



State of Georgia
In conjunction with
NASPO ValuePoint

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Attachment F -
Pharmacy Benefit Administrator Services
Scope of Work

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1 INTRODUCTION

The Contractor shall provide the design, development, implementation, and maintenance of a modular Pharmacy Point-of-Sale (POS) Claims Processing Solution (“Solution”) and Pharmacy Benefit Administrator (PBA) services for the Fee-for-Service (FFS) Medicaid pharmacy program.

The Pharmacy Benefit Administrator Program (PBAP) is comprised of the following Components: Preferred Drug List (PDL) services, POS Claims processing, Third Party Liability (TPL) and Coordination of Benefits (COB), Prior Authorization (PA) services, financial management services, and customer support (including a customer call center and web portal).

The Solution must offer a configurable Commercial Off-the-Shelf (COTS)/ Non-Proprietary product that uses sound, efficient business and system operations meeting or exceeding current industry standards and that encompasses all technology and services as defined in this Scope of Work to administer a comprehensive pharmacy benefit program managed by the State.

The State recognizes that successful health care systems of the future will be those that can simultaneously deliver excellent quality of care at optimized costs while improving the health of their population. An effective implementation of the Solution and services will allow the State to meet the following goals:

- **Provide Cost Effective Utilization Programs:** The Contractor shall be responsible for serving as the administrative and fiduciary agent of the State and for developing and implementing State-approved cost-effective utilization programs for the FFS Medicaid pharmacy program.
- **Improve Pharmacy Administrative Services:** The Contractor will assist the State in improving its ability to provide pharmacy benefit services through innovative and proven business and technical Solutions that are tailored to the State’s program and responsive to the State’s unique requirements.
- **Federal and State Law Compliance:** As federal and state laws are subject to change from time to time, the Contractor must cooperate with the State in good faith to implement all changes necessary to be in compliance with federal and state law and regulations and state policy as revised periodically.

The purpose of this document is to provide a high-level, comprehensive description of the scope and requirements to support the provisions of the Pharmacy Benefit Administrator Program (PBAP).



2 PREFERRED DRUG LIST (PDL) SERVICES

2.1 OVERVIEW

- 2.1.1 The Contractor, in coordination with the State's Clinical Management Services vendor, Pharmacy Drug Rebate Services vendor, and, as required, other third-party vendors, shall develop, produce, support, and maintain the State's Preferred Drug List (PDL), subject to review by the State Advisory Board and the approval of the State.
- 2.1.2 The Contractor shall accept and implement the State's PDL and shall implement a process for the continual monitoring and updating of Product classifications of all reviewed Products, including Products that are not traditionally outpatient drugs (e.g., spacers, peak flow meters, diabetic supplies, tubeless insulin pumps, etc.).
- 2.1.3 The Contractor shall provide real-time and historical access to the State's drug and formulary file and maintain an up-to-date copy for use. If the Contractor does not manage the PDL, the Contractor must have the capability to receive and accept a PDL file from a third-party vendor at the frequency determined by the State, up to real-time.

2.2 PDL MANAGEMENT

- 2.2.1 The Contractor shall provide an automated workflow tool for review and approval by the State of changes, modifications, deletions, and alterations to the PDL.
- 2.2.2 The Contractor shall follow the Project's Change Management Process for all changes, modifications, deletions, and alterations to the PDL. (Refer to Attachment C – Common Scope Requirements and Security Standards, Section 2.5 Change Management.)

2.3 PDL REPORTING

- 2.3.1 The Contractor shall provide reporting capabilities to track and share information as requested by the State, Pharmacy Drug Rebate Services vendor, Clinical Management Services vendor and Fraud, Waste, and Abuse Audit Services vendor. Refer below to Section 7.1 for additional reporting-related requirements.

3 POINT-OF-SALE (POS) CLAIMS PROCESSING

3.1 CONTRACTOR RESPONSIBILITIES

With regards to Claims processing, the Contractor shall:



- 3.1.1 Work with the State, Providers, and other key stakeholders to maintain a claims processing environment that meets the current and future needs of these stakeholders to comply with HIPAA and any other applicable new and revised rules that may be adopted by the Centers for Medicare and Medicaid Services (CMS) and other federal and state partners.
- 3.1.2 Ensure that the Solution fully integrates the State PDL and PA program requirements.
- 3.1.3 Upgrade to the new National Council for Prescription Drug Programs (NCPDP) standard no later than the State-identified compliance date at no additional cost to the State.
- 3.1.4 Upgrade the Solution and any dependent interface transmissions to new standards (including, but not limited to, new versions, code sets and valid values, etc.) no later than the State-defined compliance date and prior to the federal compliance date. Updates to achieve federal compliance must be approved by the State prior to deployment and must be made by the Contractor at no additional cost to the State.
- 3.1.5 Configure and continuously maintain its systems and processes to properly administer all aspects of the State's pharmacy benefit Claims processing requirements to include modifications to benefit plan design. (e.g. annual copay updates, dispensing fee updates)
- 3.1.6 Maintain and update the State's customized pricing lists on a continuous basis in the Solution. State customized pricing lists shall be updated at a frequency determined by the State, up to real time, for Maximum Allowable Cost (MAC) list and 340B pricing for the Medicaid program.
- 3.1.7 Develop and execute, as approved by the State, a pricing Appeals process, regarding, but not limited to, MAC, National Average Drug Acquisition Cost (NADAC), Federal Upper Limits (FUL), Wholesale Acquisition Cost (WAC), 340B, and Actual Acquisition Cost (AAC), for Provider inquiries.
- 3.1.8 Research and correct MAC and 340B customized Medicaid pricing lists, as necessary, and provide notification of the error and its correction to the State within forty-eight (48) hours of the State's or Contractor's detection of the error.
- 3.1.9 Obtain all pricing sources and pricing elements identified by the State and ensure the Solution applies the appropriate rate consistent with the State's reimbursement methodology.



- 3.1.10 As requested by the State, outside the standard quarterly review process, review and provide feedback on individual rates for Products.
- 3.1.11 Provide, maintain access to, and integrate into the Solution a national drug pricing compendium that meets the business needs of the State for the purposes of Claims processing including enforcement of benefit plan configuration rules such as PDL management, pricing, and Prospective and Retrospective Drug Utilization Review (DUR) within the Solution and across the broader Medicaid Enterprise System (MES). The Contractor shall be responsible for obtaining any drug pricing compendia at its sole expense.
- 3.1.12 Ensure rate and pricing file updates are completed in the Solution within one (1) Calendar Day of the pricing files' official release from the pricing compendium delivery to the Contractor. All pricing files must reflect the Effective Date assigned by the organization publishing the pricing.
- 3.1.13 Coordinate with all necessary entities [e.g., U.S. Food and Drug Administration (FDA), CMS, drug data base vendors] in determining the drug/non-drug status of any Product(s) in question and include that determination on the file for purposes of adjudication.
- 3.1.14 Develop and maintain a 340B Provider Network to include pricing logic at the Claim level as required by the Covered Out-Patient Drug Rule (42 C.F.R. Part 447).
- 3.1.15 Coordinate with the State to secure and maintain necessary sources of information [e.g., daily Health Resources & Service Administration (HRSA) file, Medicaid exclusion file] used in the proper identification of 340B Covered Entities and their associated Claims pursuant to NCPDP standards.
- 3.1.16 Furnish a fully automated Prospective Drug Utilization Review (ProDUR) Component that meets all applicable state and federal requirements including those identified in the Omnibus Budget Reconciliation Act (OBRA) 1990 and OBRA 1993.
- 3.1.17 Ensure the Solution has the capability to:
 - a. Apply any State-defined limitations or accommodations on specific Pharmacy Providers in a configurable way.
 - b. Allow for real-time customization of the drug file through configurable means. This may include, but not be limited to, the ability to customize pricing, apply specific Quantity Limits or PA requirements down to the NDC-11 level, or allow for payment of specific Products, such as



medical supplies, not considered Covered Outpatient Drugs. The drug files must be able to accept non-NDC Product identifiers consistent with FDA standards when applicable and required by law, including Unique Device Identifiers (UDI), or the Device Identifier (DI) portion thereof (21 C.F.R. Part 830).

- 3.1.18 Be responsible for testing any modifications to edits [e.g., Quantity Level Limits (QLLs), diagnosis, age, etc.] prior to implementing any configuration change in the Production environment, to confirm accuracy of those changes and receive approval from the State. This shall include State access to the testing environment, by specified Authorized Solution Users, for State approval.
- 3.1.19 Ensure correct Claims processing for members based on rules as defined by the State (e.g., Members enrolled in a lock-in program, copay updates).
- 3.1.20 Collaborate with the State to develop, implement, and maintain payer sheet(s) using the NCPDP published template and following the guidance it contains.
- 3.1.21 Edit Claims based on specific characteristics of the dispensing Provider or prescribing practitioner (e.g., Claims for drugs prescribed by a psychiatrist versus non-psychiatrist provider specialty) and/or therapeutic class of the prescribed drug(s), as directed by the State.
- 3.1.22 Produce the requested mass adjustment report or data set containing all Claims to be adjusted and the potential payment/recoupment amount both at a Claim and summary level. All mass adjustments must be approved by the State before being performed in a production environment.
- 3.1.23 Enter mass adjustments into the Solution upon receipt of approval from the State or its designee.
- 3.1.24 Assign a unique tracking number to all Claims and adjustments.
- 3.1.25 Correctly capture, adjudicate, and price partial fill Claims based on NCPDP standards and State-defined rules, and ensure Claims are readily identifiable on all Claim's extracts and within the Claims data reference tables.
- 3.1.26 Ensure the State and any authorized delegate(s) have access to the State's current and historical pharmacy Claims data to run queries and produce independent audit reports.
- 3.1.27 Maintain all necessary information regarding the Medicaid Provider network as defined by the State.



- 3.1.28 Be responsible for oversight and enforcement of the pharmacy provider network to ensure payments for allowable Claims are paid correctly.
- 3.1.29 Develop and maintain Third-Party Liability (TPL) edits that conform to federal and state regulations to ensure that Medicaid is the payer of last resort, as appropriate or required.
- 3.1.30 Maintain edits, Prior Authorization (PA) programs, override codes and business processes to support “emergency supply” provisions for covered outpatient drugs in compliance with Federal requirements and as directed and approved by the State.
- 3.1.31 Provide online, real-time operations for receipt, adjudication, and notification to billing Providers regarding the disposition of a Pharmacy Claim (e.g., as payable, denied, or requiring more information) and adjudicate drug Claims online in real-time to pay or deny the Claim based on State-defined criteria and PA status.
- 3.1.32 Deny Claims if an enrolled Provider bills a Claim using the wrong Bank Identification Number (BIN) or Processor Control Number (PCN) based on a Member’s eligibility as defined by the State.
- 3.1.33 Test and validate additions, changes, and removal of adjudication rules, edits, and customized messages, subject to the State’s review and approval, to confirm they are accurate prior to moving changes into the production environment. This shall include State access to the testing environment by specified Authorized Solution Users for State approval.
- 3.1.34 Provide a process for multi-level review and approval that will validate logic errors, conflicts, redundancy, and incompleteness across business rules to identify any conflicts in rules and edits as they are being developed, tested, and implemented.
- 3.1.35 Track and report rule usage, exception usage, and when the rules fail to work as designed, and provide recommendations to resolve rule failure.
- 3.1.36 As mutually agreed by the Contractor and the State, provide Authorized Solution Users access to capabilities including, but not limited to:
 - a. Viewing all Claim data points and steps of the adjudication process.
 - b. Viewing, adding, editing, and deleting reference data and program elements.
 - c. Viewing, adding, editing, and overriding active and inactive rules and edits.



- 3.1.37 Provide any applicable tax information for Provider payments and the federal government to the Fiscal Agent to meet federal and state requirements and deadlines.
- 3.1.38 Research proposed cost savings/cost avoidance as needed based on the State's specific data.
- 3.1.39 Develop and conduct a State-approved periodic quality assurance (QA) process to confirm accurate Claims processing, including editing, Utilization Management, and pricing, and provide the results to the State upon request.
- 3.1.40 Submit all records, documentation, reports, data, etc. which are required to be produced under the terms of the Contract to the State or its designee no later than the timeframe specified in the State-approved Turnover Plan.
- 3.1.41 Ensure state eligibility interfaces are in sync with the State's MMIS eligibility data. All outbound "834 Files" shall be loaded to the Contractor's data base within twenty-four (24) hours of receipt from the State. This requirement includes any "834 Transactions" that must be handled manually by the Contractor. The Contractor shall submit to the State weekly eligibility/enrollment reports which will be defined during the Design, Development, and Implementation (DDI) Project Phases. These reports shall provide weekly counts of enrollment by eligibility categories, benefit categories and any other category determined by the State. If the counts do not reconcile with the MMIS eligibility and enrollment counts, the Contractor shall research the discrepancies to explain the differences to the State and resolve them within five (5) Business Days. The Contractor shall deliver a Corrective Action Plan (CAP) to the State within forty-eight (48) hours of the five (5) Business Day period for any differences that are not resolved.

3.2 POS CLAIMS PROCESSING SOLUTION REQUIREMENTS

With regards to Claims processing, the Solution must:

- 3.2.1 Be consistent with Chapter 35 of Title 44 of U.S. Code relating to coordination of federal information policy.
- 3.2.2 Operate in compliance with the current NCPDP HIPAA transaction standard version.
- 3.2.3 Provide Claim and eligibility processing services that are compliant with current and future HIPAA adopted Transactions and Code Sets standards, including but not limited to:



- a. NCPDP Telecommunication and Batch Standards, including, but not limited to, the B1, B2, B3, and E1 transactions.
 - b. International Classification of Diseases (ICD) codes.
 - c. Healthcare Common Procedure Coding System (HCPCS) codes.
- 3.2.4 Support the following functionality for Provider validation:
- a. Validate the billing and prescribing Provider on the Claim using the National Provider Identifier (NPI). The Solution must ensure that Claims from non-participating Providers are rejected.
 - b. Capture the Prescriber's Drug Enforcement Administration (DEA) and NPI number on all drug Claims and provide the ability to validate and edit against the prescriber NPI on the Claim.
 - c. Verify that the Provider is enrolled on the date of service.
- 3.2.5 Include the most current version of the NCPDP standard and external code list for Governmental Programs to allow appropriate reimbursement and coordination of a Member's benefits. The State must have the option to use any and all NCPDP standard transactions as determined appropriate by the State.
- 3.2.6 Provide NCPDP standard and customized response messaging, as specified by the State, for its current or future programs, including but not limited to:
- a. Bill [Primary Health Plan] and [phone number] and BIN/PCN, Member ID number and group number for Primary.
 - b. Bill Medicare Part B.
 - c. Bill Medicare Part D [plan name] and [phone number] and BIN/PCN, Member ID Number and group number for Medicare D.
 - d. Program has no pharmacy benefit.
 - e. Bill as Medical Supply.
 - f. If Claims paid using PA, PA expires or expired on [date].
 - g. Drug not covered – included in long-term care/hospice per diem rate.
 - h. Proposed Less-Than-Effective (LTE) Drugs.
 - i. Provider Not Valid on Date of Service.
- 3.2.7 In accordance with State policies and reimbursement formulas, process all Medicaid Pharmacy Claims submitted electronically or on paper. The Contractor must ensure paper Claims are transformed to electronic format,



consistent with the current NCPDP HIPAA transaction standard version, adopted code sets – including all mandatory and required data fields, and operating rules (45 C.F.R. Part 162 Subpart I).

- 3.2.8 Verify dates of service are within allowable timeframe for payment as directed by the state.
- 3.2.9 Support NCPDP multi-ingredient Compound functionality to process Compounded Claims in accordance with current state policy and procedures.
- 3.2.10 Provide the capability to ensure that ingredients used in Compound Drugs are validated through all Claims and ProDUR edits and audits.
- 3.2.11 Correctly capture, adjudicate, and price multi-ingredient Compounded Drug Claims at the header and ingredient line level detail. Line detail must be maintained and transmitted on all Claim extracts and within the Claims data reference tables.
- 3.2.12 Provide real-time access to Provider Enrollment, including the Pharmacy's and Prescriber's NPI for electronic submission of Claims and taxonomy.
- 3.2.13 Allow a Provider to cancel or override a ProDUR alert/message in accordance with State defined criteria and as allowed by the State.
- 3.2.14 Be able to apply results of ProDUR processing in the Claims adjudication process. Claims that are rejected because of ProDUR processing must include situation-specific messaging and error codes that enable the Pharmacy Provider to take appropriate actions. The Contractor may use an existing ProDUR package but must make any modifications required by the State at no cost to the State. The Contractor must work with the State in setting the disposition of ProDUR edits that may vary by type of submission (e.g., real-time versus batch).
- 3.2.15 Provide flexibility so that the maximum dollar threshold for single drug Claims and Claims for multi-ingredient Compounds could be different, can be overridden, and that certain drugs (defined by any standard criteria) can be excluded from a threshold, if necessary.
- 3.2.16 Edit for drugs requiring submission of specific diagnosis codes and specific member age restrictions as approved by the State.
- 3.2.17 Allow enrolled Providers to prescribe electronically, select appropriate preferred medications using the online searchable State PDL, and electronically request PAs for Medicaid Members.



- 3.2.18 In compliance with federal standards for the Medicaid program, process Claims using pricing benchmarks including, but not limited to, AAC, NADAC, FUL, and WAC.
- 3.2.19 Be able to receive and process multiple drug pricing files from drug compendia publishers (e.g., First DataBank and Medi-Span) and State-set rates.
- 3.2.20 Have the flexibility to apply configurable benefit plan pricing logic across all Claims processing rules.
- 3.2.21 Be capable of adding, changing, or removing adjudication rules, edits, pricing, Product status and any and all adjudication elements to accommodate State-required changes for its current and future pharmacy programs via a flexible, Authorized Solution User configurable interface in real-time.
- 3.2.22 Be able to process Claims consistent with Coordination of Benefit (COB) rules and payer specifications defined by the State including, but not limited to, the ability to incorporate outcomes from third party coverage, such as Other Payer Amount Paid (OPAP), Other Payer Patient Responsibility Amount (OPPA), Benefit Stage Qualifier (BSQ), and Primary Payer Reject Codes.
- 3.2.23 Have customizable rebate validation logic, as defined by the State.
- 3.2.24 Be able to identify which Manufacturers have signed rebate agreements with CMS and ensure that only valid NDCs from CMS-rebateable Manufacturers are considered for payment. Repackaged Products shall be excluded.
- 3.2.25 Deny payment for medications distributed by Manufacturers not participating in the Medicaid drug rebate program, except as directed by the State, for specific pharmacy programs or Products.
- 3.2.26 Deny payment for Products covered by Medicare Parts B and D when the enrolled Member has any Medicare coverage.
- 3.2.27 Ensure that each and every line-item Product (NDC-coded, UPC-coded, HRI-coded, or other code) included on the drug file that the Contractor utilizes in adjudicating pharmacy Claims has an indicator on the file specifying whether the Product is, or is not, a Covered Outpatient Drug per the definition outlined in Section 1927 of the Social Security Act.
- 3.2.28 Be able to accept and utilize the State-specific 340B identifiers for purposes of identifying Providers that are participating in the 340B Drug Pricing Program and drugs purchased through the 340B Program.



- 3.2.29 Be able to accept, process, and price Claims from 340B Covered Entities according to the State's 340B reimbursement methodology.
- 3.2.30 Allow a Solution administrator to provide State staff with online access using role-based permissions to the adjudication platform for viewing eligibility, Claims history, PA drug file, standard reports, etc. The access must be to a real-time environment so that State staff can make custom queries with user-defined parameters and filters. The access must allow Authorized Solution Users with select roles to submit Claims for trial adjudication.
- 3.2.31 Process Claims to assure that the quantity of services is consistent with the State's policy (i.e., verify drug-specific minimum and maximum quantity limitations are followed, including any day's supply limitations, package size restrictions and frequency limitations). Claims for non-standard metrics Units must be denied.
- 3.2.32 Confirm Member eligibility on date of service. A valid Claim is a Claim for service for those Members eligible to receive pharmacy services at the time the services were rendered.
- 3.2.33 Support online, real-time operations for receipt, adjudication, and notification to billing Providers regarding the disposition of a Claim as either payable or rejected.
- 3.2.34 Be able to create mass adjustment events in response to retroactive changes in data used for Claims processing (e.g., Product pricing, dispensing fee rates, policy, eligibility determination) at the direction of the State. The Solution must have a non-production environment where mass adjustment events can be modeled and the results reviewed (e.g., affected Claim count, net financial impact, supplement Encounter files generated).
- 3.2.35 Utilize Provider enrollment information provided by the State.
- 3.2.36 Process Claims in accordance with existing state policy and rules and regulations for professional dispensing fees. The Solution should be easily configurable to allow for multiple types (e.g., vaccine administration) of dispensing fees.
- 3.2.37 Maintain a history of professional dispensing fee rates to include all updates, changes, and modifications.
- 3.2.38 Integrate with Electronic Health Record (EHR) program(s) at the State's discretion.



- 3.2.39 Calculate varying Co-payment amounts for different pharmacy programs, drugs, and Member demographics in accordance with the Pharmacy Benefit Design (PBD).
- 3.2.40 Verify the Drug Efficacy Study Implementation (DESI) status of the drug and deny payment for drugs that the federal government has identified as proposed less-than-effective [e.g., those drugs categorized as ineligible for Federal Fund Participation (FFP) DESI Categories 5 and 6].
- 3.2.41 Pay and deny drugs based on the State-approved Hierarchical Ingredient Code (HIC) list, Generic Sequence Numbers (GSNs), Generic Code Number (GCN) or National Drug Code (NDC), or Drug Classes covered by a Member's pharmacy program and notify the Provider through an online, real-time response. Exceptions must be allowed based on State-approved PA criteria, Step Therapy criteria, and grandfathered exceptions.
- 3.2.42 Identify and display the Split Claim Indicator when a provider administered drug is split from a parent medical or outpatient Claim.
- 3.2.43 Maintain all Claim attachments, Claim notes, and supporting information to the original Claim and associated applicable transaction for a State-defined timeframe and in accordance with state and federal policies.
- 3.2.44 Be capable of adding, changing, or removing Claim adjudication processing rules at no cost to the State to accommodate State-required changes to the pharmacy program. The State reserves the right to override any system edit whenever it deems appropriate and necessary.

3.3 THIRD PARTY LIABILITY (TPL) & COORDINATION OF BENEFITS (COB)

3.3.1 The Solution must:

- a. Provide the ability to administer a COB program using cost avoidance logic and messaging technology during the Claims adjudication process.
- b. Be able to deny Medicaid coverage for all Claims where the Member is covered by one or more primary carriers until the Provider indicates that the Claim has been fully adjudicated to all applicable Third-Party Liability (TPL) carriers.
- c. Be able to message Pharmacies in real-time with the TPL data provided by the State.
- d. Be able to identify Claims in Member situations federally mandated as 'pay-and-chase' and clearly designate Claims where Providers



voluntarily coordinate benefits to the primary carrier to the advantage of the State.

- e. Be able to message Providers with information for all TPL carriers (e.g., carrier code, policy number, policy holder, Effective Dates of coverage, etc.) during Claims adjudication, for both commercial and Medicare, to efficiently administer the State's COB program.
- f. Correctly code all COB Claims records (paid and denied) for the State weekly Claims file extract.
- g. Have auditing capabilities that can assist the State in identifying Providers that report inaccurate or fraudulent primary payer payment amounts and/or adjudication results.
- h. Provide COB services for dually eligible Medicare/Medicaid Members, including the implementation of cost avoidance methodology for those specific Claims covered under current Medicare Part B legislation and any other federally proposed, future Medicare prescription drug reforms (e.g., Medicare Part D), and process Medicare crossover Claims if requested by the State.
- i. Provide daily/nightly TPL leads generated from Claims processed by the Contractor to the State to be validated by the State's TPL vendor.
- j. Identify non-compliant TPL carriers as those who fail to respond to billings and continually deny Claims.
- k. Track and report payments made by TPL carriers as reported by retail pharmacies.
- l. Be able to automatically bypass TPL in situations designated by the State such as the State requires brand over generic or an OTC product that is not covered by the primary payer.
- m. Provide real-time override capability of TPL to State-designated Authorized Solution Users.
- n. Be able to identify and deny COB Claims when the primary carrier is associated with a discount program or manufacturer patient assistance program.
- o. Provide the State with the ability to update/override the Solution's Database within two (2) hours of receiving the validation/verification from the State's TPL vendor so that Members can receive medicine in emergency situations.



- p. Provide COB reporting to include, but not be limited to, cost avoidance dollars broken down by other coverage codes. In the event the State requires reporting that the Solution is not able to provide, the Contractor shall supply the requested report at no additional cost to the State within an agreed upon timeframe. Refer to Section 7.1 Reporting for additional reporting-related requirements.

3.3.2 The Contractor shall:

- a. Report Providers who potentially abuse any third-party related override codes.
- b. Work with the State to implement new TPL requirements as required by CMS and the State including, but not limited to, pay-and-chase for Products the State has given Prior Authorization when the Member has primary insurance.

4 PRIOR AUTHORIZATION (PA)

4.1 GENERAL REQUIREMENTS

- 4.1.1 The Contractor shall manage and operate a Prior Authorization (PA) program and develop procedures for the State for Products that are included on the PDL & Provider Administered Drug List (PADL). Components of the PA program include, but are not limited to:

- a. Implementation of the operational processes to support drug coverage decisions for all clinical and non-clinical criteria.
- b. Compliance with all State PA rules, regulations, and policies.
- c. Notifications of decision to Providers and Members.
- d. Operation of a Provider call center staffed with appropriate clinical personnel (meeting any State clinical licensure or locality requirements, if applicable).
- e. Assistance to the State, as needed, to administer and support the Appeal process.
- f. Detailed reporting and analysis on all aspects of the PA program.

- 4.1.2 The Contractor must support a fully electronic PA process which must:

- a. Have the capability to accept PA requests electronically and adjudicate automatically either online in advance of a Claim being submitted or during Claims processing by reviewing or adjudicating against pharmacy and medical Claims history.



- b. Maintain a Utilization Management process that integrates with Electronic Prescribing (ePrescribing) and Electronic Prior Authorization (ePA) functionality.
- 4.1.3 The Contractor's PA process flow and notification format must be approved by the State prior to implementation and before any changes are made by the Contractor. The Contractor must disclose operational criteria and updates to the State for review and approval on a frequency determined by the State.
- 4.1.4 The Contractor shall develop and maintain protocols, subject to the State's approval, for:
 - a. All Products identified as requiring Prior Authorization by the State.
 - b. Developing web-based versions of criteria at no additional charge. Customized criteria must allow for open-ended question responses and the Contractor's clinical staff's review of any required supporting faxed documentations or letters of medical necessity during initial PA request reviews.
 - c. Scripted protocols that may be used to approve PA service requests.
- 4.1.5 As directed by State, the Contractor shall implement PA program capabilities for processing PAs for provider administered drugs, regardless of whether the Claim is submitted through the Solution or through the State's medical Claims system.
- 4.1.6 The Contractor shall supply the State with a real-time, automated electronic PA tool for PA requests based on current and historical paid pharmacy Claims, Member eligibility, Provider eligibility, and reference medical Claims data including, but not limited to, diagnosis codes and procedure codes. The tool must be HIPAA compliant.
- 4.1.7 The Contractor must provide a PA platform within the Solution that must:
 - a. Be accessible to Authorized Solution Users (i.e., designated staff).
 - b. Maintain and allow the query of all pertinent information about PA requests and determinations including, but not limited to, the following:
 - i. Requesting Provider name.
 - ii. Date and time of request.
 - iii. Member identifiers.
 - iv. Requested drug name, strength, form, and quantity.
 - v. Program eligibility of the member at the time of the determination.



- vi. Request status (i.e., approved, pending, denied).
 - vii. All reasons for denial or exception.
 - viii. PA beginning and end dates.
 - ix. Date and time of action on the request.
 - x. Comprehensive and flexible “free-text” notation functionality.
 - c. Have the capability to allow the State access to directly enter PAs.
 - d. Be configurable to allow the State to enter PA with State-specified values (e.g., dose, date, all levels of drug hierarchy, prescriber).
 - e. Deny a POS Claim when it does not match the PA information.
 - f. Provide automated algorithm-based PA functionality to automatically override PA requirements during Claims processing based on historical data available from pharmacy Claims paid by the Contractor and on medical Claims history files provided to the Contractor.
 - g. Have the ability to create and utilize “reverse PAs” which restricts a Member's access to particular medications by NDC or applicable drug classifications (Medi-Span, First Databank).
- 4.1.8 The Contractor must successfully migrate all existing PAs into the Solution from the State vendors’ and CMOs’ Legacy Systems and honor, for use in real-time Claims processing, all existing PAs that have not expired regardless of whether they were manually or electronically approved.
- 4.1.9 The Contractor must have the ability to accept and integrate Clinical Data from other systems necessary for PAs and Claims adjudication, including but not limited to, diagnosis codes and lab values, and must use those values in the Prior Authorization and adjudication processes.
- 4.1.10 The Contractor shall respond to initial requests received from Providers within twenty-four (24) hours of receipt one hundred percent (100%) of the time. The Contractor shall communicate the PA decision back to the Provider within twenty-four (24) hours of receipt of all necessary information to make a decision. Receipt is defined as the time of the initial call to the PA call center, the receipt of a fax at the call center, or the receipt of an electronic PA request, whether through electronic transaction, a web-based transaction, or an automated PA process.
- 4.1.11 The Contractor must send required notifications to the Provider when the PA is approved or denied in the same media type as the PA was requested. The required notifications for denied PAs must include all the



reasons for which the PA was denied and any additional criteria needed for approval.

- 4.1.12 The Contractor shall complete review for all possible Claims' edits during the first interaction with the Provider. For example, if a Provider calls in for a PA, the Contractor must have a process in place where staff are required to do a Claim test to check for any other edits that may interfere with the Claim processing, such as Quantity Limits, age limits, etc., before the call is terminated to ensure no other edits need to be addressed. The Contractor must develop and maintain a current list of all edits and identify those edits that require Prior Authorization and provide them to the State at its request.
- 4.1.13 The Contractor must include a review of the Member's eligibility record as part of its PA processing to retrieve the information needed for PA determinations including, but not limited to:
- a. Program eligibility.
 - b. Existence of authorized prescribers.
 - c. Existence of program coverage restrictions.
 - d. Existence of alternative insurance (e.g., Medicare Part B, commercial coverage).
 - e. Other elements specified and approved by the state.
- 4.1.14 The Contractor must ensure that PA requests containing insufficient information to render a final decision are assigned a "pending" status. The Contractor must pursue additional information from the requestor sufficient to render a final decision and, after a State-specified period has lapsed, deny, or close the request.

4.2 APPEALS AND DENIALS

- 4.2.1 The Contractor must maintain written policy, which must be reviewed and approved by the State in writing, governing its handling of denials and Appeals of such denials. The Contractor must comply with State requirements, including communications and processing time, regarding governing denials, first level Appeals and second level Appeals.
- 4.2.2 For each PA review where denial is the result, the Contractor shall have a pharmacist review it to determine whether the PA criteria was accurately applied before the denial decision was issued. A pharmacist must be available to speak directly with the Member or Provider if requested.



- 4.2.3 The Contractor must provide clinician review of all PAs that are deemed to be deniable and, if necessary, medical director review prior to the denial notification to the Provider. The State and the Contractor must jointly determine the types of reviews that should be appropriately escalated to clinical staff.
- 4.2.4 The Contractor must notify the Member when their PA is denied. The Contractor must comply with state and federal policies and procedures for Member Appeals including, but not limited to, the following:
 - a. Notifying Providers and Members of their Appeal rights.
 - b. Preparing the appropriate reports and documents to support the Contractor's actions resulting in the request for an Appeal.
 - c. Appearing at hearings to defend a PA denial decision.
 - d. Providing the services of a clinician to engage in peer discussions with the State's Medical Director, or designee, and other State clinical personnel to address an Appeal related to pharmacy benefit services.
 - e. Complying with the mandates and timelines stipulated by state and federal policies for response/resolution of any Appeal.
- 4.2.5 The Contractor shall produce and deliver all relevant information used in the PA review within twenty-four (24) hours of receipt of a request from the State pertaining to a Member Appeal.
- 4.2.6 For first level Appeals, the Contractor shall receive, review, and provide a final decision within seventy-two (72) hours of request one hundred percent (100%) of the time from the Provider (does not include time in which a request may have been sent to a State employee for review). The Contractor must mail, email, or send electronic notification of the written decision letter to the Member and/or Provider as applicable.
- 4.2.7 The Contractor shall provide appropriate and qualified staff to attend hearings regarding Prior Authorization decisions as requested by the State.
- 4.2.8 The Contractor will track and report on the decisions/outcomes of Appeals as requested by the State.

4.3 PEER-TO-PEER REVIEW

- 4.3.1 The Contractor shall develop policies and procedures regarding the peer-to-peer review processes. These must be reviewed and approved by the State prior to implementation.



- 4.3.2 The Contractor shall have a peer-to-peer review process, administered by a board-certified physician, available to Providers who wish to challenge adverse PA decisions. This process shall ensure that appropriate decisions are made and communicated to the prescriber within one (1) Business Day of the initial request by a prescriber.
- 4.3.3 The Contractor shall notify Providers of the review process with respect to re-review of an adverse PA decision.

5 FINANCIAL MANAGEMENT SERVICES

5.1 OVERVIEW

- 5.1.1 The Contractor shall be responsible for:
 - a. Providing business processes and automated functions necessary to support pharmacy payments, record keeping providing transparency, and proper management of state and federal funds used for those payments in compliance with Generally Accepted Accounting Principles (GAAP) and State-mandated record-keeping rules.
 - b. Performing reconciliation of pharmacy payments, accounts receivable, and management of agency funds.
 - c. Supporting audits of financial activities.
 - d. Coordinating payments to pharmacies on behalf of the State. Payment amounts will be determined using reference data supplied by the State indicating the cost of the drugs and a dispensing fee that may vary based on the attributes of a given pharmacy.
 - e. Establishing an automated framework, where applicable, following the State's specifications, to track, monitor, and process financial transactions, including, but not limited to, the following transaction types:
 - i. Accounts Receivable: Funds due from a Provider to the State.
 - ii. Non-Claim Payments: Payouts not related specifically to a Claim.
 - iii. Cash receipts: Refunds received from Providers.
- 5.1.2 The Solution must have the capability to support the implementation of internal control mechanisms as defined by the state through timely and accurate financial reports, detailed audit trails, and financial trending.
- 5.1.3 The Solution must manage financial reference data essential to financial processes. All Financial Management Services activities will require



integration with the State's accounting system and accounting office and is subject to significant oversight by the State's fiscal operations unit. Required activities related to the financial management include, but are not limited to:

- a. Managing State-supplied reference data including rates to be paid to pharmacies (e.g., drug costs, dispensing fees for pharmacies).
- b. Managing accounts payable activities (e.g., payments to pharmacies for filled prescriptions).
- c. Managing accounts receivable activities (e.g., reversing of payments due for canceled prescriptions, balancing and offsetting pharmacy reimbursement, and appropriately directing overpayments to state-identified entities) and the disbursement of payments to pharmacies on a state-specified schedule.
- d. Generating and delivering remittance advices associated with payment disbursement.
- e. Applying and storing adjustments.

5.2 ACCOUNTS RECEIVABLE (AR)

5.2.1 The Contractor shall process all financial transactions within the same weekly payment cycle and guarantee Electronic Funds Transfers (EFT) and checks to Providers will be made within the current payment cycle.

5.2.2 The Solution must have the ability to:

- a. Designate specific reason codes for various types of dispositions and accounts receivable for tracking and reporting purposes as defined by the State including all data necessary for proper state and federal reporting and claiming of federal moneys.
- b. Provide Authorized Solution Users as determined by the State the ability to see the accounts receivables incurred and their balance.
- c. Create Claim and Non-Claim-based receivables using criteria as defined by State.
- d. Provide the ability to set an AR not to recoup or recoup at a percentage or dollar amount defined by the State.
- e. Recoup or apply a receipt to any AR balance and have the attributes of the AR defined in the Accounting Interface (AI) apply to the recoupment and receipt.



- f. Adjust (partially or complete) all types of AR transactions and have the adjustment reduce the AR balance and reflect such on reports.
- g. Create Claim receivables as well as Non-Claim receivables.
- h. Create Non-Claim receivables weekly within one (1) payment cycle.
- i. Separate receivables based on specific reason codes outlined by the State and include these reason codes in reports.
- j. Post cash receipts against both types of receivables, recoup the receivables from subsequent Claim activity, post to multiple receivables and payees from a single remit, post to a specifically identified receivable, and allow for the write-off of these receivables.
- k. Generate one (1) report itemizing each of these types of transactions each week in a detailed summary and roll forward receivable balances from week to week.
- l. Provide reporting of payments, receivables, and receipts in the format and frequency requested by the State.
- m. Allow for the transfer of accounts receivables from one Provider to another at the request of the State without adjusting claims.
- n. Convert all data into a format consistent with the requirements of the State's Accounting Office, or equivalent department, for interfacing with the State's financial accounting system as defined by the State.
- o. Set an accounts receivable (AR) not to recoupment at a percentage or dollar amount as defined by the State.
- p. Suspend payments to a Provider.
- q. Void checks and have all related activity (claims, AR, etc.) either voided or the AR for recoupment automatically reinstated on the provider detail with transactions clearly defined on a history window and voided transactions process correctly through the AI as defined by the State.
- r. Create Non-Claim related payments using specific criteria reasons codes and AI criteria defined by the State.
- s. Reopen claims from previously voided checks and have the data process through the AI correctly.
- t. Void and reissue multiple checks to the same Provider within the same payment cycle.
- u. Change FFP for Medicaid, Children's Health Insurance Program (CHIP), and Breast and Cervical Cancer (BCC) each federal fiscal year.



5.3 NON-CLAIM PAYMENTS

- 5.3.1 The Contractor shall process all financial transactions within the same payment cycle and guarantee all data and processes needed for the State to make Electronic Funds Transfers (EFT) and checks to Providers will be made within the current payment cycle.
- 5.3.2 The Solution must have the ability to issue payouts that are Non-Claim based and, when the payout is in advance, systematically being able to create a corresponding accounts receivable balance.

5.4 CASH RECEIPTS

- 5.4.1 The Contractor shall process all cash receipts within thirty (30) Calendar Days from the date of receipt.
- 5.4.2 The Solution must have the ability to:
 - a. View the cash receipts that have been received for each Pharmacy provider and drill down to the image of the cash receipt received by the bank.
 - b. Designate specific reason codes for various types of dispositions for tracking and reporting purposes as defined by the State.

5.5 GENERAL TRANSACTION REQUIREMENTS

- 5.5.1 When a check needs to be voided, the Contractor shall void checks and have all related activity either voided or the accounts receivable for recoupment automatically reinstated on the provider detail. Such transactions need to be clearly defined for the Contractor to track and report.
- 5.5.2 The Solution must have the capability to:
 - a. Reopen Claims from previously voided checks and have the data process through the AI correctly.
 - b. Void and reissue multiple checks to the same Provider within the same payment cycle.
 - c. Suspend payments to a Provider at the discretion of the State.
 - d. Change the FFP for each transaction type for each federal fiscal year based on rates provided by the State.
 - e. Void a returned Automated Clearing House (ACH) payment and replace it with a check and have the data process through the AI correctly.



- f. Interface with a third-party financial vendor for Claims payment, at a frequency determined by the State, up to real-time, after Claims adjudication.

6 SUPPORT

6.1 CUSTOMER SUPPORT

- 6.1.1 The Contractor shall develop a Customer Service Support Plan, based on a State-approved Project Schedule, and submit it to the State for review and approval.
- 6.1.2 The Contractor must maintain, staff, and operate a Dedicated customer service team, and at least one (1) Dedicated toll-free customer service telephone number, TDD number, and multilingual access via a reputable, industry-recognized telephone translation service for the following purposes:
 - a. Prior Authorization Call Line.
 - b. Provider Claim Troubleshooting Call Line.
 - c. Technical Call Line.
 - d. Member Call Line.
- 6.1.3 The Contractor must provide telephone support twenty-four (24) hours a day, seven (7) days a week (hereinafter, "24/7") via the Dedicated toll-free number(s) at no additional cost to State.

6.2 CALL CENTER-RELATED REQUIREMENTS

- 6.2.1 The Contractor shall provide a 24/7 PA call center which must:
 - a. Offer clinical staff accessible 7:00a.m. to 8:00p.m. State-specific time Monday through Friday, excluding agreed-upon holidays or Contractor Downtime approved in advance by State.
 - b. Support PA processing through toll-free telephone, toll-free facsimile, postal mail, and web-portal based requests.
 - c. Be staffed with appropriate technical and clinical staff, sufficient to handle call volume, meeting State licensure and/or locality requirements, if applicable.
- 6.2.2 The Contractor shall provide a technical call center that shall assist Participating Pharmacies, physicians, other Providers, Members, and special requestors with inquiries regarding a variety of issues such as:



- a. Member eligibility and benefits verification.
 - b. Questions regarding reimbursement.
 - c. Covered Drugs.
 - d. PA requests.
 - e. Pharmacy locations.
 - f. Other inquiries related to the Contractor's services and Medicaid Fee-for-Service pharmacy program.
- 6.2.3 The Contractor must staff each call line with a core team of Dedicated staff. At a minimum, the Contractor must staff based on the staffing ratio as set forth in its Technical Proposal (provided in Attachment R – PBA Services Mandatory Scored Questions) to include pharmacy technicians, nurses, pharmacists, and other healthcare professionals. For the Dedicated Prior Authorization Call Line, the core team must consist of pharmacy technicians. The Contractor must supplement the core team with additional staff (which may be Non-Dedicated) as needed based on call volume. The Contractor must schedule and utilize Dedicated Call Center Staff on all call center shifts to serve as subject matter experts.
- 6.2.4 The Contractor must ensure that no more than two percent (2%) of all calls per month are abandoned as reported by the Contractor's call management software.
- 6.2.5 The Contractor must ensure that all Call Center Staff are English proficient and that adequate resources are available to meet other language needs, as required by the State.
- 6.2.6 The Contractor must have the ability to log all Member and Provider calls through a system capable of tracking and reporting relevant service data, including, but not limited to, average speed of answer, average time on hold, average call transfer time, nature of problems or request, and call resolution statistics.
- 6.2.7 The Contractor shall allow for remote call monitoring conducted by the State, at State offices, of calls processed through the Dedicated line(s), without any preselection of calls or prescreening by the Contractor. The Contractor will also provide call center recording, in accordance with HIPPA privacy law. The objective of using call monitoring and recording is to make certain that Customer Service Representatives (CSRs) provide timely, functional, and valuable support for the State Pharmacy Program – while being professional, considerate, supportive, and responsive to the needs of the Providers and Members



- 6.2.8 The Contractor must provide an Interactive Voice Response (IVR) system with functionality including, but not limited to, customizable options, voice activation and pharmacy locator services.
- 6.2.9 The Contractor must ensure the call center returns all messages and makes outbound phone calls to resolve open issues within forty-eight (48) hours.
- 6.2.10 The Contractor must ensure that the call center has call-back functionality.
- 6.2.11 The Contractor must ensure all CSRs are located in the United States.

6.3 WEB PORTAL

- 6.3.1 The Contractor shall develop, implement, and maintain a State-specific pharmacy program web portal for the public containing two (2) years of historical comprehensive information that includes, but is not limited to, the following:
 - a. Searchable Database of all Products covered by the State's pharmacy program with effective coverage dates.
 - b. Reimbursement rates for all Products.
 - c. PDL Status & PDL Class.
 - d. Provider Administered Status and Class.
 - e. Billable Unit.
 - f. Quantity Limit.
 - g. Link to appropriate criteria document and PA form, as applicable, if Product has coverage limitations.
 - h. Pharmacy Provider Manual, including historical provider manuals.
 - i. PA Criteria Documents (e.g., PA, Quantity Limit, Step Therapy and any other PDL management restrictions).
 - j. PA Forms.
 - k. Contact Information for helpdesk and State.
 - l. Provider Notices and Alerts.
 - m. Current NCPDP Formulary and Benefit Standard Files (Formulary Status List, Cross Reference List, Formulary Alternatives List, Benefit Coverage List).
 - n. State Advisory Board website(s) to host materials for meetings and the public.



6.3.2 The Contractor shall develop and implement a secure State-specific Provider web portal, accessible only to enrolled Providers, State staff, and Contractor staff that includes, but is not limited to, the following capabilities:

- a. Link to Provider Network Management Portal for enrollment.
- b. View individual Member Claims history.
- c. Submit inquiries to the customer call center.
- d. View Drug Utilization Review alerts.
- e. Sign up for email notification of:
 - i. PA outcome.
 - ii. Drug Utilization Review (DUR) alerts.
- f. Member Inquiry – Ability to look up Member demographic information, including eligibility, PAs, and current and historic pharmacy Claims.
- g. Pharmacy Inquiry – Ability to find pharmacy information such as location and phone information.
- h. Preferred Drug List Inquiry – Ability to view Covered Outpatient and provider administered drugs and Products.
- i. Diagnosis Inquiry – Ability to look up diagnosis code definitions.
- j. Program alerts, announcements, and updates.
- k. Prior Authorization – Ability to submit ePAs, track current PA submissions, view determination results, and submit electronic prescriptions through the fax submission.
- l. Seventy-two (72) hour emergency override requests.
- m. Delegate Management – Ability to designate and manage other office staff access to the portal for PA submission, eligibility inquiries and Member drug profile history. Pharmacists shall have additional capabilities through the Provider Portal: Delegate Management – Ability to designate and manage other Pharmacy technician staff access to the portal.
- n. Audits.

6.3.3 The Contractor shall have a user guide available on the portal.



6.4 AVAILABILITY

- 6.4.1 The Solution and operations must be available 24/7, including holidays, at least 99.9% of the time – except for Contractor-Scheduled Downtime approved by the State.
- 6.4.2 The Solution must provide an average POS response time of five (5) seconds or less on all transactions. Response time refers to the time from when the Claim is received by the Contractor's processor to the time the results are transmitted from the Contractor's processor, including all procedures required to complete the Claim adjudication.
- 6.4.3 The Contractor shall provide written notification to the State and Providers with at least seventy-two (72) hours prior notice for any Scheduled Downtime prior to all Downtimes that occur outside of the agreed upon schedule maintenance window that affect any part of the Solution necessary to process Claims, including but not limited to adjudication, eligibility, Provider files, drug files, Third Party Liability (TPL) files and PA files.
- 6.4.4 The Contractor shall notify the State immediately in the event of an emergency or of any Unscheduled Downtime for which the State has received prior notice and any portion of the Solution is affected.

7 REPORTING AND DATA-RELATED REQUIREMENTS

7.1 REPORTING

- 7.1.1 The Contractor will provide accurate electronic reports in accordance with the requirements mutually agreed upon during implementation of the Requirements Analysis Document (RAD).
- 7.1.2 The Contractor must produce ad hoc and other reports not previously identified or requested by the State for review and approval at no additional cost to the State.
- 7.1.3 The Contractor must provide any additional reports not requested previously but required by the State within the designated time parameters set at the time of the request with capabilities for flexibility, scalability, and changeability of the reporting tools.
- 7.1.4 The Contractor must report down to a drug and therapeutic class level as well as down to an individual aid category.
- 7.1.5 The Contractor must provide detailed monthly operational, clinical, and financial reporting on all PA activities including, but not limited to, number

of PAs, denial and approval rates, number of automated vs. manual PAs, drug, and overall health care savings, and return on investment. Reports must be available by drug, drug class, Member, Provider, and other defined parameters.

- 7.1.6 The Contractor must capture and report PA denials and approval rates up to a second level Appeal.
- 7.1.7 The Contractor shall provide a searchable, online repository of previously created and vetted reports to be used by Authorized Solution Users and State staff.
- 7.1.8 The Solution shall provide the functionality for Authorized Solution Users to create customized queries against all data elements. Authorized Solution Users must have access to run queries including, but not limited to, drug pricing compendia, Claim data points and reference data.
- 7.1.9 The Contractor shall provide the ability to export data and reporting results into various formats (PDF, XLS) as requested by the State.

7.2 DATA MANAGEMENT

- 7.2.1 The Contractor must work with the State and all the State-identified third-party vendors to accept its existing file formats either currently or with modifications prior to go live date. In the event any file formats are required to change, the Contractor shall conduct trouble-shooting or problem-solving exercises and make any necessary modifications to its existing file formats to effectuate information exchange at a cost agreed upon with the execution of a Deliverable Expectation Document [refer to Attachment C – Common Scope Requirements and Security Standards, Section 7.2 Deliverable Expectation Document (DED)].
- 7.2.2 The Solution must be able to receive data from and/or send data to any given data source identified by the State. The Solution must store all data for the life of the Contract and satisfy the turnover requirements specified in the Contractor's State-approved Turnover Plan.
- 7.2.3 The Contractor must ensure that the Solution adheres to data retention requirements in accordance with all federal and state laws and regulations. The State may require a longer retention period on an exception basis to support ongoing business needs (e.g., TPL recovery and drug rebate).
- 7.2.4 The Contractor must be able to demonstrate the ability to support requirements for backup and archiving consistent with State, CMS, and industry standards. The Contractor shall also adhere to data retention



requirements cited in 45 CFR 164.316 and the State's Administrative Rules.

- 7.2.5 The Contractor shall be responsible for backup and retention of data to include:
- a. Daily incremental backups with retention of sixty-one (61) days.
 - b. Weekly incremental backups with retention of twelve (12) weeks.
 - c. Monthly full backups with retention of eighteen (18) months.
 - d. Annual full backups with retention of seven (7) years.
- 7.2.6 The Contractor shall reference Attachment EE – Pharmacy Benefit Services Data Exchanges as an example of data sources. Note: The list is not intended to be complete and exhaustive and the State will provide its data sources during the Participating Addendum phase.
- 7.2.7 For all established PBA Data Exchanges, the Contractor shall assist with defining the data elements that will be received, in addition to creating the Extract, Transform, Load (ETL) process for the identified data elements. The Contractor must ensure data synchronization between each State-identified third-party vendor to the greatest extent possible.
- 7.2.8 The Contractor shall document all data elements, processes, methodologies, mechanisms, protocols, and other related information for each data source in an Interface Control Document. The Contractor shall create and maintain a separate Interface Control Document for each data source.
- 7.2.9 The Contractor shall expect to make the necessary changes to data via the ETL process. Current State vendors will not be responsible for adjusting data to meet the needs of the PBA unless determined by the State and agreed to by the data source vendor.
- 7.2.10 Data transmission between the Solution and other systems must have the ability to use standard protocols [e.g., Secure File Transfer Protocol (SFTP), secure web services] and physical reports.
- 7.2.11 The Solution must be able to understand and manage the data structure of sources and know how to handle sources with different natures such as flat files with and without headers/trailers, re-defined areas, relational, hierarchical, XML, HTML, and other file structures.
- 7.2.12 The State shall not consider changes to third party vendors as new interfaces or Data Exchanges. The Contractor shall include possible changes to these Data Exchanges as ongoing maintenance.



7.3 DATA GOVERNANCE

7.3.1 The Contractor shall participate in the Data Governance process, as defined and administered by the State. The Data Governance process will define processes and adjudicate concerns for items including but not limited to:

- a. Enterprise data lifecycle management processes (including master Data Management) and alignment to the State's Enterprise Data Management Strategy (EDMS).
- b. Data synchronization processes.
- c. Data formats for data exchanged by/between systems in the State's Enterprise.
- d. Management of reference data (i.e., code list versions).
- e. Dispute resolution for Data Management issues.

7.4 DATA MODEL AND DATA DICTIONARY

7.4.1 The Contractor shall organize the data within the Solution into a logical, flexible, scalable, and extensible configuration in which individual elements and tables can be linked to each other across conformed dimensions for multiple business uses.

7.5 EXTRACT, TRANSFORM, AND LOAD (ETL)

7.5.1 The Solution must be able to extract data in different formats from the various source systems, transform the many different formats into a common format consistent with the Data Model and Data Dictionary, utilizing Data Cleansing procedures to ensure extracted data is standardized and aligned with data quality standards and then load the data to the appropriate data tables. The ETL processes must be extensible and scalable for ease of changes and to transform many different data structure formats.

8 PHARMACY BENEFIT ADMINISTRATOR SERVICES COMMON REQUIREMENTS

8.1 OVERVIEW

8.1.1 This section contains additional requirements related to those provided in Attachment C – Common Scope Requirements and Security Standards for which the Contractor is responsible.



8.2 PROJECT STAGES AND PROJECT PHASES

- 8.2.1 The Contractor must ensure that the Solution meets CMS Certification approval for the maximum allowable FFP. The goal is to achieve CMS Certification on the first attempt and within six (6) months of go-live as part of Project Phase IV – Initial Operations and CMS Certification.
- 8.2.2 The Contractor must ensure that the data, processes, and documentation required for CMS Certification process and for Streamlined Modular Certification (SMC) Milestone reviews, are provided to CMS in a timely manner. The CMS Certification requirements are provided in Attachment C – Common Scope Requirements and Security Standards Section 6.3 Certification Requirements, the CMS required Outcomes for PBA can be found in Attachment D – Pharmacy Benefit Management (PBM) & Point of Sale (POS) CMS-Required Outcomes and other relevant documentation and guidance can be found in the Suppliers Library.

8.3 COMMUNICATION MANAGEMENT

- 8.3.1 The Contractor shall furnish Pharmacy Providers, stakeholders, Members, and pharmacy software vendors any and all information regarding the program as required by the State. Communicated information may include, but not be limited to, the following:
 - a. Announcement of the Contract
 - b. Bank Identification Number(s) (BINs)
 - c. Processor control numbers
 - d. Customer services numbers
 - e. Plan contact information
 - f. Policies and procedures
 - g. Billing tips
 - h. Changes in program administration
- 8.3.2 The Contractor shall prepare all communication documents, including Provider/Member information letters for notification of plan design or coverage changes and ad-hoc requests, for release to third parties consistent with the requirements of the State as requested. All communication documents must be approved in writing by the State prior to release or distribution.
- 8.3.3 The Contractor must respond to verbal inquiries from Providers within two (2) Business Days regarding any services provided by the Contractor.



- 8.3.4 The Contractor must respond to written inquiries from State it receives by mail, facsimile transmission, email, or other methods within two (2) Business Days of receipt and written inquiries from Providers [other than Provider PA requests and Appeals] within two (2) Business Days of receipt.
- 8.3.5 The Contractor shall have no more than three (3) documented instances per quarter in which it fails to:
 - a. Provide a directly responsive answer by a live person to telephonic inquiries received from Providers, Members, and the State within two (2) Business Days of receipt.
 - b. Provide an answer to written inquiries received from Providers, Members, and the State within two (2) Business Days of receipt.
- 8.3.6 The Contractor shall correspond and communicate regularly with select Provider associations to ensure an adequate flow of information between the State and Providers.
- 8.3.7 Communication Alerts: In the event of a drug recall, the Contractor shall perform communications to Members and/or Providers as follows:
 - a. For Level 1 (Urgent) Drug Recalls, the Contractor shall send an electronic communication (e-blast) to Providers and Members along with a written communication to Members at no additional cost to State.
 - b. For all other Level Drug Recalls, the Contractor shall provide an electronic communication (e-blast) to Pharmacy Providers.
- 8.3.8 Public Relations: The Contractor shall, at the State's direction, perform field inquiries from State stakeholders regarding the pharmacy benefit and program statistics (e.g., Manufacturer/industry surveys, research inquiries, trade association surveys, Manufacturer coverage questions, legislative inquiries, etc.) and attend Provider regional and annual meetings.

8.4 STAFFING – GENERAL REQUIREMENTS FOR ALL STAFF

- 8.4.1 The Contractor shall have staff available Monday through Friday from 7:00 AM to 6:00 PM in the time zone of the State.

8.5 TRAINING

- 8.5.1 The Contractor shall provide the State with all training required to facilitate the State's understanding of the Solution, its Components, and their functionality in order to support the provision of PBA services (including, but not limited to, real time Claims inquiries, PA status and Ad hoc Reporting).



- 8.5.2 The Contractor must ensure that all CSRs are regularly trained on the specific Components of the State Medicaid Pharmacy Services program using materials approved by State.

8.6 SECURITY REQUIREMENTS

- 8.6.1 Alternative Operations Site: The Contractor must maintain or otherwise arrange for alternate site(s) for its system operations, in particular POS Claims processing, in the event a catastrophic or other disastrous event prevents continued operations at the Contractor's primary site(s).
- 8.6.2 Backup Call Center Support: The Contractor must maintain a plan for immediate rollover of the call centers to alternate locations in the event of the disruption of public utilities or other interruptions of the call center or help lines. All backup staff must meet all staffing requirements including criminal background checks.