DATE: OCTOBER 26TH, 2012

STATE OF VERMONT
DEPARTMENT OF VERMONT HEALTH ACCESS (DVHA)
DIVISION OF HEALTH REFORM (DHR)

REQUEST FOR INFORMATION (RFI)

TITLE: MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)
PHARMACY BENEFIT MANAGEMENT (PBM)

REQUISITION NUMBER: OCT2012 _VT_PBM_RFI

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SECTION I: INTRODUCTION AND PURPOSE OF THE RFI

The Agency of Human Services (AHS) has the widest reach in state government and one of the most critical missions: to improve the conditions and well-being of Vermonters today and tomorrow, and protect those who cannot protect themselves.

The Department of Vermont Health Access (DVHA) assists beneficiaries in accessing clinically appropriate health services, administers Vermont's public health insurance system efficiently and effectively, and collaborates with other health care system entities in bringing evidence-based practices to Vermont Medicaid beneficiaries.

Vermont seeks input from the vendor community about contemporary Pharmacy Benefit Management (PBM) offerings that will be built on MITA 3.0 compliant architecture meeting CMS 7 standards and conditions. Vermont is targeting release of a request-for-proposal (RFP) in the spring of 2013 for a full MMIS replacement. Understanding the marketplace offerings of PBM systems is an important step as Vermont crafts its MMIS replacement RFP.

PHARMACY PROGRAM GOALS

In support of the Agency and Department goals, the goals of the Vermont Health Access Pharmacy Benefit Management Program are to:

- Assure the availability of clinically appropriate medication services, and
- To do so at the most reasonable cost possible

With the fiscal challenges facing the state, at stake is preserving, to the greatest extent possible, the benefits that have evolved in Vermont's programs.

VERMONT STRATEGIES IN PHARMACY BENEFITS MANAGEMENT

The Vermont pharmacy best practices and cost control program was authorized in 2000 and established in SFY 2002 by Act 127. This program, as the Vermont Health Access Pharmacy Benefits Management (PBM) Program, is administered by the DVHA. Operational strategies include:

- Partnering with a vendor with skills and expertise in pharmacy benefit administration
- Managing and processing claims
- Managing benefit design
- Monitoring and managing utilization through retrospective and prospective drug utilization review and other utilization management programs and initiatives
- Evaluating new-to-market drug and preferred drug list placement
- Procuring supplemental rebates on drugs used
- Managing reimbursement
- Responding to change

PHARMACY BENEFIT ADMINISTRATION

Pharmacy benefit management (PBM) services support the program in the following areas:

- Claims operations
- Benefit management
- Utilization review and PDL management
- Drug Utilization Review Board coordination
- Rebate management
- Analysis and reporting

DVHA's current PBM contract ends on December 31, 2014. This RFI is an effort for DVHA to assess the capabilities of PBMs in the health care marketplace prior to issuing a formal request for proposal in the spring of 2013 in accordance DVHA's competitive bid process.

DRUG UTILIZATION REVIEW (DUR) BOARD

The Drug Utilization Review (DUR) Board of the Department of Vermont Health Access (DVHA) is a committee composed of physicians, pharmacists, and other community health care providers. Currently, the Board membership includes six physicians, four pharmacists, and one nurse practitioner. The DUR Board meets eight times per year, approximately every six weeks. Its goal is to optimize the pharmaceutical care received by DVHA Members. The Preferred Drug List has been developed with the assistance of the DUR Board acting as the Program's Pharmacy and Therapeutics (P&T) Committee. The Board also routinely reviews therapy by examining patterns in prescribing, dispensing and consumption of medications. As an outcome of these reviews, the Board identifies specific therapeutic and clinical behaviors that, if altered, may improve patient outcomes and lower costs.

BACKGROUND ON VERMONT'S PHARMACY BENEFITS PROGRAMS

Medicaid provides low-cost or free coverage for low-income children, young adults under age 21, parents, pregnant women, caretaker relatives, people who are blind or disabled and those age 65 or older.

Vermont Health Access Plan (VHAP) is a health insurance program for adults age 18 and older who meet income guidelines and have been uninsured for 12 months or more – with exceptions for Vermonters who recently lost their insurance because of a life change such as a divorce or loss of a job.

Dr. Dynasaur provides low-cost or free health coverage for children, teenagers under age 18 and pregnant women.

Vermont also has several Prescription Assistance programs to help uninsured Vermonters and those enrolled in Medicare pay for prescription medicines based on income, disability status and age.

These programs include:

- VPharm assists Vermonters who are enrolled in Medicare Part D with paying for prescription medicines. This includes people age 65 and older as well as people of all ages with disabilities and includes an affordable monthly premium.
- VHAP-Pharmacy helps Vermonters age 65 and older and people with disabilities who are not enrolled in Medicare pay for eye exams and prescription medicines for short-term and long-term medical problems and includes an affordable monthly premium.
- VScript helps Vermonters age 65 and older and people of all ages with disabilities who are not enrolled in Medicare pay for prescription medicines for long-term medical problems. There is also a monthly premium based on your income.
- Healthy Vermonters provides a discount on short-term and long-term prescription medicines. There are no monthly premiums and eligibility is based on your family income.

Claims processing activities include:

- Accepting drug claims according to the rules of coverage under Vermont programs
- Providing the mechanisms to transmit program requirement messages to pharmacies as drugs are dispensed and claims are processed (e.g., eligibility verification, federal/state drug rebate requirements, coverage limitations, prior authorization needs, automated step therapy review, quantity limits, prospective and retrospective drug utilization review (DUR) issues, etc.
- Authorizing payments according to reimbursement rules.

The maximum reimbursement is established on a per-claim basis at the individual drug level in all cases but VPharm. Currently, the reimbursement amount is the lesser of:

- Average wholesale price (AWP) less 14.2% plus a dispensing fee,
- The Centers for Medicaid and Medicare Services' established Federal Upper Limit (FUL) plus a dispensing fee,
- The State Maximum Allowable Cost (currently PBM managed) plus a dispensing fee, or
- The pharmacy's usual and customary/submitted fee including a dispensing fee

The beneficiary in the Healthy Vermonters Program pays the rate established applying this methodology. For programs other than VPharm, Vermont pays the difference between the rate set and any other insurance payment.

DVHA provides a wrap-around benefit to Medicare Part D coverage. For traditional Medicaid beneficiaries who have Part D, DVHA covers those drug classes excluded from Medicare Part D health plan coverage (Part D excluded drugs).

Under VPharm, Medicare beneficiaries receive coverage for covered drugs in classes excluded from Medicare Part D coverage (Part D excluded drugs), as well as coverage for coinsurance, copayments, and the coverage gap for drugs that are covered by the Part D plan. This coverage gap, or "donut hole," as it is often referred to, is the period in a coverage year when there is a lapse in Part D coverage.

DUAL ELIGIBLE INTEGRATED DEMONSTRATION

In May of 2012, Vermont submitted a proposal to the Centers for Medicare and Medicaid Services (CMS) to participate in a State demonstration to integrate care for approximately 20,000 dual-eligible (Medicare and Medicaid) individuals. The goal of Vermont's "Duals Demonstration" is to fully integrate the delivery and financing of Medicare and Medicaid services for Vermont's dual eligible individuals. Vermont's demonstration will focus on providing person-directed interventions to improve care coordination and service delivery, with performance measures and outcomes linked to payment reform.

According to CMS, "There are around 9 million individuals who are dual eligibles; that is, eligible for both Medicare and Medicaid. While this 9 million represents a small percentage of the approximately 100 million people enrolled between the two programs, they account for a disproportionate amount of spending (about $300 billion a year) across both programs. For example, dual eligible beneficiaries account for 16 percent of Medicare enrollees but 27 percent of Medicare spending; in the Medicaid program, individuals dually enrolled make up 15 percent of the program but account for 39 percent of costs." (CMS, 2012)

Partnering with States to Coordinate Care for Dual Eligibles

Under the State Demonstrations to Integrate Care for Dual Eligible Individuals, 15 states have been selected to develop new approaches to improve the coordination care for dual eligible individuals. Each state will be awarded up to $1 million to develop a model describing how the state would structure and implement its planned intervention. Vermont was selected as one of the 15 states to work with the Centers for Medicare and Medicaid Services (CMS) to design strategies for implementing person-centered delivery models that:

- offer high quality, seamless and cost-effective care
- coordinate primary, acute, mental health, substance abuse treatment, and long-term supports and services
- meet the unique needs of all individuals who are dually eligible for Medicare and Medicaid

Development of Integrated Medicare-Medicaid Service Delivery Model

Through the Duals Integration Initiative, Vermont and CMS have the opportunity to develop a fully integrated model for financing and delivery of the full array of health care services for the dual Medicare-Medicaid population. As part of the initiative, Vermont intends to integrate benefits covered under Medicaid and Medicare (Parts A, B and D), thereby providing beneficiaries a truly comprehensive and seamless set of services. The proposed integrated approach also offers Vermont the opportunity to work with CMS to eliminate some of the regulatory conflicts and cost-shifting incentives under Medicare and Medicaid, including those related to prescription drug coverage.

The current delivery model available for dual eligibles is far from seamless, particularly from an administrative standpoint. Dual eligibles receive different covered benefits under Medicare and Medicaid. Both programs are managed differently and use different funding sources to provide these benefits. The Medicare-Medicaid Coordination Office (MMCO) and the Center for Medicare and Medicaid Innovation (Innovation Center) are partnering with states to develop and implement initiatives

that *offer high-quality, seamless and cost-effective care through a coordinated, person-centered delivery model* that meets the unique needs of all people who are dually eligible for both programs.

As a voluntary program, dual eligible Vermonters will have the option of participating in this initiative beginning January 1, 2014 or continue receiving benefits through the current programs. This includes accessing pharmacy services through Vermont's proposed pharmacy program or retaining coverage under the beneficiary's Medicare Part D drug plan.

Vermont proposes to provide coverage through it unique, public Medicaid managed care model to manage both Medicaid and traditionally Medicare-covered services. Dual eligible Vermonters will have the option to access all of their Medicaid and Medicare covered services (including prescription drug coverage) under the authority of a single entity – DVHA. This transition also will offer Vermont more flexibility with program design and improvement as funding would be integrated to allow Vermont to provide services that meet the needs of dual eligibles who elect to participate in the initiative. If successful, this model of pharmacy benefits delivery would support a more seamless transition to Vermont's single payer healthcare system in which pharmacy benefits will be integrated through use of a single formulary.

Vermont has been actively engaged with CMS to rebuild and expand the Vermont Learning Health Network (LHN), commonly referred to as Vermont's Health Services Enterprise (HSE). The State is in the midst of many initiatives to modernize not only its technology (systems, hardware, software, etc.) but also its business processes. The single State Medicaid Agency, the Agency of Human Services (AHS), is currently involved in a modernization effort to integrate AHS' systems and make them more flexible, integrated and better positioned to support AHS service integration and improve client outcomes. AHS is also seeking to improve and further develop partnerships, so that human services can be provided in a seamless fashion, addressing the full range of client and community needs leveraging shared services, common technology, and detailed information.

CMS Medicaid Information Technology Architecture (MITA) will provide the framework, allowing the State to meet the goals of increasing electronic commerce and transitioning to a digital enterprise.

SECTION II: RFI SCOPE OF SERVICES

This RFI seeks information from vendors with information technology offerings and business processes that will facilitate Pharmacy Benefits Management (PBM). Listed below is a brief description of each of the key functions for which information is requested. Vendors are encouraged to identify additional functionality or services related to PBM that they feel would be beneficial to Vermont's Medicaid Management Information System (MMIS) and to describe expertise in supporting public sector benefit systems. **Vermont is most interested in receiving responses from vendors that can provide the full array of applications and outsourced services that will align with Vermont's plan to realize a single payer system.**

Vermont's PBM vendor is responsible for operational, clinical, consultative, and financial services for the State's publicly funded pharmacy benefits programs. This includes but is not limited to, pharmacy point of sale claims processing, management of the Preferred Drug List (PDL) including rebate management, and effectively managing the cost and quality of pharmacy benefits.

The scope of services involved in this RFI includes the provision of pharmacy benefit management (PBM) services to the Department of Vermont Health Access. The services involved include:

I. Claims Processing and Operational Support

The PBM contractor must ensure claims processing policies and procedures are in compliance with all applicable state and federal laws, regulations, rules, and policies. Please elaborate on how you would support compliance and operations in each of the key areas below:

1. Operation of a real-time (POS) online claims processing system with current NCPDP format and guidelines with an emphasis on drug utilization review (DUR), utilization management (UM), prior authorization, messaging, processing and reimbursement for clinical services (MTM, Immunizations, and other), and 340B eligible drugs. This may include point-of-sale durable medical equipment claims processing, point-of-service medical claims processing, and other types of claims processing.
2. Automated Coordination of Benefits (COB) structure and capabilities
3. Pharmacy enrollment, network management, and compliance monitoring
4. Pharmacy services support center
5. Benefit Design and Structure, in particular the ease of making programmatic changes to the benefit program:
    - Ability to implement, operationalize and manage DVHA's complex benefit designs with multiple funding sources and various eligibility requirements
    - Flexibility in pharmacy reimbursement structures such as Average Acquisition Cost (AAC) and 340B pricing designs
    - Ability to modify benefit plans in a timely and cost-effective manner for DVHA

- Ability for DVHA staff to make changes to the benefit design and operational features, such as POS messaging
- Screens and Menus are logical, intuitive to use, and support efficient workflow

6. E-Prescribing and E-Prior Authorization(e-PA) Capabilities (originating at both POS and office-based electronic health records (EHR))
7. Administrative Simplification: Identifying and promoting best practices that minimize administrative burden on providers (prescribers and pharmacies) and improve the provision of quality healthcare and service delivery. Some of these practices include but are not limited to:
   - Promoting physician access to e-prescribing; developing and refining a formulary interface through electronic health records; and working toward a consistent and accurate display of formulary information to providers
   - Developing recommendations for quality improvement and monitoring to improve accuracy of e-prescribing systems
   - Developing a common measurement tool for assessing provider satisfaction
   - Promoting a more seamless interface for the provider community
   - Development of a common, statewide prior authorization request form
   - Development of a single statewide formulary in accordance with Vermont's single payer plans
   - Close monitoring of the development of national electronic prior authorization EHR standards and e-PA pilots

II. Pharmacy Benefit Management and Clinical Programs

Pharmacy benefit management (PBM) services support the program in the following areas: claims operations, benefit management, utilization review and management, Drug Utilization Review (DUR) Board coordination, rebate management, and analysis and reporting. Using the specific services identified below, please describe how you would provide these PBM services to DVHA.

1. Prior Authorization Program and Provider Support Center
2. Utilization Management programs
   - Prior authorization, quantity limit, step therapy, and PDL exceptions
   - Development and dissemination of clinical criteria, procedures for its application, and proper documentation of all clinical decisions
   - First reconsideration review of denials by a clinical pharmacist when requested and access to independent physician reviewers
   - Proper notification of all denials and approvals to members and prescribers within timelines established by applicable law and DVHA policies
3. Drug Utilization Review activities including but not limited to: prospective and retrospective drug utilization review (DUR); provider profiling; educational outreach/activities related to assuring best practice compliance; management of drugs of abuse and drugs used for substance abuse treatment; management of psychotherapeutic drugs in adults and children; and peer-to-peer education

4. Medication Therapy Management programs
5. Specialty Pharmacy with an emphasis on patient management and cost containment
6. 340B program management and expertise
7. Development and administration of the State Maximum Allowable Cost (SMAC) program
8. Management of the Preferred Drug List (PDL).
    - Develop and maintain a Preferred Drug List (PDL) based on sound clinical evidence encouraging patient safety and cost-effective medication use
    - Use of established policies by which the PDL development and management is performed
    - Manage and support the activities of the Drug Utilization Review Board with responsibility for oversight of both DUR and PDL activities of the Board
    - Manage all rebate programs (federal, state, and supplemental) including contracting (where applicable), invoicing, collection and disbursement of rebate funds, administrative support and activities, and reporting to meet state and federal regulations
    - Communication to members, prescribers, and pharmacies as needed
9. Management of Drugs in the Medical Benefit
10. Support of the State's appeal process for denied prior authorizations
    - Assistance in complex clinical cases
    - Superior management systems and processes to support PA's, reconsideration, and appeals workflow

III. Financial Support Services

Financial support services are an important component to the PBM contract. DVHA relies on its PBM contractor to process and report on claims for people enrolled in DVHA's multiple health programs, each of which may have multiple funding sources and rebates (Federal OBRA '90 rebates, supplemental rebates and state-only rebates). It also relies on its PBM to manage the state's supplemental rebate negotiation process. Within the scope of the bullet points outlined below, please describe how you expect to support DVHA's goals.

1. Management of DVHA's rebate programs including federal, state, and supplemental rebate programs, and the ability to report on net cost of medications.
2. Pharmacy remittance advice/reimbursements, claims payment, accounts payable, accounts receivable, and program budget management
3. A strong interface with other financial management applications
4. Administrative support for existing supplemental rebate multi-state consortium
5. Reporting on and managing pharmacy trend, including forecasting

IV: Data Management

With more than 2.5 million outpatient pharmacy claims processed each year, data and reporting capabilities are at the forefront in understanding drug utilization and cost trends. Please comment on the user interface and ease of use of each data and reporting tool (including but not limited to):

1. Pharmacy Claims Inquiry Platform
2. Data query and analysis support (pharmacy and medical claims encounter data)
3. Standard and ad hoc reporting including ability for DVHA staff to run reports
4. Document Management system

V: Account and Program Support

DVHA expects its PBM contractor to provide initial implementation services and ongoing support throughout the term of the contractual agreement. Ongoing support includes, but is not limited to, providing clinical and operations support services to the DVHA pharmacy unit staff; regular reporting of DVHA's performance in measurable categories such as pharmacy trend, generic utilization, PMPM cost trending; and overall PDL management. Account support should include, but not be limited to:

1. Account team providing clinical and operational support
2. Defined process and timeline to transition PBM services from the current vendor to your organization
3. Project Management Methods
4. Benefit design recommendations
5. Clinical and cost management information and recommendations
6. Recommendations regarding operational, programmatic, and clinical modifications that would result in improvements in quality of care, service delivery and drug trends; and system controls designed to prevent the opportunity for fraud, waste and abuse
7. Monitoring compliance with federal and industry requirements
8. Development of and reporting on specific clinical and operational performance measures
9. Privacy, security, disaster recovery, and business continuity practices

Section III: Request for Information (RFI) Questions

1. Please provide general organizational information including structure and history, scope of services offered, clients served and current service area
2. Discuss your organization's experience in providing services targeted to public program enrollees including Medicaid and Medicare and how this experience supports your organization's vision/mission.
3. Please explain why your pharmacy benefit administration capabilities are considered best practice for health plans. Please elaborate based on each of the core processes listed in the scope of services above.
4. Explain your approach and successes related to managing drug costs and pharmacy trend and in particular your approach to managing increasing specialty pharmacy costs and drugs in the medical benefit.
5. Explain how your PBM platform is flexible, adaptable and intuitive.
6. How do your programs, services, and people support Vermont's benefit programs to ensure quality of care and clinical integrity?
7. Regarding the scope of services described above, please describe how you distinguish your unique capabilities from those of your competitors.
8. In addition to these core services, please describe any new and innovative services that would be beneficial to the DVHA and uniquely position you as an industry leader.
9. How are you uniquely positioned to support the pharmacy needs of Vermont's proposed Duals Demonstration Project?
10. How are you uniquely positioned to support Vermont's health reform plans to transition to a statewide single payer/ single formulary health care system by 2017?
11. Regarding Vermont's migration to a Service Oriented Architecture (SOA), discuss your system's compliance with SOA and CMS's 7 conditions and standards
12. Please describe your approach to security, privacy, and business continuity as either a stand-alone system or as an integrated SOA set of applications as in the context of CMS's seven conditions and standards.

RFI Procedure

To answer this RFI, please reply to each area described above in a Word document attachment referencing the RFI by title & number. Please indicate in your response whether the solution must be purchased or licensed, and what Business process outsourcing (BPO) components are included and their related costs models. Responses should be limited to 100 pages. Also include your company's answers in the attached "Pharmacy Benefit Management Subject Area" spreadsheet and return it to Vermont with your RFI response. The contact person listed below is available for assistance if needed.

Organization of Response

Your final submission to should be organized in the following manner:

A. Cover Letter (1 page maximum)

B. Executive Summary
C. Information

This section should provide brief but complete answers to the scope of service questions and describe your services and your organization's ability to meet the DVHA's requirements. Your responses present the opportunity to demonstrate your organization's insights, experience, and capabilities. In addition, your response should address your familiarity with and commitment to serving a high-needs population including both Medicaid and Medicare eligible low-income, disabled, and elderly beneficiaries.

In responding to this RFI, please reproduce each question in numerical order, followed by your response. Clearly reference any attachments that support a specific response and label each attachment accordingly.

Response Delivery

Send your answers referencing the RFI title and Number and submit in Word-format (12 pt font) as an attachment by email to scott.brown@partner.state.vt.us. Also attach the completed "Pharmacy Benefit Management Subject Area" Excel spreadsheet.

Confidentiality

All submitted information connected to this RFI may be subject to disclosure under the State's access to public records law. Upon receipt of the State all material associated with this RFI is a matter of public record except for those materials that are specifically exempted under the law. One such exemption is material that constitutes trade secret, proprietary, or confidential information. If the response includes material that is considered by your organization to be proprietary and confidential under 1 V.S.A., Ch. 5 Sec. 317, the submitted packet must clearly designate all material as such prior to bid submission. The submitter must identify each page or section of the response that it believes is proprietary and confidential and provide a written explanation relating to each marked portion to justify the denial of a public record request should the State receive such a request. The letter must address the proprietary or confidential nature of each marked section, provide the legal authority relied on, and explain the harm that would occur should the material be disclosed.

Contact

For questions regarding this RFI, please email: dvha.dhr@state.vt.us

Timeframe

10/26/12 – RFI released

11/02/12 – Vendors should email their intent and contact information to the RFI point of contact no later than 5:00 p.m. Eastern Time.

11/16/12 – Responses due to the State no later than 5:00 p.m. Eastern Time.