Increased automation of Medicaid business processes, including 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 Fiscal Agent services, including operation of call centers; development, operation, and support of the MMIS; data center hosting services; privacy and security management services; receipt and distribution of letters and operation of a mailroom; professional review services to support prior authorization of participant services; data entry; document imaging; and project management services, with the majority of these services provided by staff located in Missouri
- A MMIS solution(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
- MMIS 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 MMIS solution(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 claims 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
- A robust participant web portal that allows users to view claims history, verify services provided, and find Medicaid healthcare service providers
- Privacy and security services ensuring compliance with privacy and security laws, regulations, and industry best practices and aggressive management of security risks
- A MMIS solution(s) supporting the Integrating the Healthcare Enterprise (IHE) standards to facilitate interfaces with other state systems and with the statewide Health Information Network (HIN) to share Medicaid claims data and retrieve clinical data



- A MMIS solution(s) supporting the Missouri Healthcare Home Program and the case management and coordination of care business functions within the MME
- Effective data management to facilitate secure distribution of Medicaid claims data to other partners while ensuring timeliness, security, and data integrity

The MME anticipates MMIS solution(s) and Fiscal Agent services that take 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.

1.3 Vendor Demonstrations

As a result of the RFI response, the MHD may choose to have vendors demonstrate their solutions. The proposed timeframe for these demonstrations is currently July 24, 2017 through August 10, 2017. Formal invitations will be sent at a later date, once all responses have been received and reviewed.

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) 2016 (July 2015 through June 2016) is provided below:

- On average, 964,610 people were enrolled in *MO HealthNet* each month.
- Percentage of enrollees:
 - ◆ 62.9% – Children
 - ◆ 16.5% – Persons With Disabilities
 - ◆ 12.5% – Pregnant Women & Custodial Parents
 - ◆ 8.1% – Seniors
- 280,962 claims were processed daily, 99% of which were submitted electronically.
- *MO HealthNet* Expenditures – \$8,149.6 M annually.
- Percentage of Expenditures:
 - ◆ 46.7% – Persons With Disabilities
 - ◆ 25.3% – Children
 - ◆ 18.2% – Seniors
 - ◆ 9.8% – 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 and the Clinical Management Services and System for Pharmacy Claims and Prior Authorizations (CMSP). 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.

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).

In 2001, the MHD 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 participates in the Missouri-based Health Information Network (HIN) operated by Missouri Health Connection (MHC). The MME currently shares claims information with Missouri providers through the HIN. The MME intends to access clinical data through the HIN in the future to support key business functions including prior authorization and pre-certification of services, case management, and coordination of care.

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 released an RFP for 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 RFP has been closed and the responses are being evaluated.
- The MME released an RFP for 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 RFP has been closed and the responses are being evaluated.
- The MME released an RFP for a Business Intelligence Solution – Enterprise Data Warehouse (BIS-EDW) to replace the existing MMIS data warehouse and data analytics tools. The RFP has been closed and the responses are being evaluated.
- The MME is drafting an RFP for purchase of a Provider Enrollment Solution to manage the provider enrollment function including the provider screening and monitoring functions.



- The MME has completed the procurement of a Third Party Liability (TPL) service for providing verified TPL leads used in claims processing and for collections on paid claims.
- 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.

2.3 CMS Definition of System Integrator Role and Duties

CMS has provided new guidance to the States regarding investments in Information Technology using Medicaid Management Information System (MMIS) enhanced funding. The guidance has been provided in the updated regulation 42 CFR 433 Subpart C, State Medicaid Director Letters (SMDL), and CMS presentations. CMS has identified the following overall goals and guidance to support changes to the Medicaid Program:

- MMIS systems now require a very complex system enterprise model;
- CMS can no longer consider a single vendor providing the entire MMIS solution;
- CMS will discourage states from functioning as their own technical MMIS Systems Integrator (SI);
- Solutions must support frequent changes in payment models; and
- Solutions must become faster, better, and cheaper to keep up.

A primary objective for CMS related to supporting transformation of MMIS systems is reducing the barriers to entry into the MMIS solution market by new vendors. To accomplish this, CMS is interested in:

- Increasing the number of potential vendors with a modular approach to system architecture and procurement by separating MMIS components (e.g. claims, provider enrollment, third party liability, decision support);
- Building non-proprietary products when possible using shared solutions with “plug and play” components; and
- Ensuring the technology is leading edge where options for change or improvement are unlimited and comparatively inexpensive for the state and low risk for the vendor with faster performance, cheaper hosting costs, and leverage experience from similar sectors

CMS has provided guidance to States through SMDLs and presentations by CMS staff promoting the utilization of System Integrators (SI) for supporting the design, development, implementation, and operation of MMIS enterprise systems. CMS has defined the role of SIs as having a specific focus on ensuring the integrity and interoperability of the Medicaid IT architecture and cohesiveness of the various MMIS modules incorporated into the Medicaid system. CMS envisions SIs fostering best-in-breed and ever-evolving solutions for MMIS enterprise systems with the SI responsible for successful integration of the chosen solutions and infrastructure into a seamless system. CMS considers managing risks for an MMIS project involving multiple vendors and modular solutions central to the SI role.

States are encouraged to use an acquisition approach that limits the potential conflict of interest an SI may have in choosing the modular solutions to be incorporated into the MMIS. SIs may be precluded from bidding on procurements of the MMIS module application software, though the SI may provide elements of the technical infrastructure such as the enterprise service bus, master data management tools, identity and access management tools, etc. The goal of CMS is to avoid lock-in to a single vendor or an otherwise



closed set of solutions. Instead, CMS is encouraging States to procure MMIS modules from multiple vendors.

CMS intends for SIs to mitigate the risk of failures in the integrations between multiple MMIS modules provided and operated by multiple vendors. SIs will mitigate this risk by ensuring that:

- The MMIS module vendors work together and that conflicts are identified and resolved in a timely and technically sound manner;
- System designs account for technical requirements of multiple interfaces and that all of those interface requirements are adequately tested;
- There are no orphaned functions;
- When the system is delivered, Medicaid transactions are accurate and seamless as they transverse multiple modules;
- The re-use of assets is facilitated between States;
- Open Automated Programming Interfaces (APIs) are utilized; and
- MMIS modules remain loosely coupled.

CMS defines the duties of the SIs as follows:

- At a detailed technical level, helps establish standards and ensures that all modules work together seamlessly and work securely with external systems;
- Ensures that overall security and privacy remain intact when various modules and components are integrated;
- Manages, coordinates, and supports the work of multiple MMIS module vendors and negotiates solutions to disagreements that may arise between different development contractors;
- Ensures modules are being built using appropriate interoperability standards;
- Manages risks that may arise when schedule or technical slippage in one module affects other modules;
- Cooperates with a state Project Management Office (PMO) and the Independent Verification & Validation (IV&V) contractor to give an accurate, honest reporting of project status;
- Provides planning services including:
 - ◆ Vision, strategy, assistance in developing goals and objectives;
 - ◆ Concept of operations;
 - ◆ Enterprise functional and non-functional needs analysis;
 - ◆ Continuity of operations and disaster recovery planning;
 - ◆ Architectural and engineering decomposition; and
 - ◆ Communications planning
- Provides management framework services including:
 - ◆ Enterprise design, pattern and portfolio management;
 - ◆ Enterprise architecture, modeling, and integration;
 - ◆ Continuity of operations and disaster recovery planning;
 - ◆ Architectural and engineering decomposition; and
 - ◆ Communications planning
 - ◆ Enterprise technical roadmap orchestration with sequencing and transitioning plan;
 - ◆ Enterprise functional and non-functional requirements;
 - ◆ Development life cycle; and
 - ◆ Enterprise management of master integrated schedule, scope, change control, risk management, and quality assurance



- Functional implementation services including:
 - ◆ Standards selection;
 - ◆ Integration services;
 - ◆ Business architecture and modeling; and
 - ◆ Information architecture and modeling
- Technical implementation services including:
 - ◆ Environment/infrastructure;
 - ◆ Network services;
 - ◆ Portal, module portal;
 - ◆ Enterprise service bus;
 - ◆ Identity management;
 - ◆ Platform services layer, data services layer, master data;
 - ◆ Enterprise services registry;
 - ◆ Standards selection; and
 - ◆ Security architecture and framework

2.4 MME MMIS System Integration Needs

The MME has procured MMIS solutions from multiple vendors for many years. While one vendor is responsible for the hosting, development, operation, and maintenance of the state-owned core claims processing system, the MME utilizes an eligibility and enrollment system, an advanced pharmacy claims and prior authorization system, a fraud and abuse detection system, and a third party liability lead verification and collection service provided by other vendors. The MME is familiar with the many challenges involved in integration of MMIS modules to create an enterprise solution. Those challenges include the following:

- No standards for the exchange of data between MMIS modules - While the MME does utilize standard transactions (e.g. X12, HL7) for the exchange of data with external partners, virtually all data exchanged between the MMIS modules is in proprietary formats. Many MMIS modular solutions available in the market today utilize proprietary formats and services for data exchange.
- No standard MMIS data models – The MME utilizes a claims processing system that was originally built during the 1980s. The data model has evolved over time to reflect Missouri business needs, but has not been aligned with any external standards. The MME anticipates and has experienced significant differences in the data models with available MMIS modules from the existing MMIS data model.
- No standard MMIS modules – There is no defined list of MMIS modules or standards for the functionality included in each module. This lack of standards inhibits the development of services that would be included in each module and “plug and play” integration with other MMIS systems.
- Vendor Hosting of MMIS modules – The MME has long employed a strategy of vendor hosting of MMIS modules. Unfortunately, this strategy results in the maintenance of multiple platforms preventing the reuse of technology components, increases the complexity of integrations and data exchanges between the systems hosted in multiple data centers, requires the maintenance of secure data connections between the data centers which increases the number of failure points, and increases security risks with the replication of MMIS data.



- No clear definition of the responsibility of each MMIS module vendor for interfaces between modules – Due to the lack of standards for integration and data models, the interfaces between the MMIS modules are largely proprietary and sometimes require middleware to reformat or transform the data. The interfaces also require ongoing monitoring and support with difficulties determining which part of an interface (source, target, or middleware) is causing issues. Developing and supporting these interfaces requires coordination and cooperation between the vendors.
- Existing MMIS management and staffing model – The MME is currently staffed for managing the existing number of system contracts based on the model of system integration services and technical expertise being provided by the MMIS solution vendors.
- The Medicaid Program is changing and continues to become increasingly complex – Many changes are being discussed in Congress related to funding for the Medicaid Program. In addition, the MME has been experimenting with alternate payment methodologies, care and case management programs, and service delivery models, all of which has significantly increased the complexity of the MMIS claims processing and financial management systems.
- System integration does not end when system implementation is complete – System integration is an ongoing function within an enterprise solution requiring constant monitoring, maintenance, and support. In addition, the constantly changing business needs and technology require ongoing changes to systems and integrations.

2.5 MMIS System Procurement, Implementation, and Operations Process

It is important for the MME to determine when system integration services need to be procured and applied to the overall procurement, implementation, and operations process.

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. The primary high-level steps in this process are as follows. Note that the order of these steps may vary.

1. Complete a Medicaid Information Technology Architecture (MITA) State Self-Assessment and develop MITA Roadmap
2. Secure State approval for MMIS procurement and establish the governance model
3. Secure CMS approval for MMIS procurement planning
4. Meet with business staff to determine organization structure, workflows, and business requirements
5. Obtain information from other States regarding recent RFIs, RFPs, and implementations
6. Gather information from vendors regarding available solutions and services (RFI).
7. Develop a strategy for procurement of modules aligned with the business needs, the organizational structure, and the available MMIS solutions and services
8. Develop a technology strategy for hosting and architecture aligned with the vendor offerings and the State technical requirements
9. Submit the procurement and technology strategy to CMS for approval
10. Draft an RFP for each MMIS module that aligns with the State's procurement process and that reflects the governance model, the business requirements, and the technology strategy
11. Procure Project Management Office (PMO) services (if needed) and Independent Verification and Validation (IV&V) services (required)
12. Trace the RFP requirements to the MMIS/MITA certification checklists



13. Have the IV&V vendor verify the RFP requirements and certification checklists and submit progress report to CMS
14. Submit the RFP and checklists with a project budget to CMS for approval to release the RFP
15. Release the RFP for bid
16. Evaluate the bid responses and determine recommended contract award
17. Submit recommended contract award and request for funding to CMS for approval
18. Award contract
19. Initiate project for MMIS module implementation and replacement of existing MMIS system
20. Gather business requirements and align to MMIS module solution
21. Build the test, development, and production system environments
22. Design MMIS module configuration and deployment, data conversion, and integration with other MMIS systems and with business workflows
23. Develop MMIS module configurations, data conversion processes, and system integrations
24. Conduct system, integration, and user acceptance testing and defect resolution
24. Implement MMIS module with related system integrations, complete data conversion, and train end users
25. Transition the MMIS module to maintenance and operations
26. Conduct MMIS certification processes to verify MMIS certification requirements have been met
27. Obtain MMIS certification
28. Initiate ongoing MMIS module and system integration enhancements, upgrades, and modifications to accommodate changing business needs and systems

3.0 VISION – FUTURE STATE

The MME envisions a 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 continuation of Fiscal Agent services to assist with program administration. 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.

As described in Section 1.2, MHD is gathering information regarding available MMIS solutions to serve as valuable tools in support of key business functions, including claims processing, management of the Managed Care Program, participant benefits management, financial management, and provider management. 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 providing most or all MMIS functions
- 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 through 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 May 22, 2017**. **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 obtaining information to develop the strategy for the MMIS modularity procurement. 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 13 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	10
	Total	13

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 and care management



- Length of time the organization has been in business, as well as how long the organization has been providing MMIS solutions

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.

4.2.3 Response to RFI Questions

The State of Missouri requests each vendor to provide responses to the following questions regarding their MMIS Solution:

Modularity

1. Please identify and describe the MMIS modules offered by your company and address each of the following:
 - a) Please explain if these modules are vendor platform agnostic.
 - b) Please identify and describe the functions that are included within each module.
 - c) Please identify for each module listed above if the reference data/operational database is shared across the modules or separate (i.e. duplicate reference data/operational database for each module).
 - d) Please identify any module listed above that has been successfully deployed independent of your other MMIS modules as either a stand-alone solution or integrated with modules provided by other vendors. If so, please identify in which state(s) this has been accomplished, and whether the module has been integrated with modules provided by other vendors.
2. Does your system allow providers to use a web portal to request prior authorizations for services? If so, does your system provide an automated, web-based clinical edit process that interrogates paid claims history to make a determination before asking a provider to supply additional clinical information? Please describe.
3. During the claims adjudication process, 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 service? Please describe.

Third-Party Systems Integration

4. For answering the following questions, assume the MME has contracted with a third-party Systems Integrator to implement, operate, and maintain all system integrations between MMIS modules:
 - a) What would you be willing/able to be responsible for in regards to the successful integration of your MMIS modular solution and infrastructure into a seamless system? What do you envision your role would be in integrating your solution and what would be the role of the Systems Integrator? Note that the MME may enforce the responsibilities of the MMIS module vendor through contract requirements, service level agreements, and liquidated damages related to the performance of the integrated system.



- b) What strategy/methodology and technology/tools do you employ or expect the Systems Integrator to employ to integrate your MMIS module with modules from multiple other vendors when there are no standards for the format, content, or method for the exchange of data? What would your role and responsibilities be as the MMIS module vendor for establishing standards? What requirements, service level agreements, etc. would need to be enforced with the System Integrator or other MMIS module vendors to make your strategy successful?

Hosting and Cloud Technology

5. In the case where the MMIS is purchasing MMIS modules from multiple vendors, what strategy would you as an MMIS module vendor propose for the hosting of MMIS modules that would minimize the number of platforms; maximize the reuse of technology components; decrease the complexity of integrations and data exchanges between systems hosted in multiple data centers; maintain secure and reliable data connections; and/or reduce security risks? What role and responsibility would you envision having as the MMIS module vendor for executing this strategy?
6. The MME is considering utilizing FedRAMP-authorized cloud services for hosting the MMIS modules with the MMIS module vendors responsible for operating and maintaining the modules. This approach would definitely include Infrastructure-As-A-Service (IaaS) and Platform-As-A-Service (PaaS) services provided by the cloud service provider. The MME would contract directly with a cloud services broker for purchase of the cloud services or have a third-party System Integrator provide and manage the service. Are you willing to implement, maintain, and operate your MMIS modules within this environment? What challenges, risks, or concerns do you see with this approach?

Encounter Data Processing

7. To determine how your system treats Fee for Service (FFS) Claim Adjudication versus processing of Managed Care Organization (MCO) Encounter Data, please answer the following questions:
 - a. Does your system process both FFS claims and encounter data claims? If yes, is it one application that processes both or are there separate applications? Do they share any components (i.e. rules engine, edits, file layout)?
 - b. Please describe the level of validation performed on encounter data claims.
 - c. Does your system perform shadow pricing on encounter data claims or use some other pricing model? Please describe.
 - d. Does your system accept encounter data claims using the ASC X12 and NCPDP transaction standards or a proprietary layout? Please specify the transactions used.
 - e. Please describe, if any, your system's use of translation/crosswalking of the data submitted in the transactions to the data stored in your system for FFS claims and encounter data claims.
 - f. Does your system enroll FFS providers with MCO providers. How do you store the FFS and MCO provider data and cross-reference providers between MCOs?
 - g. If MHD became 100% Managed Care what modules of the MMIS do you think would still be needed by the MME?
8. Does your solution include functionality related to MCO performance measurement (i.e. withholds and releases for management of MCO contracts)? Please describe the functionality.



Third Party Payer Coordination of Benefits

9. Please describe how your system identifies and differentiates between primary, secondary, and tertiary payers along with the corresponding applicable coverages.
10. Please describe how your system processes Coordination of Benefits (COB) segments based on reason codes.
11. How are the policy coverages mapped to the covered services?

Medicare Claims Processing

12. Does your system treat Medicare coverage the same as other third party coverage? Or does Medicare coverage lead to a separate path of processing? Please describe.

Configuration

General

The Medicaid Program is subject to rapid and significant change as was evidenced by the implementation of the Affordable Care Act. The program often becomes more complex as the federal and state governments look for opportunities to reduce costs while improving health outcomes. Bearing this in mind, the following questions will be used to understand how your system is configured and maintained.

13. Please describe any innovative service delivery or pricing models that have been deployed in State Medicaid Agencies using your MMIS solutions.
14. What strategy and technology/tools do you employ to support innovative service delivery or pricing models when the business needs and related systems are subject to significant change?

Member Benefit Package

15. Does your system utilize a member benefit package model? If so, are the benefit packages configurable? Please describe how this model is utilized in claims processing.
16. Please address the following scenario: A participant is eligible for Medicaid State Plan services. The same participant becomes eligible for additional services under a waiver program while remaining eligible for the Medicaid State Plan services. Explain how this change would be made in your system for these additional services. Assume that the costs must be assigned to the Medicaid State Plan for covered plan services separate from costs assigned to the waiver program for covered waiver services. Also assume that there are overlaps in the services covered by the Medicaid State Plan and the waiver, and that the costs for overlapping services must be assigned to the waiver program.
17. Please address the following scenario: There is a covered service included in the benefit packages for two separate Medicaid programs that have two separate funding sources. The costs for this covered service must be allocated to the specific Medicaid program for which each individual participant is eligible. For example, inpatient services provided to an elderly participant must be allocated to the Medicaid Program while inpatient services provided to a child must be allocated to the CHIP



Program. How and where does your system determine which fund to use (i.e. claims adjudication or financial system)?

Provider Services

18. Please describe how your system groups providers based on their unique enrollment attributes such as provider type, specialty, licensure, certificate, etc.
19. Please address the following scenario: How would your system reimburse a provider with a special certification an additional amount for a specific service, beyond the standard fee paid to similar providers without the certification?

Program Service Code Sets (HCPCS, CPT, ICD10, etc.)

20. How are these program service code sets stored and accessed by the claims adjudication system? Are these codes sets maintained in one master list, or are they separated or grouped together (i.e. by program, by provider, by designated health service categories, etc.)? How are changes (additions, deletions, updates) made as needed to these services (i.e. versioning, change process, configuration)? How are the rates and/or payment methodology related to these services maintained? Where in your system are these rates applied to determine payment?

Pharmacy Claims Adjudication System

21. Please describe the transactions supported with your system (i.e. X12-837, 270/271, 835 and/or NCPDP-E1, B1, B2, N1, N2, S1, S2, S3, compound segments).
22. Please describe your pharmacy claim adjudication and payment process, including pricing update processes, and pricing methodology when more than one fee is maintained in the pricing file (such as AWP, WAC, MAC, etc.)
23. Does your pharmacy system integrate with other vendors for eligibility, claim editing, third party information, etc.? Please describe the data exchanged, how it is used, and if it is stored or maintained.
24. Does your pharmacy system incorporate medical claims or other clinical data within its editing and claim adjudication? Please describe.
25. Does your pharmacy system incorporate the drug rebate processing and collection? Please describe.
26. Does your pharmacy system negotiate, contract for, and apply supplemental rebates for specific drug categories? Please describe.
27. Does your pharmacy system complete the claim adjudication/finalize claims for payment, including all responses to the provider or integration options for provider reimbursement? Please describe.
28. Please describe the edits currently available in your pharmacy system (DUR, step therapies, PDL, brand/generic) and the configurability provided to incorporate additional editing based on State



request, P&T Committee recommendations, etc. Please describe the level of visibility into the editing provided to State staff. Please describe the level of configurability available to State staff.

29. Does your pharmacy system support add-on dispensing fees or payments based on generic dispensing and other enhanced fee structures? Please describe.
30. Please describe the reimbursement methodologies available in your pharmacy system to various providers (i.e. 340B, Federally Qualified Health Center (FQHC), Long Term Care (LTC), etc.).
31. Does your pharmacy system provide a web portal and/or provider help desk for physicians and/or pharmacies to verify preferred drugs, apply patient specific criteria to a proposed drug to determine coverage, or communicate with a help desk?
32. Please describe your pharmacy system's prior authorization process including the manual processes, automated processes, and reporting capabilities.

Transformed – Medicaid Statistical Information System (T-MSIS)

33. CMS requires the submission of claims, encounter, provider, and other data into the T-MSIS system. Would data extracted from your system have to be transformed for submission to T-MSIS in the required T-MSIS format? If so, please describe the transformations required.

5.0 PROCEDURE AND INSTRUCTIONS

5.1 RFI Submission

As noted above, the purpose of this RFI is to obtain information to support development of a procurement approach for consideration by MHD in preparing one or more Requests for Proposal (RFPs) to be awarded in one or more distinct contracts. 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:

Todd Meyer
MO HealthNet Division
615 Howerton Court
PO Box 6500
Jefferson City, MO 65102-6500
Phone: (573) 751-7996
Email: Todd.Meyer@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
APIs	Automated Programming Interfaces
BIS-EDW	Business Intelligence Solution – Enterprise Data Warehouse
CAQH	Council for Affordable Quality Healthcare
CD	Children’s Division
CMS	Centers for Medicare & Medicaid Services
CMSP	Clinical Management Services and System for Pharmacy Claims and Prior Authorizations
COB	Coordination of Benefits
CORE	Committee on Operating Rules for Information Exchange
COTS	Commercial Off-the-Shelf
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
EHR	Electronic Health Record
FA	Fiscal Agent
FADS	Fraud and Abuse Detection System
FFS	Fee For Services
FSD	Family Support Division
HHS	Health and Human Services
HIN	Health Information Network
HIPAA	Health Insurance Portability and Accountability Act
IaaS	Infrastructure-As-A-Service
IHE	Integrating the Healthcare Enterprise
ITSD	Information Technology Services Division
IV&V	Independent Verification & Validation
LTC	Long Term Care
MAGI	Modified Adjusted Gross Income
MARS	Management and Administrative Reporting
MC	Managed Care
MCO	Managed Care Organization
MEDES	Missouri Eligibility Determination and Enrollment Systems
MHC	Missouri Health Connection
MHD	MO HealthNet Division
MITA	Medicaid Information Technology Architecture
MMAC	Missouri Medicaid Audit and Compliance
MME	Missouri Medicaid Enterprise
MMIS	Medicaid Management Information System
OA-ITSD	Office of Administration- Information Technology Services Division
PaaS	Platform-As-A-Service
PDF	Portable Document Format



Acronym	Definition
PI	Program Integrity
PMO	Project Management Office
RFI	Request for Information
RFP	Request for Proposal
SI	System Integrator
SMA	State Medicaid Agency
SMDL	State Medicaid Director Letters
SOA	Service Oriented Architecture
SS-A	State Self-Assessment
SURS	Surveillance Utilization Review System
TPL	Third Party Liability