DEPARTMENT OF SOCIAL SERVICES
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Strong Families - South Dakota's Foundation and Our Future

November 16, 2017

To: All Interested Vendors
Re: Request for Information

The State of South Dakota, Department of Social Services is requesting information regarding a prior authorization system and services for the South Dakota Medicaid program.

The State of South Dakota invites all interested parties to submit a written response to this Request for Information (RFI).

This RFI is being sought strictly for the purpose of gaining knowledge of services and supplies available with an estimate of their corresponding costs and should not be construed as intent, commitment, or promise to acquire services, supplies, or solutions offered. No contract will result from any direct response to this RFI.

Information submitted in response to this RFI is considered confidential and will become the property of the State of South Dakota.

The State of South Dakota will not pay for any information herein requested nor is it liable for any cost incurred by the vendor.

RFI responses must be received prior to 8:00 am, January 18 at the following address:

Department of Social Services
Division of Medical Services
Attention: Mark Close
700 Governors Drive
Pierre, SD 57501

Email responses may be sent to Mark Close at mark.close@state.sd.us with the subject line “Prior Authorization RFI.”

Procedural, administrative, technical, requirement, or contractual questions and answers may be directed to the Point of Contact listed above.

We appreciate your response to this request.

1.0 PURPOSE AND OBJECTIVES

1.1 The purpose of this RFI is to gather information regarding a prior authorization system or services for use in South Dakota's Fee-for-Service (FFS) Medicaid program and the Division of Behavioral Health's substance use disorder treatment program. Information being sought includes product functions, technology platform(s), customization ability, costs and other specifics including ease of development, maintenance and enhancements, and prior authorization services available to purchase.

1.2 The objective of this RFI is to determine the feasibility of whether a prior authorization system could fit the needs of the Department of Social Services.

2.0 PROJECT DESCRIPTION

2.1 The Division of Medical Services (DMS) currently utilizes a combination of Mainframe and PC systems to track and complete prior authorization requests for medical and behavioral health prior authorizations; prior authorizations for prescriptions filled through a pharmacy are not within the scope of this RFI. Medicaid recipients must frequently obtain prior authorization for services and treatment for the services listed on the department's prior authorization website: http://dss.sd.gov/medicaid/providers/pa/. Prior authorization staff review and approve prior authorization requests based on medical necessity and DMS regulations and policies. The Medicaid program is a traditional FFS delivery model without the assistance of any third party vendors for the purposes of prior authorizations, thus State staff are the primary reviewers for prior authorization and medical necessity determinations. Collectively, the Prior Authorization Unit (PA Unit) is responsible for processing approximately 500 to 700 South Dakota Medicaid member prior authorization requests per month.

The PA Unit utilizes two main platforms to store incoming and outgoing prior authorization data: (1) the State's MMIS and (2) a localized Microsoft Access database to track additional prior authorization data not currently captured in the MMIS. The two platforms act entirely independently, without feeds or automatic updates between the two systems. Providers fax in Prior Authorization requests to the Department, the PA Unit retrieves the hard copy forms, scans the documents into electronic pdf format, manually enters in required data fields into the MMIS and Access databases, and makes the required medical necessity determination. The staff then approve or deny the request based upon internally identified clinical criteria and South Dakota Medicaid policy, and faxes the resulting approval/denial to the requesting provider. The authorizing RN and

Medical Director also attend administrative hearings to support their denial determinations if appealed.

South Dakota's MMIS is on a legacy mainframe that is maintained by the State. There are discussions of migrating away from the existing system and proposed solutions should consider feasibility of a transition in the future.

The Division of Behavioral Health (DBH) performs a clinical review and prior authorization of certain high intensity levels/programs for substance use disorder treatment:

- Level 3.7 intensive inpatient services for adults and for adolescents, also known as Psychiatric Residential Treatment Facility or PRTF for substance use disorder treatment;
- Level 3.7 intensive inpatient services;
- Level 3.1 clinically-managed low intensity residential treatment for pregnant women and/or women with dependent children; and
- Specialized intensive methamphetamine treatment.

Each service requires a clinical review completed by a Certified or Licensed Addictions Counselor using Addiction Society of American Medicine (ASAM) Criteria, 3rd Edition to ensure referrals to high intensity services meet clinical and medical necessity. Services are reviewed in accordance with the eligibility requirements found in Administrative Rule of South Dakota (ARSD) §67:61. DBH is required to make the determination of clinical appropriateness for high intensity substance use disorder treatment within 1 business day, including notification to the referring entity. Funding for services is prior authorized within the second business day of receipt. In FY 2017, DBH received 131 referrals on average per month. Each referral review and prior authorization process takes approximately a half hour to complete.

2.2 The goal of this project is to significantly improve the existing prior authorization process by obtaining a commercial "off-the-shelf" electronic prior authorization system, develop an electronic prior authorization system, or purchasing prior authorization services to replace multiple existing systems for the Department of Social Services. The system must interface with the state MMIS to facilitate automated claims processing.

2.3 DSS is seeking the following capabilities from a system, service, or combination thereof. The system/service should have the ability to:

- Meet the federal and state certification requirements for the Department of Social Services.
- Meet the timeframes for completion of a clean PA designated by the state.

- Provide interfaces for other agencies/sub-agencies as needed.
- Automate PA determinations with flexibility to add new or modify existing rules.
- Create and add service codes to PA automated system, including:
    - mental health with service limits
    - inpatient psychiatric units
    - special diagnosis/procedure codes
- Identify service categories that are subject to the same limitation and accumulate the same combination of services. Use combined services to compare to service authorization limit.
- Update PA records based on claims processing to indicate that the authorized service has been used or partially used, including units and/or dollars, during each PA request period.
- Provide flexibility to allow PAs to be capped at a dollar amount at the recipient level, at the service level, at the provider level or any combination that can be controlled and/or measured through available claim/PA file data as determined by business rules approved by the State.
- Allow electronic submission of PA requests including electronic submission of medical documentation; e.g., electronic medical records.
- Store digital photos or electronic imaging of PA attachments and link them to the PA request, regardless of mode of submission.
- Link attachments to PA request with tracking number.
- Generate correspondence and provide ability to communicate electronically or print for mailing.
- Notify provider of invalid web-based and Electronic Data Interchange (EDI) PA entries.
- Automatically alert providers of the need for additional PA information (e.g., HIPAA 278 transaction).
- Alert/notify PA reviewers of PA requests awaiting provider feedback if the provider has not responded within a timeframe defined by the State.
- Generate PA approval or denial notices to recipients and providers when a determination is made.
- Provide a workflow management system to track PA staff productivity and the status of the PA.
- Capture and display the PA service information, including modifiers, place of service, description of service, quantity requested by days, number of services, dollar amounts, quantity authorized, quantity used, dollar amount charged, adjudication date, and review date.
- Capture and display the PA data which includes status of the PA request, including pending, denied, approved, or modified, PA number, recipient information, receive date, date approved, expiration date, date adjudication notice sent to provider and recipient, ID of authorizing person, free-form text area for special considerations and capturing notes which will be printed on the PA notice, using

predefined messages as well as unique messages (e.g., informing providers of cases where the original code requested was changed to reflect the diagnosis on the PA) or special considerations.

- Allow users to add tracking notes for approval or denial of a PA.
- Provide generic PA search functionality including the ability for users to define search criteria that can be used alone or in combination with other criteria.
  - Display information for a PA match including PA numbers, PA status, procedure codes, line item status, reasons, process dates, service dates, coverage types, amounts approved, amounts used, and provide quick links to PA related claim information including status.
- Provide access to eligibility data when reviewing the PA request, including information about the recipient's participation or enrollment in other programs that would affect the disposition of the PA during the PA process. For example, enrollment in hospice, Third-party Liability (TPL), Medicare coverage, enrollment in enhanced care management or some case management program, enrollment in a waiver program, etc.
- Prohibit PA approval from occurring if State business rules prohibit coverage of the service if the individual’s enrollment or eligibility precludes coverage of the service by Medicaid and the business rules do not allow PA to override this business rule.
- Provide the ability to amend an existing PA record, retain the original PA number and assign a unique status to reflect the PA has been amended.
- Allow staff to review PA history and filter results.
- Create PA request/service utilization history to contain data elements specified and defined by the State. Link the paid claim record used to decrement the PA record (including units and/or dollars used) to PA history.
- Monitor outliers with linkages by services and providers for post-payment PA review.
- Retain incomplete PA request submissions for state-defined number of years before deleting the record.
- Allow PA request forms to be available for download by users for manual submission.
- Alert/notify specified staff when a PA request suspends indicating the edit and a brief description of what caused the PA request to suspend.
- Create PA edit system so state-defined edits will return the PA request to the provider prior to initiating the PA approval process, while other edits will allow receipt of the PA request and will be used to determine or assist in the determination of the final disposition status of the PA

request (i.e., PA edits can result in the following outcomes; deny, defer, approve with amendments/adjustments, approve, etc.).

- Identify and report duplicate PA requests for exact service requests and for related or similar type service requests (e.g., services bundled into other prior authorized service codes).
- Generate reports, including:
  - Denials with denial reason, approvals, modifications, amendments, pending (including suspend reason), with Year-to-Date (YTD) totals.
  - Services authorized vs. services received.
  - Status of PA, type of PA and in which location/disposition (e.g., contractor, State) the PA is.
  - Summary and detail report by provider/agency on how many PAs were requested, approved, modified, or denied; outstanding PAs (authorized but unused services) and who authorized the services.
  - Frequency of service codes requested and authorized, open Prior Authorizations at any point in time.
  - Statistics on the number and types of PA requests (as well as other criteria defined by the State) entered into the system, reviewed, and pended.
  - Trend reports based on the types and quantities of services authorized.

3.0 RFI RESPONSE INSTRUCTIONS

3.1 The State is asking all interested parties to submit a response containing the following information:

- Proposed solution to meet the above described criteria including possible staffing configurations.
- Proposed solution to facilitate all prior authorization requests and/or prior authorization requests for specific services e.g., durable medical equipment, behavioral health, home health services, etc..
- Brief description of past experience providing similar software/services in a Medicaid FFS environment.
- From your past experience, has the State identified all the major components necessary to complete this project? Have other state Medicaid agencies requested other criteria? Please provide information on other necessary components.
- Please provide a list of potential problems/risks that the State may encounter during this project. Please provide any ideas or suggestions about how such problems/risks should be addressed in a solicitation.
- Please provide a list of challenges encountered during implementation and how challenges would best be addressed during implementation.

- Your best estimated price range to provide the software/services as stated, lowest estimate to highest estimate. Please provide a description of unexpected costs experienced in past projects.
- Your best estimated time frame for completing the project including an example or estimated project schedule as well as assumptions and needs for project completion.