



TAB 4C: APPROACH TO OPERATIONS

Building upon a successful takeover of the legacy MMIS and associated operational areas of claims administration and mailroom management, the Agency, IME professional service contractors and all program stakeholders will benefit significantly from the operational transformation that will take place as a result of the implementation of a new MMIS which is based 100% on the MITA business processes.

4.3.4.4 Approach to Operations. (Label as Tab 4C in your submission)

Behind Tab 4C, the bidder is directed to describe how their proposed solution will meet the Operational Specifications of Section 2.7 of the RFP and all Operational and Performance Measure requirements (excluding those with identifiers OTR, SCR, CR, TOVR and TOVP) in Attachment L – Operations Requirements Matrix, in accordance with the instructions in Section 4.3.4.1.

Iowa’s new Medicaid contract represents an exciting opportunity for collaboration among some of the country’s leading operations experts in MITA-aligned best practices, workflow and automation efficiencies, and service-driven quality initiatives. We have evaluated your current program thoroughly and it’s clear that the new contract expands beyond traditional Medicaid claims processing, provider payments, and system modification to align with MITA business process guidelines. Our proposed MIDAS MMIS, APHP, is designed from the ground up to support the MITA 3.0 Business Processes and will increase the MITA maturity across the IME. The operational model for mailroom management and claims administration offered to the Agency meets all of the requirements of the RFP and will position the greater IME services to operate in a cohesive, integrated, and efficient manner.

To assist the Agency in accomplishing this operational transformation for the IME, we will collaborate with IME stakeholders, leverage the fully integrated business processes from APHP and our team’s extensive experience with Commercial Healthcare Business Process Outsourcing (BPO) and build on insight and knowledge gained from a successful takeover of the current MMIS and claims administrative operations. Together, we can create a model of operations excellence that underscores the benefits of aligning “best of breed” solutions and teams for a single, achievable goal. The Table below offers a summary of features, experience and benefits that the Agency will receive from our team.

Focus on Quality Operations	Value to the IME
Fully integrated COTS product based solution provides significant operational efficiencies through increased automation and real-time reporting across all operational business units as activity occurs	Enables the IME with an insight driven approach to effective program management and timely, decision making
Previous MIDAS project experience and insight applied to current operational approaches further enhances our ability to apply our proven Medicaid System Management experience	The IME gains a familiar, strategic, trustworthy partner capable of advising on technology and healthcare business needs for future change and sustainability
APHP product Business Processes align with MITA 3.0 and were designed based on quality measurement, innovative approaches to operations and ease of use for workers and other stakeholders	Brings a cultural fit for the IME professional services model plus adds MCO/HMO like alignment with efficient operations, productive, dedicated staff and positive working environment demonstrating continuous process improvement

The Iowa Medicaid program leadership can count on our team to place significant emphasis on measuring and maintaining consistent quality standards in claims receipt and administration activities while always looking

The IME will Operate in Alignment with a MCO/HMO Model for Cost Effective Healthcare Benefit Administration

- IME will operate effectively in a multi-plan environment and adapt to the ever changing Medicaid environment
- Business processes operate in real time and deliver improved care coordination for IME operations such as greater self-service and increased communication capabilities
- IME claims administration plus other professional service contractors will have full transparency into business rules, edits, reports, benefit plans, member and provider data – reducing claim processing errors or other surprises

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for ways to improve operational processes that impact the overall IME model. The Agency will benefit from a holistic reporting management approach for the IME that focuses on real time activity of the members, providers, Claims and Financial Management Services. Native to our corporate culture, we will promote an innovative, collaborative partnership with the Agency through strategic planning and thorough execution across business, program and product operational initiatives.

We acknowledge and accept the 2.7 Operational Specifications Scope of Work (SOW) elements and requirements. This section, approach to operations, is compliant to all requirements listed in sections 2.7, 4.3.4.4, and Attachment L. We have organized our response in this section according to the 22 operational areas listed in section 2.7. These 22 sections have counterparts in Attachment L. Attachment L also lists 4 additional operational areas which we have provided requirement responses to in the following Sections:

- Operations Take Over Phase (4B.1.a)
- Certification Phase (4D)
- Systems Certification (4D)
- Turn Over Phase (4E)

2.7 Operational Specifications

The Operations Phase is the daily performance of all ongoing operations activities by the Contractor. The Contractor shall accept, process, and accurately adjudicate all Iowa Medicaid claims, managed care payments, and adjustments. Additionally the Contractor shall integrate, maintain, enhance, and operate the MMIS to support the business of Medicaid operations.

The Contractor shall provide technical assistance for MMIS related issues such as availability of the system, system access and user notifications as system changes are implemented.

The Contractor shall ensure the MMIS is fully operational, defined as:

Having five years of claims data online.

Correctly processing all claim types, claims adjustments, and other financial transactions.

Maintaining all system files.

Producing all required reports.

Meeting all system specifications.

Supporting all required interfaces.

Paying all provider types.

Performing all other contractor responsibilities specified in the RFP.

The Contractor shall implement all hardware and software required to support the MMIS. The Contractor shall operate and maintain all hardware and software. In the event the Contractor hosts the hardware and software or if the Contractor installs and operates the MMIS hardware and software in the Agency's data center in Des Moines, IA, when the Contractor's operation of the MMIS ends, ownership of all hardware and software licenses shall transfer to the Agency. The Contractor shall continue to maintain and support the MMIS hardware and software throughout the life of the Contract.

Compliance with the successful deployment of the new MMIS on the scheduled dates agreed upon in the Contract is critical to the Agency's interest.

The Contractor shall create and maintain ongoing knowledge transfer schedules for the Pharmacy Point-of-Sale (POS) contractor, Professional Services contractors, and the Agency staff. The Contractor shall provide knowledge transfer throughout the operations phase for new staff and staff who change positions. Knowledge transfer must be provided at the IME facility or at a facility approved by the Agency. The knowledge transfer shall be conducted Monday through Friday, excluding the Agency holidays, between the hours of 8:00 a.m. and 4:00 p.m. Central Time. The Contractor shall furnish the trainees with all necessary knowledge transfer materials.

Operational responsibilities for the following areas are provided in the Operational Requirements matrix in Attachment L of this RFP:

We acknowledge and accept the 2.7 Operational Specifications Scope of Work (SOW) elements and requirements. Our proposed approach summarized below meets each RFP and contractor requirement.

RFP Section	Proposal Section
1. Staffing	4C.1 Staffing
2. Internal Quality Assurance	4C.2 Internal Quality Assurance
3. Change Management	4C.3 Change Management
4. Mail and Courier Service	4C.4 Mail and Courier Service
5. Member Management	4C.5 Member Management
6. Provider Management	4C.6 Provider Management
7. Medically Needy Program	4C.7 Medically Needy Program
8. Claims Entry and Receipt	4C.8 Claims Entry and Receipt
9. Claims Adjudication	4C.9 Claims Adjudication
10. Encounter Management	4C.10 Encounter Management



RFP Section		Proposal Section
11.	<i>Reference Management</i>	4C.11 Reference Management
12.	<i>Prior Authorization</i>	4C.12 Prior Authorization
13.	<i>Third-Party Liability</i>	4C.13 Third-Party Liability
14.	<i>Program Management and Federal Reporting</i>	4C.14 Program Management and Federal Reporting
15.	<i>Financial Reporting and Management</i>	4C.15 Financial Reporting and Management
16.	<i>Program Integrity</i>	4C.16 Program Integrity
17.	<i>Managed Care</i>	4C.17 Managed Care
18.	<i>Eligibility Verification System (ELVS)</i>	4C.18 Eligibility Verification System (ELVS)
19.	<i>Web Services</i>	4C.19 Web Services
20.	<i>Workflow Management</i>	4C.20 Workflow Management
21.	<i>Business Rules Management</i>	4C.21 Business Rules Management
22.	<i>Technical Operations</i>	4C.22 Technical Operations



4C.1 STAFFING

2.7.1 Staffing

The Contractor shall supply the staff described in this section. The Contractor shall maintain the number and qualifications of this staff for the operations phase.

The journey to build a healthy future for Iowa requires, in large measure, a team of talented and experienced professionals committed to the success of the IME project. We have the capabilities and record of proven performance to deliver and sustain operational excellence for the Iowa Medicaid Enterprise (IME). In addition, our Des Moines based team has experience with the IME and is committed to the success of Iowa’s Medicaid program. The key factors in helping the State successfully improve the quality of healthcare delivery are:

- **Well-Rounded Team** – individuals who have the knowledge domain of systems integration and operations, industry specific knowledge in healthcare and Medicaid, and first-hand access to the tools and training of the APHP product set
- **Committed Team** – qualified and committed individuals with proven performance and a focus on collaborating and delivering successful programs with clients in healthcare
- **Cohesive Organization** – cooperates with all resources, stakeholders, and organizations involved to confirm successful integration of all solution components and efficient delivery

We developed our staffing plan and proposed organization for the Operations Phase of the IME Project based on RFP requirements and our experience with similar operations scope. We bring talented and experienced staff to fill the identified roles for the Agency. Our staff meets all contractual requirements for the positions in which they serve.

a. Systems Management Staff - Sufficient staff to perform rules engine, benefit plan, workflow, interfaces and reporting management and maintenance as necessary to support Medicaid program management and federal reporting requirements .

Systems Management Staff

We provide the Systems Management staff with responsibility for system maintenance and ongoing configuration/modification of the APHP and the integrated software components of which it is comprised. The systems management staff is responsible for system and application rules configuration, benefit plan and workflow maintenance, database administration, technical services, computer operations, interfaces, and reporting activities. The Iowa Team has the right people who are competent and highly motivated to support the IME and the Systems Management Staff requirements.

b. Claims Expert(s) – Research claim inquiries. Provide expert witness testimony in judicial proceedings on the Agency’s behalf.

Claims Experts

The Iowa team is comprised of claims experts with in-depth knowledge of the capabilities of APHP and Medicaid claims processing. The Iowa leadership team has extensive Medicaid claims processing experience and experience with the IME and working as part of the IME Core Unit. Having this experience allows them to not only perform tasks such as resolving suspended claims, but researching any claims-related inquiries as well. Should the Agency research request require escalation due to any type of judicial proceedings, these staff would be supported by the Operations Lead and Operations Manager who would be made available to provide expert testimony on the Agencies behalf.

c. Quality Assurance (QA) Support Personnel. The QA support team shall have a minimum of one staff member who has demonstrated experience in developing, executing and reporting formal quality assurance plans. Quality assurance applies to all operational processes within the Contractor unit.

Quality Assurance Support Personnel

Quality is the foundation of a high performing operations team which strives to exceed performance standards and focus on continuous improvements. Accenture utilizes an industry leading operational excellence approach based on Six Sigma and Lean Manufacturing principles which has been deployed on thousands of large



Handpicked, Highly Skilled Iowa Based Team with Direct and Relevant IME Experience as well as Perspectives from other State Medicaid Operations

- Provides reduced delivery risk through known potential risks and field-tested mitigation strategies
- Focuses on supporting Iowa’s business and reducing adverse impact on its members and users
- Experienced team both technically and functionally lowers effort and decreases time demands on Agency employees

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scale complex outsourcing engagements that require extremely high levels of quality. Our quality approach is recognized as industry leading as demonstrated by the number one rating by the IAOP five years in a row.

During operations we provide a dedicated Quality Assurance (QA) Coordinator for this function. Our Operations Manager, [REDACTED] is responsible for performing auditing and review activities to monitor and measure performance accuracy, process efficiency, productivity, and meeting performance requirements. The QA Coordinator also supports the Agency during the CMS Certification of the MIDAS MMIS.

In addition to performing quality control audits, [REDACTED] proactively initiates process improvements to support Agency initiatives and MIDAS MMIS improvement goals, often leading teams of IME staff in analyzing processes, defining root causes, and developing solutions and improvement plans.

d. Business Analyst(s). Meet with IME policy and unit staff to capture and document modifications to the MMIS systems to support organization and mandated change. The analyst(s) must work across multiple levels of the organization and be able to identify and articulate the necessary workflow, configuration, rules, reporting requirements, interfaces, and modifications needed to support the business process change.

Business Analysts

Business Analysts are the heart and soul of any operation. They collaborate with users and other team members to understand and document business requirements needed for design, development, and implementation of changes and enhancements to workflows, configuration, business rules, interfaces and reporting requirements. In addition, they assist in troubleshooting issues and problem solving, assist in training staff on operations, processes and procedures and support testing and release activities including reviewing test plans and test cases. Several of our BAs are returning from the original MIDAS project including [REDACTED] and have spent time on the APHP product development team. They bring knowledge of the IME and an in-depth understanding of the APHP product.

e. Support Personnel - The Contractor shall provide sufficient staff to process mail, enter claims, and conduct manual claims review, internal and external communications, status reporting, and work needed to meet the operational requirements.

Support Personnel

We are aware there are many talented lowans currently staffing the IME CORE Unit support team. We will aggressively recruit and hire the existing staff during takeover and provide training to update their skills during the transition to the new MIDAS MMIS. When we are unable to fill a position with the incumbent staff we will hire and train sufficient, qualified personnel to perform all support functions within the IA MMIS. This support includes all mail room functions such as receipt, screening, sorting, imaging and entering of claims into the MMIS, manually reviewing claims as necessary, status reporting and all other functions to meet RFP operational requirements.

f. HIPAA electronic data interface help desk - Sufficient staff dedicated to Iowa Medicaid providers via phone calls and e-mail communications.

HIPAA Electronic Data Interface Help Desk

As part of our ongoing operations, Accenture staffs a help desk to support, via phone calls or e-mail, providers, billing agencies or clearinghouses who are having trouble with their EDI submissions. This help desk would operate between the hours of 7:30 am to 5:00 pm and be staffed with personnel knowledgeable with all healthcare related EDI transactions and fully trained in the EDI technologies being deployed. The EDI help desk would be able to handle the majority of issues that submitters are encountering with only complex software issues being escalated to the technology support teams.

Response to Attachment L Requirements

For each Attachment L requirement narrative response we provide a cross reference of the **requirement number and the page** of the matrix provided in Tab 4G: Worksheets for Submission.

Att. L Req.	Tab 4G Page
GR-1	Att L - 1

The MIDAS MMIS Team provides necessary technical assistance for MIDAS MMIS related issues. We bring a strong team that provides deep experience and expertise in Iowa Medicaid, MMIS, claims processing solutions, and SOA-

based solutions. The helpdesk will be staffed with experienced technical personnel and supported by the Iowa technical support team. When issues such as availability of the system and system access do occur, the helpdesk will assist and resolve the issue at the point of contact or escalate the problem to the appropriate support staff. The helpdesk staff will pro-actively notify affected uses of planned outages or changes that affect users and notify and update affected users when unplanned outages occur.



GR-2 Att L - 1

In developing our staffing plans and identifying the roles that will be assigned during the Operations phase, we have utilized a standard methodology and estimating models that have been proven through hundreds of prior engagements. The estimating models are 'bottoms-up' calculators that utilize key input parameters such as transaction volumes, transaction execution times, and required turn-around (service level) to determine staffing in each of the Operations support areas. The result is a highly accurate staffing estimate on which the IME can rely to provide sufficient staff counts to meet the specific service levels required.

GR-3 Att L - 1

The rules engine, benefit plans, and workflow are all configurable components of our solution and do not require any coding changes to provide support to the IME. The staffing for these components is provided by our business process operations team by dedicated staff. Interfaces and reporting support is provided by our application maintenance team.

GR-4 Att L - 1

Our MIDAS MMIS team has broad Medicaid claims management and processing experience including recent and relevant IME experience. We combine our team with staff from the existing claims operations team in a 're-badge' model during takeover to maintain continuity and consistency in the application of Iowa specific Medicaid policy to the operation and add Accenture's proven operational excellence practices.

GR-5 Att L - 1

The Quality Assurance team is led by [REDACTED]. His experience and credentials can be referenced from his resume in Tab 5, Section 5.2.2.3.

GR-6 Att L - 1

Accenture's Operations Support team includes business analysts who possess knowledge and experience in Medicaid policy and have working knowledge of the APHP toolset. In order to provide continuity, key current staff would be targeted for 're-badge' offers during the Takeover phase. These analysts have experience working with all levels of Medicaid operations, from the Director, to the policy experts, to IME user staff, including State IME staff and Professional Services IME contract staff. The staff would apply Accenture's proven methods to effectively and efficiently promote business change into the technical solution set.

GR-7 Att L - 1

All software used within IME Operations to support the MMIS would be recorded in the software inventory using our standard Application Inventory Tracking tool. The tool provides the capability to record the software name, description, owner, release, installation dates, and upgrade dates. Procedures would be provided to all IME Professional Services contractors via the Project Management portal so that all components remain visible to the IME.

GR-8 Att L - 1

Our base product training material is Medicaid Information Technology Architecture (MITA) aligned and includes a role-based curriculum matrix with a recommended list of courses based on a resource's role in the organization. In addition to Provider and Member-facing training, the base curriculum contains material addressing system functionality that supports all of the MITA business functions including Eligibility and Enrollment, Member Management, Care Management, Provider Management, Financial Management, Performance Management, Plan Management, Operations Management, and Business Relationship Management.

GR-9 Att L - 1

Throughout the Operations and Maintenance Phase, the schedules for knowledge transfer will be updated to meet the needs for new staff, staff that change positions, system changes to the MIDAS MMIS, and changes to MIDAS MMIS operational procedures. We conduct orientation activities according to the Staffing Management Plan and ongoing knowledge transfer according to the Knowledge Transfer Plan. We schedule ongoing knowledge transfer activities in the Operations Phase on an as needed basis and modify the schedule we created during the ACD Phase to reflect new or modified knowledge transfer sessions. Our knowledge transfer schedule includes a calendar, which provides a summary view of sessions planned, and a Microsoft Excel spreadsheet that provides detailed information for each session.

We work collaboratively with the Agency in developing our Knowledge Transfer Schedule. Our schedule for Operations aligns with defined Agency requirements. Table 4C.1-1 indicates our acknowledgement of these requirements.



Table 4C.1-1 APHP connects seamlessly to various programs and trading partners for data exchange.

Operations Phase Knowledge Transfer Schedule Requirements	Acknowledgement
Maintain ongoing knowledge transfer schedule for Professional Services contractors and the Agency Staff	✓
Provide ongoing knowledge transfer sessions throughout operations phase for new staff or staff that change positions	✓
Schedule knowledge transfer facility use with the Agency and IME units	✓
Schedule knowledge transfer sessions between the hours of 9:00 a.m. and 4:00 p.m. CST	✓
Schedule knowledge transfer sessions for business days, excluding state holidays	✓
Provide knowledge transfer materials for session attendees	✓

GR-10 Att L - 1

Accenture has analyzed the requirements and understands in detail the interfaces required to make the new MMIS a successful and complete solution for the IME. The APHP solution uses the BizTalk Enterprise Service Bus to provide the ability to invoke a service by a variety of protocols. BizTalk provides multiple, standard adapters to allow services to be invoked by a web services, file inputs, and queues, to name a few. Services are not limited nor bound to a specific protocol, binding occurs at run-time/deployment.

GR-11 Att L - 2

We have demonstrated our commitment to go 'above and beyond' our clients expectations in bringing innovation and thought leadership to all of our engagements. We will work with the Agency in key planning and strategy meetings and bring individuals from our Public Health Sector that continually monitor developments at the State and Federal level to identify trends and innovate new strategies and approaches. Additionally we research new tools in the market that may be of value to the Agency and help inform decision making to the optimal solution.

GR-12 Att L - 2

We understand that the IME is comprised of State leadership and policy personnel with eight key primary Professional Services contractors that deliver a comprehensive set of integrated services. Our approach will promote continued collaboration using our governance and management approach. In addition, the APHP platform enables system integration through its architectural foundation. APHP is a comprised of a set of standard COTS products that enable 'plug and play' components to work seamlessly with minimal effort to enable such integration.

GR-13 Att L - 2

We will support all system modifications through a structured Change Management process with specific configuration of the process agreed to with the Agency. The fundamental process starts with the initiation of a request, which could be initiated by each Unit Manager. Review of requests will be done jointly and will include all Professional Services contract units and the Agency. Prioritization and approval of requests will rest with the Agency who will have full authority over what work is progressed.

GR-14 Att L - 2

The team assigned to the IME will be fully available to support State, Federal, and independent audits. Data requests will be satisfied in our Production reporting environment, most of which will be available through standard reports for things such as the CMS standard required reporting. In addition, the Production Reporting environment and query tools will be made available to authorized Agency personnel to perform any additional required data extracts.

GR-15 Att L - 2

All current and historical data is maintained online and available within the APHP application for the term of the contract. Disk storage has been estimated to support the entire production life of the contract, which is estimated to be 90 months. Audit trails are provided through standard database auditing tools that comply with audit guidelines. Our proposed retention approach exceeds state and federal regulations for data retention of public health data.



GR-16 Att L - 2

APHP provides configurable user security roles and responsibilities that enable the business, instead of the technology, to dictate access to various components of the APHP solution from a job description perspective. The front-end configuration screens enable our system maintenance team to configure access requirements to support all the required functions of Agency, IME professional services contractors, and our service staff. This configurable approach limits user access to only the required and necessary data to comply with CMS, HIPAA, and Agency specified regulations.

GR-17 Att L - 2

The help desk will support IME staff using the existing telephony and call ticketing infrastructure and will be enhanced with our standard problem and issue management tool, ITSM, a Remedy based solution.

GR-18 Att L - 2

The help desk will include staff dedicated and expert in our proposed EDI solution. These team members would fully support all channels for EDI submitters and escalate only the most complex issues that stem from core EDI software product issues.

GR-19 Att L - 2

The APHP SOA design insures efficient utilization of web services for real time interfaces. For batch interfaces the MMIS System Operations team will schedule, execute, and monitor all production interfaces using our standard System Process Scheduler, UC4. The schedules are executed automatically according to the configured timing and dependencies, which can be time initiated, event initiated, and manually initiated. Automated monitoring and notification is built in and notifies support staff of any unexpected or delinquent events.

GR-20 Att L - 2

All project management and governance dashboards, artifacts, and production reports will be made available to all authorized IME staff via the MIDAS Portal. APHP production reports are developed using the Microsoft toolset, and as such integrate easily with the SharePoint based MIDAS Portal.

GR-21 Att L - 2

The APHP toolset utilizes standardized code sets and applies NCCI edits accordingly. All code sets and edits are maintained throughout the term of the contract to verify claims are accurately and efficiently adjudicated. As federal and state rules and regulations evolve the code sets and edits are modified accordingly. The MIDAS MMIS staff will collaborate with State policy to validate changes are applied accurately and with Agency approval.



4C.2 INTERNAL QUALITY ASSURANCE

2.7.2 Internal Quality Assurance

The Contractor shall monitor its operations to ensure compliance with Agency-specified performance requirements. The Contractors shall provide continuous workflow improvement in the overall system and Contractor operations. The Contractor shall work with the Agency to identify quality improvement measures that will have a positive impact on the overall program. The quality assurance function includes providing automated reports of operational activities, quality control sampling of specific transactions and ongoing workflow analysis to determine improvements needed to ensure the contractor not only meets the performance requirements for its operational area, but also identifies and implements improvements to its operations on an ongoing basis.

A fundamental element of our quality assurance function is to provide continuous workflow improvement to the overall MMIS system and operations. The IME will benefit from Accenture’s operational excellence approach which incorporates Six Sigma and Lean Manufacturing principles. The IME will achieve optimal performance results from our approach which combines continuous, in-line quality steps, post-execution statistical sampling, and periodic quality assurance audits to deliver superior results.

The Agency will Benefit from a Collaborative, Compliant, High Quality Performer Leveraging Best-Practices for Continuous Improvement

- Operational activities are monitored using APHP in near real time automatically tracking compliance through configurable indicators
- Workflow triggers and automated reporting incorporate the Six Sigma approach for operational excellence and produce ongoing opportunities for IME improvements

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Operational Excellence methods are the basis of our Operations approach and these methods consist of seven principles focusing on ongoing quality and control of business processes, which we will incorporate into the MIDAS Quality Management Plan. Our strict focus on quality is prevalent in every level of operations and enables proactive identification of improvements to provide high quality results that are continuously being evolved throughout the term of the contract. We employ the following seven principles, described in Table 4C.2-1, to foster a culture of ongoing improvement and efficiency into the services we provide to the IME.

Table 4C.2-1. We offer an Operational Excellence approach which enables high quality delivery, reduction in risk and a catalyst igniting continuous improvement for the IME.

OE Practice	Definition	Benefits
Process Documentation	Defines and simplifies the process; Sustain high process compliance	<ul style="list-style-type: none"> ■ Reduce cycle time by eliminating non-value-added work and unnecessary rework through simplification of the process. ■ Drives consistent execution and process stability.
Process Risk Management	Identify and address potential process failures that can be monitored, prevented or controlled	<ul style="list-style-type: none"> ■ Lower risk of process failure (improved cost by reducing work). ■ Lower risk of being surprised by process failure, which enables proactive management of customer expectations. ■ Response plans equip process operators to implement pre-defined solutions without delay.
Process Metrics	Define and implement process metrics, data collection processes, and reporting tools to monitor process performance	<ul style="list-style-type: none"> ■ Enables a comprehensive understanding of process performance and focus on key operational levers. ■ Equips us to effectively manage our service delivery operations through improved decision making. ■ Enables identification and prioritization process improvement opportunities.
Process Control	Implement control mechanisms to verify that processes are meeting defined standards	<ul style="list-style-type: none"> ■ Provides for predictable performance. ■ Equips us to manage change effectively and establish stability in a new situation. ■ Enables early detection: identifying a potential problem prior to it becoming a problem, prompting proactive efforts. ■ Common Process Change Control and Review Procedures.
Process Stability	Implement control charts to reduce and monitor assignable sources of process variation	<ul style="list-style-type: none"> ■ Provides essential basis from which to achieve and maintain predictability and repeatability. ■ Enables sustainable process improvement. ■ Identifies and separates problems with process execution from problems with process design. ■ Drives focus to and improvement of problems with execution.



OE Practice	Definition	Benefits
Visual Management	Manage process performance through the use of prominently displayed process standards and scorecards	<ul style="list-style-type: none"> Improved workplace productivity and communication. Encourages process compliance. Enables quick response to changing demands on the workforce. Provides clear line of sight for the workforce to see the impact of their activities on the process outputs.
Management Operating System	Establish and conduct routine meetings and processes for reviewing performance, managing work, and assigning actions for daily operations and process improvement	<ul style="list-style-type: none"> Sets priorities and expectations for operations teams. Drives coordination and accountability for performance through routine, consistent follow-up. Performance is discussed every day and tasks are assigned to appropriate role. Sets cadence for communication, discussion and issue resolution.

Accenture’s quality control procedures include standard claims quality monitoring and reporting via a post processing random sample audit to measure items such as system defects, claim processing accuracy, payment accuracy, and financial accuracy. We record the results of the audits and implement a feedback loop that ties to the process performance. Processes are audited on a tiered rating system, meaning that if they are found to have a higher error rate, they are subjected to more random sampling audits than those with a lower error rate. As corrective action plans are implemented and analyzed, if the process error rate improves, they move down a tier and are not subjected to as much review. This allows the Quality Assurance (QA) team to target their focus on areas needing immediate improvement.

We feel that the Quality Assurance function is paramount to the success of the IA MMIS and has therefore dedicated a Quality Assurance Coordinator to support this function

Response to Attachment L Requirements

For each Attachment L requirement narrative response we provide a cross reference of the **requirement number and the page** of the matrix provided in Tab 4G: Worksheets for Submission.

Att. L Req.	Tab 4G Page
<u>IQAR-1</u>	Att L - 3

The Accenture Delivery Method’s (ADM) Operational Excellence methodology is the overarching CMMI Level 4 certified set of processes that the our team adheres to for the delivery of quality services to the Agency. CMMI ratings provide a validation that processes and methodologies are well defined and executed by organizations. A rating of 5 is the top rating achievable within the CMMI assessment, however the highest rating of any organization operating within the Medicaid program space is a rating of 4 - Accenture rates higher than other organizations in the specific area for Operational Excellence. The ADM Operational Excellence methodology, including the use of Six Sigma's Define Measure Analyze Improve Control (DMAIC) model, guides the development of the Quality Management Plan. This plan provides the foundation for proactive improvements through the identification and resolution of issues that may impact the delivery of high quality services to the State. We work with the Agency to implement the Quality Management Plan.

The Quality Management Plan is developed in close collaboration with the IME using the ADM quality management artifacts, guidelines and templates. The plan documents the quality assurance processes, procedures and techniques that we follow to build quality into the work products and operational services provided to the Agency.

<u>IQAR-2</u>	Att L - 3
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The Quality Assurance Plan document addresses internal QA reviews throughout the project phases, verification and validation activities, as well as claims processing QA activities once we go into the Operations Phase. Verification activities confirm that the project “built it right” (i.e., that the deliverable or work product conforms to the defined standards). It also verifies that the correct processes are followed. Validation provides assurance that we “built the right thing.” Specifications are validated to confirm the processes are on track to provide a service and/or solution that meets the agreed upon requirements.

Internal QA reviews are used to verify and/or validate that:

- Stakeholder expectations are being met or exceeded;
- Processes and deliverables/work products comply with program standards and procedures;
- Defects in deliverables/work products are identified and removed early and efficiently;
- CMMI requirements are adhered to;



The outline for the Quality Management Plan is shown in Table 4C.2-2. We develop and submit to the Agency for approval, a Quality Management Plan tailored with quality assurance procedures suited for the MIDAS project.

Table 4C.2-2. The Quality Management Plan provides a comprehensive approach to proactive identification and resolution of issues inhibiting quality services.

Accenture Delivery Methods Quality Management Plan – Template outline	
1.0 Introduction; 1.1 Quality Management Plan Overview	
2.0 Roles and Responsibilities	
3.0 Quality Management Plan Stakeholders	
4.0 Quality Management Plan and/or Process Dependencies	
5.0 Verification	
6.0 Validation; 6.1 Validation Approach; 6.2 Validation Items and Acceptance Criteria	
7.0 Quality Review Process	
8.0 Execution of Quality Reviews; 8.1 Peer Review; 8.1.1 Prepare for Peer Review; 8.1.2 Conduct Peer Review; 8.1.3 Perform Necessary Rework; 8.1.4 Analyze Review Results; 8.2 Quality Assessments and Coaching; 8.3 Internal Quality Assurance Review; 8.4 Deliverable Confirmation Reviews; 8.5 Operation Quality Assurance Reviews; 8.6 Transition Reviews	
9.0 Milestones	
10.0 Measures	
11.0 Revision Trail; 11.1 Approval Control	

IQAR-3 Att L - 3

We will adhere to the ADM quality assurance processes and procedures, including designating a dedicated quality assurance (QA) coordinator during operations. The QA coordinator's primary responsibilities are as follows:

- Act as a liaison between Accenture and the Agency regarding our performance.
- Monitor the accuracy of the work to include:
 - Monitor project execution of quality related activities and confirm adherence of quality standards as specified in the Quality Management Plan.
 - Monitor quality metrics, identify alternatives and corrective actions, and track progress of improvement initiatives.
- Direct quality assurance and expectations management activities and maintain the quality assurance processes and plans.
- Verify quality assurance tasks are incorporated in the Project Work Plans.
- Oversee the development of Corrective Action Plans (CAP), and then oversee the execution and completion of the CAP.
- Educate all stakeholders on quality management processes documented in the Quality Management Plan.
- Consolidate data from the various quality review activities, and prepare reports based on that data.
- Update the Quality Management Plan as needed.
- Submit quarterly reports of the quality assurance coordinator's activities, findings and corrective actions to the Agency
- The QA Team continuously monitors quality and proactively works towards continuous improvements by:
 - Providing information from reviewers independent of the staff performing the function.
 - Reporting on quality compared to previous periods.
 - Initiating/documenting/implementing plans for improvement against the Service Level Metrics.
 - Documenting/implementing Corrective Action Plans (CAPs) when necessary.

IQAR-4 Att L - 3

The Quality Assurance Team submits quarterly reports of the quality assurance coordinator's activities, findings and corrective actions to the Agency. The quarterly QA report includes performance trends based on the previous quarter. This reporting capture allows reviewers to identify specific areas that may have experienced a downward trend or improvement in performance. Specific areas reported have a defined project performance goal.



IQAR-5 Att L - 3

Using the criteria established through collaboration with the IME, the inquiry and reporting capabilities of APHP provides easy access to transactional and other system metrics through operational dashboards. We will generate reports showing all quality control metrics including the number of items sampled, by category, the number of errors and the percent accurate.

IQAR-6 Att L - 3

Our QA staff remains committed to supporting the IME monitoring performance discrepancies identified during the quality assurance review process. Should any performance indicator fall below the state-specified level, the QA Team will document the problem and identify the corrective action steps needed to improve the rating. Through a collaborative review and research approach, we use a control set of inputs to resolve the issue and implement an issue prevention plan. Key factors include standard operating procedures (SOPs), system access, audit trails, and root cause analysis.

IQAR-7 Att L - 3

The QA coordinator serves as the main point of contact to respond to and oversee corrective action plans when continuous improvement opportunities are identified across all operational areas. This coordinator takes the lead in facilitating discussions and implementing improvements beneficial to the MMIS and other contractors and ultimately IME. Corrective action plans are channeled to the appropriate operations area and are resolved within the timeline approved by the Agency. Examples of possible corrective action plans include introducing automation into operational team work processes or the balancing of workload within an operational unit for long term workload increases. Our QA coordinator works with the Agency to determine the most effective method to resolve performance and claims payment issues and define the necessary actions to be taken. The approach is framed by outlining the actionable steps, the projected impact of those steps, and the projected resolution timeframe. The management of the impacted operational unit provides updates and progress reports concerning the corrective action plan during weekly management meetings.

IQAR-8 Att L - 3

The feedback loop for quality monitoring extends throughout our operations and is escalated to management in the appropriate area. Quality results are sent to supervisors on a regular basis and these supervisors counsel their team members on areas of improvement opportunities and proposed corrective actions. In addition, the QA coordinator meets with organizational managers monthly to review QA reports and collaborate on performance trends. A corrective action plan with a targeted goal may be recommended to address or improve certain performance issues. This last point is critical as we use issues that are identified not just to solve a problem, but to capture an ongoing continuous improvement opportunity. All documentation related to the QA processes, including the corrective action plans, is proactively provided to the Agency and are stored on the centralized SharePoint™ repository for transparent and easy access by the Agency.

IQAR-9 Att L - 3

The QA Team works to identify and address process issues, at the root level, to prevent repeatable errors and continually improve the efficiencies and effectiveness of the services we provide. Our ongoing quality review processes identify potential errors early on and implements preventative measures, and process and workflow improvements. Results of this analysis are reported to the Agency for review.

IQAR-10 Att L - 3

We will use the Agency approved change management process to manage workflow and process changes. We have a disciplined approach to implementing workflow modifications through documentation and controls. Prior to the implementation of a workflow and process improvement, we submit the applicable artifacts and deliverables to the Agency for approval. The Change Management Process is discussed in detail at Section 4C3 Change Management.

IQAR-11 Att L - 4

We will apply our standard process documentation and work instruction tool for the MMIS operations deployment. All workers across the system, security, and business process operations maintain IME process definitions and flows for all functions. Local Work Instructions (LWI's) are maintained online so they can be easily accessed by IME and contractor personnel.

IQAR-12 Att L - 4

Our solution for the MMIS includes the web based Checkbox Survey tool to enable all types of surveys and will be leveraged for feedback on the CMR process. This approach provides efficiency, timeliness, and flexibility in the application of all surveys.



4C.3 CHANGE MANAGEMENT

2.7.3 Change Management

All system maintenance and modifications and enhancements, including server, database, data storage and backup, and network supports as dictated by the hosting arrangement, shall be accomplished by the Contractor staff. Contractor staff will be responsible for maintenance, system changes, as well as changes in the rules engine and maintenance of the benefit plans. The Contractor shall provide sufficient resources and staff to satisfy the service level agreements, and the Contractor must provide sufficient staff at no additional cost to the Agency as necessary.

The Contractor shall provide a change management process that, at a minimum describes how the change request is documented, and how the requirements, design, testing results and approval sign offs for the change are completed. The Contractor shall include staffing at levels needed during Operations to maintain and modify the system in accordance with State and federal policy, program, or legislative changes that may occur and modifications shall be required and included in the ongoing operation of the system and within Agency-specified implementation dates. Maintenance, operations, and modifications include regular upgrades of the system on the Contractor's upgrade deployment schedule, routine changes to business rules, and refinement of work flows. Enhancements are defined as changes to the MMIS functionality outside of the contracted scope that are eligible for 90% federal funding, whether or not 90% federal funding is sought. Contractor and Agency shall obtain a mutually agreed upon change request prior to initiating any Enhancement work. Contractor's Maintenance and Operations pricing shall include 10,000 hours of Enhancement work in the base yearly Maintenance and Operations price. If the yearly 10,000 hours of Enhancements are not used, the unused hours will carry over to future years of the Contract. Enhancement work performed within a Contract year that exceeds the 10,000 hours included in Maintenance and Operations may be billed to the Agency at the Change Service Rate. However, any such Enhancement hours in excess of the 10,000 hours per Contract year included in the base price must be approved in writing in advance by the Medicaid Director. Contractor shall track and report monthly the number of Enhancement hours expended in the prior month and the total number of Enhancement hours expended for the Contract year.

The Contractor shall thoroughly test all modifications before moving them into production. The Contractor shall be responsible for maintaining the required environments to support unit testing, user acceptance testing, and integrated testing. The promotion process must include a separation of duties to ensure the proper approvals are in place before modifications are moved to production. Production moves shall occur outside of the normal working hours. The Contractor shall create an acceptable emergency sign-off and communication approval process for changes that must be implemented during normal business hours

Change Management is one of the key components that the IME will receive from our overall Project Management process. It provides prompt and efficient handling of requests for change to the MMIS, while maintaining levels of service integrity and stability. During the MIDAS MMIS Operations phase, we use the approved Change Management Plan and project management tools to estimate, track, manage and report on maintenance and enhancement changes.

Based on prior experience, we have found that incorporating a single change management process during MIDAS project start up provides a more consistent process and toolset for effective scope management. The Agency's access to this information through integrated tools also provides transparency and allows the Agency access to the estimates associated with change management requests.

Our Processes and Controls

A change management request (CMR) is used to identify all changes for system maintenance and enhancements. These can be an enhancement request, an adjustment to policy change, or a request for the resolution of incidents or problems. In a collaborative fashion with the Agency, we determine and document the purpose, scope, impact, priority, and category of the change. Additionally, we identify the materials, personnel, effort and cost needed to complete and implement the change. This information is then formally submitted as a CMR via the Microsoft Team Foundation Server (TFS) tool.

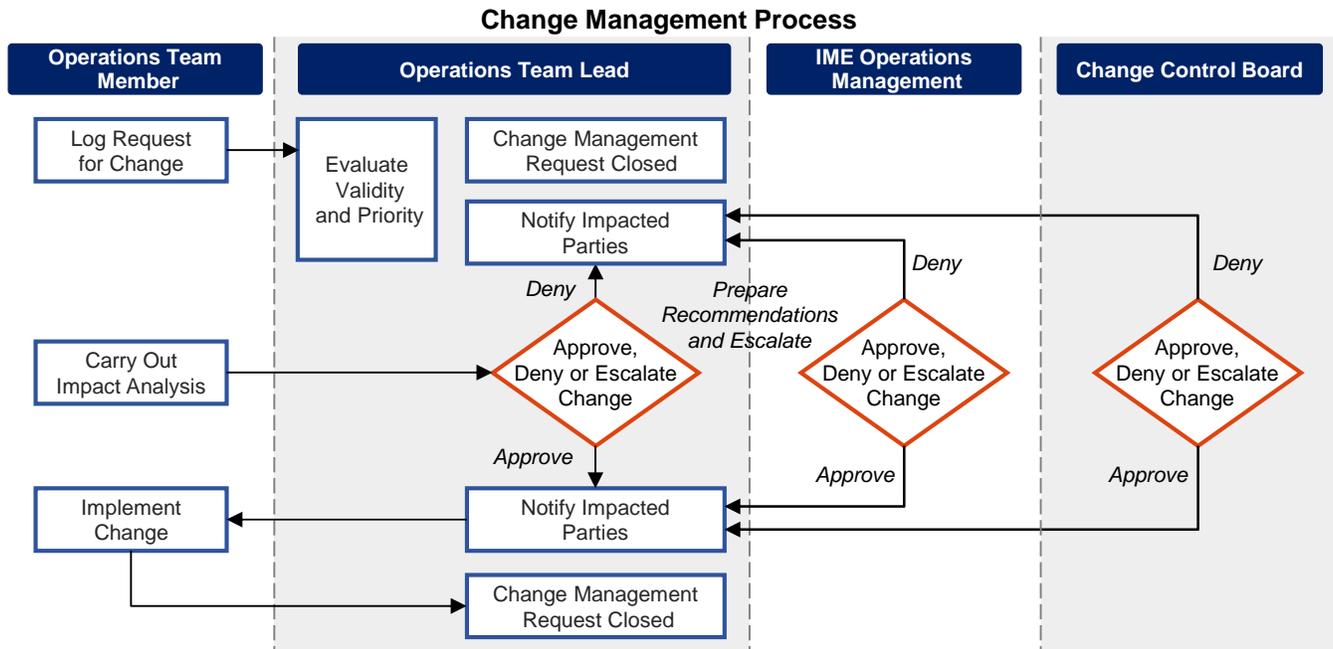
Figure 4C.3-1 illustrates the change management process and levels of decision making we use to manage changes during the Operations phase.



A Proven Approach to Change Management for the IME

- Applies Lean Six Sigma concepts and techniques to drive IME improvement via provider Operational Excellence practices
- Employs a staffing approach that provides skilled and experienced people at the appropriate time to address the changes
- Uses an integrated suite of tools to track change requests
- Transparent, collaborative process and tools that are accessible to all authorized IME staff

IA MMIS-2 4C3-01



IA MMIS-213 042

Figure 4C.3-1: Our change management process utilizes multiple decision levels based on impact of the change to allow for a quicker resolution, and controlled and accepted introduction and deployment.

We suggest organizing the Agency stakeholders into a Change Control Board (CCB) consistent with the successfully demonstrated approach used in our previous work and modified as needed for Iowa. In this process, stakeholders review and approve change requests. The CCB meets on a regular basis to review, prioritize and approve the requests. We have found that a formal CCB provides our clients with control over the scope and allows the changes to be implemented at an appropriate time.

As part of our procedures, all modifications, no matter how small, will be thoroughly tested before being moved into production. This will include unit testing, user acceptance testing and integrated testing. Each type of testing will be conducted within its own unique environment so as not to interfere with other ongoing activities. Our Configuration Management Plan defines the roles, approvals, and process steps for moving modifications from testing environments to the production environment. The plan defines the separation of duties between those actually doing the modifications and those who are allowed to promote changes to a production status. This separation of duties is strictly enforced through permissions set in our Microsoft Team Foundation Server (TFS) tool so that only approved individuals have the ability to update the production environment. Under normal conditions, production moves will take place outside of normal working hours. However, we understand there may be times when modifications cannot wait for the normal processes. As part of our overall Change Management Plan, we will develop, for Agency approval, emergency sign-off and communication approval processes for changes that must be implemented during normal business hours.

The process we follow and tools we use enable us to plan, implement, and track changes in a controlled and structured way that provides the Agency high visibility to the changes taking place. Table 4C.3-1 summarizes the features and benefits of our Change Management process.

We agree with the Agency's statement that "during the Operations Phase any system modification or operations improvement activity will be considered a project." We use the term "project" throughout this Change Management section in acknowledgement and agreement that change requests are managed with all the same methods, tools, metrics and standardization as any other project Accenture undertakes. We comply with all aspects of the approved Change Management Plan for projects undertaken during the Operations Phase on project size and comply with the development standards of the Agency for any system modification project.



Table 4C.3-1. The Agency benefits from a feature rich change management process resulting in higher quality and lower risk.

Process Features	Benefits to the Agency
Accenture's field-tested delivery methods	Reduced risk using industry-recognized change management discipline and control processes documented in our Change Management Plan.
Accessible and easy-to-use tools that automate logging, planning, tracking, and implementing system changes	Agency has excellent visibility into the pending and completed changes to the MMIS via the Project Management portal in SharePoint.
Integrated with Release Management processes and change management governance	<ul style="list-style-type: none"> ▪ Enables the Operations team to plan and manage the timely and controlled release of logical groupings of changes to minimize disruption, facilitate acceptance and reduce and/or eliminate errors. ▪ Integrates with the established Change Management governance defined in the Change Management Plan and closely with the Change and Configuration Management processes to facilitate buy-in and acceptance of the changes.

Response to Attachment L Requirements

For each Attachment L requirement narrative response we provide a cross reference of the **requirement number and the page** of the matrix provided in Tab 4G: Worksheets for Submission.

Att. L Req.	Tab 4G Page
CMR-1 (a-g)	Att L - 4

For all Operations phase maintenance related tasks we follow a defined change management process to govern how we identify, track, configure a change, test and deploy the change into production. In addition to addressing

repair defects and existing functionality that may not be working properly, this process applies to how we perform routine maintenance and address additions and modification to the APHP rules engines, benefit plans, reference files and workflow processes.

We use Microsoft TFS, accessed via the Project Management Portal in SharePoint, as the tool for tracking and automating the defect management process. The status of the defect is tracked through all stages of the defect lifecycle, from identification to resolution, testing and implementation. Maintenance during the Operations phase also includes completing or repairing functionality that never worked. We propose treating "functionality that never worked" simply as another type of defect. For both of these identified defects, TFS enables the attachment of supporting documentation which will allow us to provide results of the defect type and repair and attach them to the defect record for review.

During the Operations phase we will perform routine maintenance on the APHP reference files. This includes all standard Medicaid reference data which is comprised of procedure codes, modifiers, diagnosis related groups (DRG), and revenue codes. In addition to these elements, we maintain additional reference data specific to supporting benefit plan structures, fee schedules and reporting elements. Please refer to Section 4C.11 for detailed process descriptions regarding the steps we take in maintaining reference data.

Maintenance during the Operations phase also includes additions and modifications to the various rules engines, benefit plans and workflow processes. As described in our technical architecture, APHP is designed to be highly adaptable. We use leading COTS and business service products in a loosely coupled, modular fashion to provide end-to-end business processes. Business rules are maintained natively within each of these functional COTS. Additions, updates and deletions of rules are configured directly into the COTS configuration consoles and follow a highly controlled process of identification and analysis, configure, test and deploy. APHP also includes an automated audit trail record that is created as appropriate including the identification of rules updates, system changes, and table updates.

The change or addition of users to security levels of access during the Operations phase also adheres to the established change management processes to make efficient, quality assured and timely additions, changes, and very importantly, timely deletions of user's role-based access possible. The team also monitors unauthorized access attempts and will elevate these activities to the Agency and IME Management teams as appropriate. All changes to security designations are documented, auditable and available for review from within the Project Management Portal.



As part of our on-boarding process, the security team adds the new user and grants access to appropriate functions. Should a change be required, the user would contact the helpdesk to request a change to their access level. The change request is logged and the security specialist reviews the request, identifies the appropriate profile(s) and accesses the security administration screens to administer rights for individual users. The individual's supervisor, or someone of higher authority, would need to review and approve the request before their access level is changed.

CMR-2 (a-f) Att L - 4

Enhancements and modifications made during the Operations phase include modifications to the Agency enterprise modules. Our solution allows for the online entry of new CMR requests which shortens change cycles through IME process unification and gives the Agency complete transparency into change management activities. We provide an online tracking tool for the Agency and contractor to use to track and generate reports on the progress of all CMRs. We use the Microsoft TFS tool as part of the Project Management Portal functionality to support all change management activity, including software development, enhancements, defects, and documentation modifications. By documenting and managing change requests to resolution, MS TFS provides closed-loop change management, delivers better project control and helps improve quality. MS TFS efficiently captures, tracks, and manages all types of change-related information.

Provided are the capabilities to image and include all attachments pertinent to each CMR. TFS allows for file attachments to a change request record in order to provide additional information related to the record. An attachment could include any number of items, such as a source configuration file, test results, a shell script that reproduces the defect or problem, or a document that provides additional detailed description of observed behavior, the image of screenshots or the scanned image of a hardcopy original document.

Stakeholders impacted by a change request process needs to understand not only how changes are being implemented on an individual level, but also how the changes impact the project as a whole. Our online tracking tool provides capabilities for flexible online reporting and status inquiry into the Change Management System TFS enables us to track defects, enhancement requests, assign work activities, and assess the real status of projects throughout their life cycle.

MS TFS includes robust support for querying, charting and reporting. Charting capabilities include trending and aging charts that help visualize complex data. Charts are easily created and can be drilled into when it's necessary to analyze the underlying details. And users can generate to-do lists based on their assignments.

Automatic notifications are sent to affected parties when CMR status change occurs. We use the TFS capabilities to email notifications automatically to stakeholders or stakeholder groups when criteria are met.

TFS automatically sends an email notification to the team lead responsible for that area. The team lead reviews the change management request according to the overall change management process. Once the change has been approved for implementation, the team lead assigns the change request to a developer on the application team. TFS generates an email notification to the developer assigned to implement the change. When the change is ready for implementation, the developer updates the status to indicate that the change request is ready for testing. That update generates a notification email to the testing lead, who then assigns a person to execute the appropriate test scripts. When testing is complete, the tester updates the change request status to indicate that the change is ready to be promoted to production. At each step in the process, whenever the change request is assigned to someone for the next phase of work, TFS generates an email notification.

All CMR changes made by the Agency or Accenture are tracked and documented. We identify the changes made, the person making the change and the date and time the change was made. TFS maintains a change history for each change request. In addition, TFS is integrated with SharePoint to enable the team to link supporting documentation such as test results and related notes for each change request. SharePoint also maintains a change history for each file stored in the repository.

CMR-3 (i-xvi) Att L - 5

Our change management system produces Change Control Reports that are exportable to other formats such as Excel. Information captured includes all required information including: Change management request number, priority number, modification description, modification related notes or comments, request date, requestor, modification start dates, assigned resource(s), estimated completion date, estimated hours, hours worked to date, documentation impact status, testing status, Agency approval of the modification, implementation date and an indication if the implementation date is mandated by legislation or rules.



We will leverage the reporting capabilities of TFS to identify areas for improvement, track progress of those improvement initiatives and gain insight into the overall effectiveness of our change and improvements initiatives. These robust reporting capabilities improve our ability as well as the Agency's ability to visualize, understand, and communicate the need for change and the impact that it may have on the Agency and its constituency.

We use a variety of reports that address measures relevant to our change management processes. Whether it is at the individual change management request or project level, we use the reports to effectively manage the change projects. We also use the historical information to plan change projects and to track progress against key criteria.

CMR-4 Att L - 5

We will access all system modification requests from the Agency; regardless of how the request is categorized. As specified in the change management Performance Standards we provide a written response in a Statement of Understanding (SOU) to each CMR within 10 business days of receipt. The SOU demonstrates our understanding of the request and a high-level schedule for completion. We provide the Agency with high-quality solutions that meet the requirements, are completed on time, and are on budget. To do that, we integrate CMMI Level 4 quality processes into the delivery framework prescribed by our Accenture Delivery Methods (ADM) and apply them daily to the work we do.

CMR-5 Att L - 5

We complete the CMR on or before the requested completion date. Once a CMR is approved, we apply our successfully demonstrated Project Management Methodology and leverage our experienced delivery team to complete the request. Our field-tested estimators help us estimate and plan the system change with a high degree of confidence and accuracy. This accuracy enables us to appropriately resource each change project and accurately schedule a target completion date. Additionally, we communicate and socialize the change via the established governance process and use our release management process to determine realistic dates for the change to be released into production. We apply effective management controls throughout each phase of the change project, providing regular status reports, efficiently managing issues and mitigating risk in a timely manner.

CMR-6 (a-h) Att L - 6

In our response to CMR-2 above in the Online Tracking Tool section, we discussed how the Microsoft TFS tool captures the appropriate information to define the problem, capture the proposed solution and approach to implement the solution, proposed schedule for completion, constraints and assumptions financial impacts, and stakeholder impacts. It also includes any attached documents or other objects that enhance the captured information.

Using our approach to estimating, we determine: the labor (in hours) to complete the change, hours per task, hour per FTE, equipment needed, the amount of general and administrative support hour, ongoing support requirements, the knowledge transfer needed and the documentation changes needed. Our approach facilitates reliable estimates and schedules, which benefits the Agency in execution planning and execution. We view estimating as an integral part of our ability to develop solutions with more predictable implementation schedules and offer lower risk results. We do this by using our delivery experience over the last 30 years and refining our ADM estimating models based upon the outcomes of these delivery experiences.

Our methodology incorporates both bottom-up and top-down estimates. Top-down estimators are intended to be used early in the project life cycle, when less detailed information is known. They are used to create high-level estimates for initial planning. Bottom-up estimates are more detailed which create more accurate and comprehensive estimates. Based on our experience, the sooner we can drive to a bottom-up estimate, the more reliable the estimate.

Finally, we develop a Basis of Estimate (BoE) for each change management request project, which helps to validate that project estimates are realistic and more importantly, achievable. The Agency can benefit from an experienced based bottom-up estimate where a high degree of accuracy can translate to lower project risks and achievable implementation schedules.

CMR-7 Att L - 6

Configuration Management is a sub process within our Change Management methodology designed to confirm that we use only authorized items in the APHP environment. We monitor and track these items throughout their component life cycle. We maintain procedures for promoting code and configurations (business rules and workflows) through unit testing to implementation. All software and hardware elements are stored as configuration items within the configuration



management database, including the associated documentation. Configuration Management and Change Management provide the control mechanisms for code (rule and data) promotion, allowing us to maintain systems integrity and functionality.

The Configuration Management process also contains the recovery steps to be taken in retreating to the last stable configuration should the need arise to restore the last known stable configuration. Documentation for each release details the procedures necessary to accomplish a fallback if it becomes necessary. Rigorous testing revolves around accurate use case creation and the separation of duties between solution developers and production promotion. This process is a priority in which all releases must follow so that the likelihood of needing a fallback scenario is small. Regardless of how long the current release has been in production the fallback capability is preserved.

CMR-8 Att L - 6 To support configuration requirements as new versions and/or upgrades to the MIDAS MMIS and its underlying COTS components are released, our overall change management process for configuration management is subject to the approval of the Change Control Board (CCB). Using the change management governance process, the CCB directs change through a series of clearly defined processes that include system checks, evaluations and approvals. The process consists of identifying, testing and implementing vendor patches, fixes and enhancements. These steps reduce risks and minimize negative impacts of the configuration changes in production. We maintain the documented version control procedures that include the performance of regression tests whenever a code change or new software version is installed. This includes maintaining an established baseline of test cases, to be executed before and after each update, to identify differences.

CMR-9 Att L - 6 Our goal is to provide the Agency with high-quality solutions that appropriately address stated requirements. To accomplish that we maintain adequate staffing levels during the Operations phase in order to complete the CMRs as scheduled.

CMR-10 Att L - 6 We will address all CMRs within the timeframe determined by the Agency. We provide a successfully demonstrated project management methodology, a delivery team with healthcare industry experience, and a systems management team with extensive experience in maintaining systems of similar complexity and size as the MMIS for Iowa Medicaid. Our methodologies include effective management control throughout all phases of every CMR project. Scheduled deployment dates are also monitored through the CCB and the Change Management process.

CMR-11 Att L - 6 During the Operations phase, we continue to maintain and update the IME documentation based on the Document Management Plan established early in the project. We will provide updates to documentation within the agreed upon timeframes after the Agency approves the enhancement or modification for production. Each version would represent a complete document rather than changes to a prior version. The use of the SharePoint Repository for storage and access of project artifacts, including documentation, provides built-in version control mechanisms. Restoring to a previous version of a document is available when necessary, as is creating a delta to show the differences between one version and another, including a before and after version.

CMR-12 Att L - 7 On a schedule to be determined by the Agency, we deliver a report showing agreed upon performance standards, all new and closed CMRs and any emergency production fixes or system outages since the previous report. The report will also reflect the current status of any high priority CMRs.



4C.4 MAIL AND COURIER SERVICE

2.7.4 Mail and Courier Service

The Contractor shall maintain the mail handling function for all paper forms and correspondence and is accountable for each claim from the time it is received. The Contractor shall provide courier service to pick up mail and deliver reports or other items to external entities as required. The mailroom, which is located in Des Moines, Iowa, at the IME facility, receives all incoming mail, logs the claim, screens all claim documents and attachments and returns to the provider those claims that fail the screening criteria specified by the Agency. The Contractor shall sort and batch documents by type.

Accenture provides complete courier and mailroom support for incoming and outgoing mail and understands that we use the current IME facility and equipment for mail and courier services. To address current operational challenges with current mailroom imaging and OCR processes, Accenture will replace Dakota Imaging with Kofax. This change will occur in advance of the proposed implementation of APHP and will integrate with the current OnBase technology to improve the speed and accuracy of the current OCR process. The objective is to implement this Mailroom Intake Redesign in July 2015 to bring a toolset and processes that will automate the data capture for the high volume claim forms, improve efficiency, and reduce re-work that occurs due to data entry issues presenting in the adjudication process of the current MMIS system. With recent changes to Medicaid member eligibility legislation, Accenture understands that significant increases in Medicaid eligibles could impact transactional volumes across the IME professional services. Accenture has developed its solution to accommodate an additional 15% of current documented membership in 2014, and an additional 3% increase per annum.



Proven Automated Processes Lead to Greater Provider Satisfaction

- Error rates are significantly reduced through automated processes to capture hardcopy data with OCR software
- Automation increases speed and reduces errors which lead to faster payments for providers
- Business rule edits specifically designed for CMS 1500, UB04 and ADA claim forms

IA MMIS-2 4C4-01

The current configuration that leverages OnBase as the Enterprise Content Manager and workflow engine for the IME would continue un-interrupted during the Takeover, ensuring a seamless transition for IME users. Kofax will be integrated with the existing OnBase configuration and this work can be leveraged with the new MMIS as well. This approach will mitigate risk by deploying this key component in advance of the new MMIS implementation date, but after the Takeover has stabilized.

At the conclusion of the ACD phase, Accenture Public Health Platform (APHP) will integrate with the Agency's current OnBase Enterprise Content Manager and workflow engine. APHP also contains an enterprise wide workflow solution which provides the Agency robust and dynamic workflow. APHP provides an interoperable framework for ease in integration into the current MIDAS MMIS environment while providing the Agency the foundation for future expansion.

Our Processes and Controls

Accenture is responsible for the picking up and processing of all mail associated with the IA MMIS, including all paper forms and correspondence. This service also includes the delivery of reports to external entities as required by the Agency. All documents received into the facility are prepared by our mail room staff. This includes sorting, batching screening, scanning and imaging documents, and OCR (Claim forms). Imaged documents are then indexed and data entered, and released into OnBase. Claims data is loaded as 837 files into APHP via the EDI solution. Certain documents, for example Claim forms, that do not pass the minimum screening requirements are returned to the provider (RTP).

Documents receive a unique control number immediately upon scanning. The assigned control number resides with the document and/or claim for the life of the transaction.

Response to Attachment L Requirements

For each Attachment L requirement narrative response we provide a cross reference of the **requirement number and the page** of the matrix provided in Tab 4G: Worksheets for Submission.

Att. L Req.	Tab 4G Pag
MRR-1	Att L - 7

The document intake function includes pick-up, receipt and tracking of all incoming documents. In addition, our solution includes distribution of reports as needed. Our team will be housed within the IME mailroom facility, as they are today. Incoming documents are sorted and assigned a DCN for end to end tracking.





All documents received are prepared for processing by mailroom staff. Mail is sorted based on type, such as claim, attachment, prior authorization, or other document type. All paper is prepped by removing anything that interferes with scanning processes, such as staples or paperclips. Documents are then batched and identified through system-generated bar-coded batch header sheets. The batches are entered into our production control system. If checks or money orders are received the receipt of the check is logged and they are processed through a controlled exception handling process then routed via courier to the appropriate Contractor or Agency for deposit as per the agreed upon policies by the IME.

Documents within each batch are screened to confirm that the identified critical information is present. When required information is omitted, or if a claim is billed on an incorrect claim form, the document is 'Returned to the Provider' (RTP) with a letter detailing the reason for rejection. When a document is returned, it is first logged to allow for retrieval, as well as audit and training purposes, or for responding to provider inquiries. Our Claims/Mailroom operations lead will work with the IME Provider Professional Services contractor to communicate trends in these areas to close the feedback loop through the appropriate Provider Outreach strategy. The documents to be returned are pulled from the original batch, sorted by reject reason, and placed in the appropriate bin to be counted, batched and returned on a daily basis. When returning to the provider, a customized letter is sent explaining the reason for return and suggestions for successful resubmission.

MRR-2 Att L - 7

Hardcopy forms and correspondence that pass the screening process are then scanned and imaged. The imaging software, Kofax, integrates with the Agency's hardware scanner equipment and the software requirements. Kofax provides the following services:

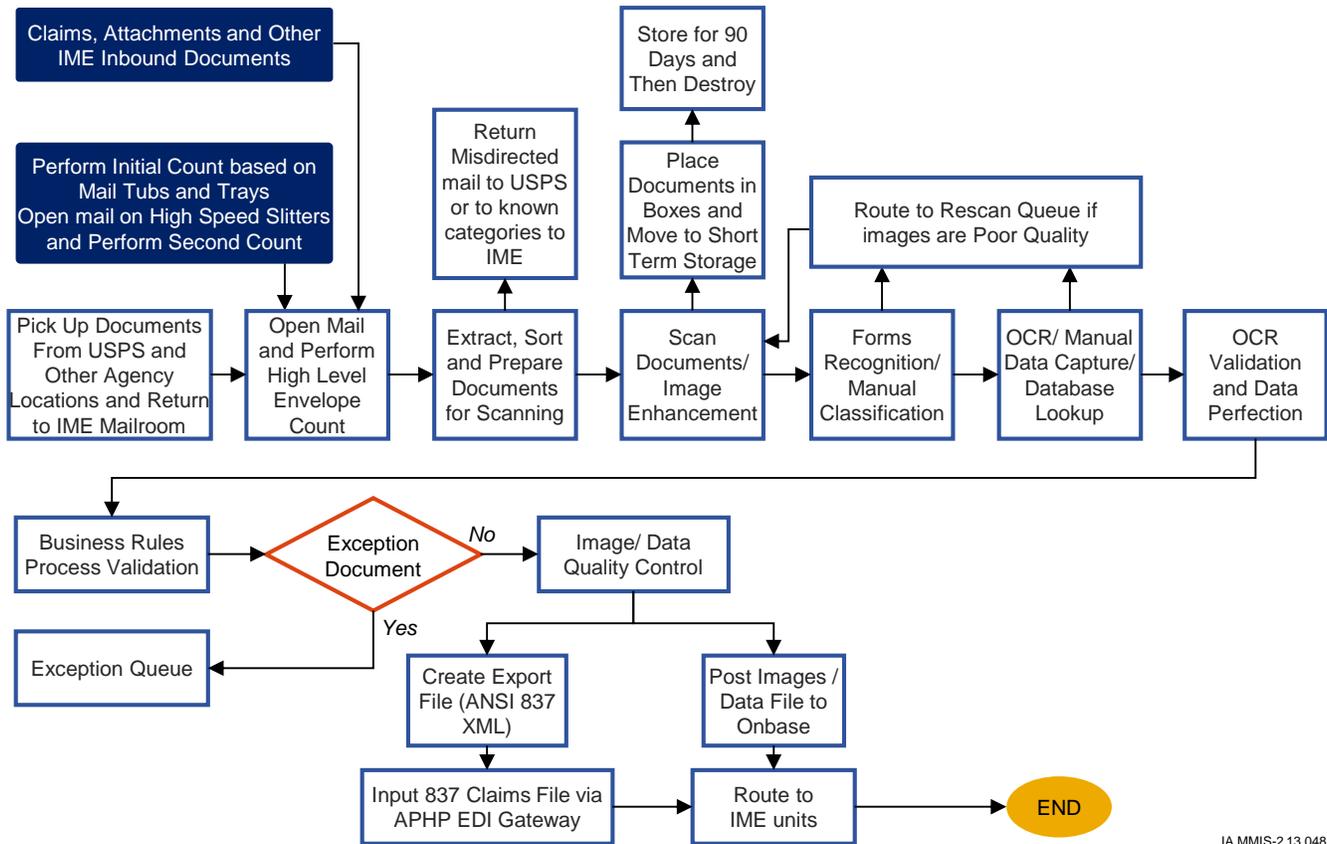
- Document scanning services
- Document indexing services
- Optical Character Recognition (OCR) of claims
- Extraction of claim data
- Automated verification of claim data against look up tables
- User assisted verification of claim data – visual verification and manual data correction
- Delivery of documents and metadata to OnBase for storage in the repository
- Delivery of claim data to integrated tool to be formed into an Electronic Data Interchange (EDI) 837 file for forwarding into the APHP claims processing engine

The Optical Character Recognition (OCR) capability of Kofax captures data from the standard claim forms, reducing the level of effort required to process paper submissions. The software uses well defined business rules and confidence levels for correct capture of data. Claims that are missing data or are unrecognizable are returned to the provider in the same manner as paper claims. Returns are logged for future reference, pulled from original batch and returned on a daily basis either through hardcopy or electronic image. The provider receives a customized letter explaining the reason for return and includes suggestions for successful resubmission. Once a document is prepared and scanned, it is uploaded into OnBase where the scanned and indexed documents reside for access through the workflow solution. Non claim documents are routed to the correct IME unit for processing, after imaging. Documents then progress through a final verification for required elements and control processes help to verify that all documents received have entered the document management system and are ready to load into the APHP claims processing engine as shown in Figure 4C.4-1.

Documents receive a unique control number immediately upon scanning. The assigned control numbers (Document Control Number or Transaction Control Number) reside with the document and/or claim for the life of the transaction. These numbers are used to maintain control of the transaction and are used to retrieve information and images from entry into the system, through final adjudication and when eventually archived. A scanned document is easily accessed by clicking on the specific claim number or via a search engine through the APHP functionality. For example, as a Claims worker is resolving open edits or clearing a suspended claim, if a reference back to the original claim image is required, that worker clicks on a link on the claims portal within APHP which opens (via OnBase) the indexed image. The same strategy will apply to other documents, such as Prior Authorizations or Provider Enrollments, to enable similar efficiency for the responsible IME Professional Services contracts as appropriate.



Mail Room Document Processing



IA MMIS-213 048

Figure 4C.4-1: All documents are scanned, imaged and uploaded to OnBase and APHP.

MRR-3 Att L - 7

We will use the current mailroom facility and mailroom equipment, plans to process daily mailings and outgoing small-volume mailings agreed upon by the Agency. We work closely with the Agency to confirm the scope of small mailings and destination agency or vendor for outbound mail data from APHP for larger/mass mailings. APHP software converts flat files of outbound mail data into print-ready copies for spooling to the designated Agency print shop. Once printed, the mailroom, staffed with resources supplemented by our team, will be responsible for preparing the outbound mailings with envelopes and labels. Once prepared for mailing, the control process will confirm the inventory of outbound mailings and reconcile against the input reports for confirmation that all documents were prepared for outbound mailing.

MRR-4 Att L - 7

APHP offers an integrated software solution that creates print ready versions of documents that are triggered via the correspondence and outbound mailing configuration rules within APHP. This software is configured in the style and format required by the Agency for forms, letters, and other mailings. The print ready versions are generated in the appropriate media and interfaced or distributed to the printer that the Agency selects as directed. We are committed to working closely with the Agency to design and implement the best method for approvals of proofs before final versions are distributed for mass mailings.

MRR-5 (a-e) Att L - 8

Prior to the Operations and Maintenance phase of work, we begin developing operating procedures that document the screening process for each claim type that is accepted at the IME.

Paper documents are date stamped upon receipt in the mailroom. Mail is sorted based on type, such as claim (and by claim type), attachment, enrollment, provider inquiry, etc. Automatic Document Recognition (ADR) is used for sorting incoming documents as applicable. Sort criterion is configurable according to specific





business needs. This tool provides powerful automation for routing documents within the workflow, saving time and human intervention. Documents are then batched and identified through system-generated bar-coded batch header sheets. The batches are entered into our production control system.

Documents within each batch are screened to confirm that critical information is present. If information is omitted or if a claim is submitted on an incorrect claim form, the document goes through the RTP process. When a document is returned, it is first logged for future reference in audit purposes or for responding to provider inquiries. The documents to be returned are pulled from the original batch, sorted by reject reason, and placed in the appropriate bin to be counted, batched and returned on a daily basis. The documents are returned by paper or by electronic means depending on the desired workflow process. When returning to the provider, a customized letter is sent explaining the reason and suggestions for successful resubmission.

Documents which pass the initial screening process are then sent for scanning. The electronic scanning solution, Kofax, helps to verify that quality requirements are met by having quality control analysts verify captured claim images. The documents receive a unique control number immediately upon scanning. The assigned control number resides with the claim for the life of the transaction. This number is used to maintain complete control of the transaction and is used to retrieve information and images from entry into the system, through final adjudication and when eventually archived.

If applicable, the process includes OCR to capture data from the forms, reducing the level of effort required to process paper submissions. Once a document is prepared and scanned, it is uploaded into OnBase. Documents then progress through a final verification for required elements and control processes help to verify that all documents received have entered the document management system and are ready to load into the APHP claims processing engine.

MRR-6 Att L - 8

Claims that are prepped, sorted, screened and scanned are available in APHP, and OnBase, for processing and viewing. Images will be made available immediately to the scanning operators for viewing and processing in our Kofax data entry and imaging tool. Upon completion of the OCR process, as claims are sent to the MMIS for processing, the images are available for viewing and processing by authorized IME staff members.

MRR-7 Att L - 8

Whenever checks come into the mailroom it is the responsibility of the Operations Manager, Mailroom/Claims Lead and Quality Analyst to work in tandem to perform control and audit procedures for checks received at the IME. Adjustments to this approach will be reviewed with IME staff to evolve the procedure to be current with State policies. Indicate amount of checks or cash amount on the envelope

- Verify amounts match
- Both people initial the envelope
- Bundle all checks (including envelopes)
- Transfer the bundled documents to the scanner
- Complete and initial a scan document coversheet
- Scan the checks
- Initial the check log spreadsheet (both parties)
- Verify all pages received an imprinter number
- Initial the Scan Job Coversheet
- Hand the Scan Job Coversheet to the second person
- The second person will initial behind the first person indicating dual custody
- Create and print a check log spreadsheet
- Place checks in lock box.



4C.5 MEMBER MANAGEMENT

2.7.5 Member Management

The Contractor shall perform operational responsibilities for the Member Management function. Member Management functionality supports the ability to capture, manage, and maintain demographic and eligibility information for the Agency's prospective or enrolled clients and support the eligibility and enrollment business processes for the IME through an interface with the ELIAS eligibility system. The Member Management function supports other MMIS functions such as claims processing, reporting, managed care and TPL. Member Management also supports business processes involved in communications between the Agency and the prospective or enrolled clients. Member Management operational responsibilities are included in Attachment L – Operational Requirements Matrix.

The IME wants to transition the Iowa member experience from transactional to participative and engaged. We do this by providing a citizen-focused portal with robust functionality designed in a manner sensitive to the needs of the member. One of the hallmarks of APHP is the capacity to easily and seamlessly capture and display available services for virtually limitless combinations of benefit plan and date segments.

APHP's member management focuses on receipt and validation of an individual's eligibility information through an interface with the ELIAS eligibility system, tracking that a member is successfully enrolled and receiving services for which they are eligible until such time that disenrollment is determined and executed successfully. It is our vision that the effective use of business processes in member management services improves overall health care outcomes for Iowa citizens and assists the Agency to attain higher levels of member satisfaction.

Our proposed team brings knowledge of IME member management business processes and current data interfaces through knowledge gained while developing Member Management Requirements Specification Documents for the MIDAS project and knowledgeable of ELIAS eligibility interface specifications.

Member Record Functionality

The member management component of the Accenture Public Health Platform (APHP) provides a configurable and flexible platform aligned with industry standards to receive, store, maintain and exchange member demographic and eligibility information. APHP maintains data for members eligible for Medicaid on behalf of the IME and makes this information available to both internal and external users/systems in support of: claims and encounter processing, reporting, surveillance and utilization reviews, TPL and eligibility verifications.

A key feature of APHP Member Management is our ability to carry and display member enrollment and eligibility information at both the individual and family levels. APHP supports storing multiple addresses for each member, including the ability to designate an address specifically for correspondence. Additionally, APHP stores and displays other state program participation on the MMIS member record. These capabilities further enhance the "member-centric" approach that is priority one within the IME.

Our Processes and Controls

The Agency wants a solution that allows members, providers, and authorized users' access to real-time eligibility information. The APHP solution does this by receiving and preserving current and historical record of the member eligibility including basic demographic data, historical eligibility segments, and identifiers on restricted data, program eligibility, Medicare coverage, and TPL data.

APHP accepts the X12 834 transaction data from ELIAS through the EDI component of the APHP product. Our EDI solution to validate incoming data against industry mandates, including HIPAA. We work with the Agency to configure these front-end edits to validate incoming member information based on Agency rules. This includes screening for required data and verifying field format and content.

Our solution provides immediate feedback to the originating source that includes reconciliation to help verify proper totaling and support error correction and synchronization, eliminating the need for manual



IME Capabilities are Significantly Enhanced Through Automated Member Functionality and Real-Time Data Accessibility

- Secure member portal for members to view and understand benefit plans
- Self service portal increases participation and communication between member and IME
- MMIS Interoperability allows immediate access to member information across the IME multi-contractor environment

IA MMIS-2 4C5-01



Want to see more? MEMBER MANAGEMENT Screenshots

available in the Technical Specifications Supporting Information folder of the electronic submittal.



reconciliation. If the system encounters an error during receipt and processing of member data, APHP generates an administrative alert and immediately rolls back the erred transaction and logs the details of the error. Integrated workflow within APHP routes errors to appropriate staff for review and resolution based on configuration rules that are maintained by authorized business users.

Audit Trail and Tracking Functionality

Our member management processes include automated quality checks and proactive monitoring to verify initial and continued maintenance of accurate member data for the Agency, members, providers and Agency Trading Partners. APHP monitors and tracks data updates completed through data interfaces or the APHP Portal. The APHP databases capture the identity and date/time stamp of the originating source whenever data updates are made. APHP enables audit trail capabilities that capture each version of reference data and each MMIS transaction.

Response to Attachment L Requirements

For each Attachment L requirement narrative response we provide a cross reference of the **requirement number and the page** of the matrix provided in Tab 4G: Worksheets for Submission.

Att. L Req. Tab 4G -
MMR-1 Att L - 8

APHP provides a flexible data exchange platform to support Agency transfer of member eligibility data to the MMIS, including from ELIAS, managed care organizations and ISIS. APHP accepts member data via Electronic Data Interchange (EDI) through the HIPAA compliant X12 834 transaction or through file interfaces on a schedule defined with the Agency during the ADC phase. The operational process to perform member eligibility updates is automated via APHP configuration for the IME. The EDI and interface solution validates data transferred per Agency policy and updates demographic and eligibility data in the MMIS member registry.

Our proposed solution includes proven monitoring tools to verify that MIDAS receives and updates member data timely. APHP provides the Agency with automated tracking of EDI X12 834 transactions through the EDI Solution that includes transaction management which monitors processing time against SLAs, creates balancing reports and generates alerts for transaction processing exceptions. Our EDI Help Desk monitors EDI transactions and creates a ticket as per our service management tools and procedures.

MMR-2 Att L - 8

We understand that maintaining secure and accurate member data is critical to the success of the IME program. Our proposed solution includes both system and operational quality assurance processes to maintain member data quality and integrity. Our solution validates that data sent to the MMIS in real-time or in batch meets defined data standards and passes configured data validations. This is completed by automatically performing checks against member data to prevent errors, such as duplicate member records. Our solution logs errors, generates appropriate response files back to the sender and uses workflow to route these errors automatically to the appropriate worker to allow for timely follow-up and resolution.

Member data reconciliation with ELIAS is one of the specific quality processes supported by our proposed solution for MIDAS. This process is run monthly or more frequently as defined by the Agency during the ACD phase or as agreed upon during the ongoing operations change management process.

In the member reconciliation process, APHP accepts a file from the eligibility system containing data records for each Medicaid member and processes this file in batch, comparing data within the MMIS Member Registry against the ELIAS member records. If the automated process identifies any discrepancies, APHP addresses each discrepancy per the defined business rules. This could include automatically updating the member record to match ELIAS or using automated workflow to generate work items for review and disposition.

MMR-3 Att L - 8

We maintain processes to identify data suitable for archiving as per Agency parameters. This data is transferred to an archive database using a data transfer utility with APHP. Archived data is readily accessible for verification or validation of any backdated detail. The Agency opens a service request to ask for archived data using the agreed upon service request process. Our Operations Team will complete this request by working with the Agency to understand the request details, verifying the requestor's authorization to access desired data and providing the requested data in the agreed format.



MMR-4 Att L - 8

APHP supports and Accenture maintains the interface between MIDAS and the CMS Federal Medicare database to support Medicare in the transfer of dual edibility information for the Iowa member population. Our operational processes consists of two separate file exchanges with CMS, one outbound/request and one inbound/response, which coordinates dual eligibility with CMS systems.

APHP contains automated transactional processes that perform balancing routines to confirm records received are processed and have final disposition within the system. This include records successfully written to the database, routed through our error resolution workflow and resolved, or reported back to the originating source for unresolved errors. Our operations team is prepared to work with the Agency and the IME Member Services Contractor to investigate and provide responses to CMS inquiries related to the Medicare dual eligibility data files. Our team tracks all actions taken and resolution through our service management process.

MMR-5 Att L - 8

APHP retains eligibility history according to data retention policies defined during the ACD phase or as modified during operations through the change management process. The proposed MIDAS solution supports maintenance of eligibility history, including benefit plans, lock-in data, managed care, waiver and long term care programs, for the requested 60 months. The operational process to maintain this history is automated per the rules configured within APHP. Operations team members will monitor the results of the archiving process proactively to validate the necessary history is being archived per IME requirements via system process monitoring procedures.



4C.6 PROVIDER MANAGEMENT

2.7.6 Provider Management

The Contractor shall perform operational requirements for the Provider Management function. Provider Management functionality supports and manages demographics and provider information, enrollment, billing, and reimbursement functions related to the providers participating in the Iowa Medicaid Program. Provider Management operational responsibilities are included in Attachment L – Operational Requirements Matrix.

We understand the importance of communication and collaboration with the contractor that performs provider enrollment processes. As a result of our history supporting Medicaid and commercial health programs, we understand the provider information is fundamental to support claims processing, management reporting, surveillance and utilization review, managed care and other facets of the MMIS operations. We propose a comprehensive solution to provider management that encompasses all aspects of the business processes. The inclusion of the APHP integration capabilities helps to verify that the operational areas always work with the most current and accurate provider data.

We offer the IME an approach that will not only improve the provider management capabilities for claims receipt, management, process and payment but will also enable providers to practice more efficiently and effectively, specifically in line with Iowa Medicaid policy. We propose to bring IME the following benefits in Provider Management:

- Provider access to essential member information including eligibility, TPL and Benefit Plan data through the APHP provider portal which will help to facilitate coordinated care and potentially provide a higher level of cost avoidance than currently exists
- Web access via the APHP provider portal for enrollment, real-time claim submission, attachment document upload and status inquiry which facilitates an efficient business regiment for providers and streamlines internal business operations.
- Communication channels that open up the ability for timely information sharing between providers, members, IMES and the entire Medicaid community

Our Processes and Controls

We understand the importance of capturing and maintaining comprehensive, current, and historical information for the providers that are eligible to participate in the Iowa Medicaid Program. Only healthcare practitioners and healthcare facilities meeting the State eligibility requirements may be enrolled in the Medicaid Program. Each provider record contains current and historical data as related to that provider. The data for both active and terminated providers remains available for use by all applicable areas of operation.

The APHP Provider Management solution is the control point and central source of data for providers, members, state and internal workers, the Provider Services Contractor or any other user authorized to access the information as authorized by the Agency. Our provider module supports the following key components.

Enrollment & Maintenance

Providers can submit enrollment applications directly through the APHP provider portal. The solution comes pre-packaged with individual, group, rendering, and facility application that is tailored during ADC to the Agency’s needs. The application is completed online allows for attachments to be uploaded, applications to be saved, and real-time status for ease of provider use. Our APHP configurable workflow tool includes automated and manual steps to assist the workers in reviewing and processing submitted applications to a final status. Through the worker portal authorized users will be guided through a checklist with access to the application (paper or electronic) to allow validation and credentialing of the provider. Ongoing maintenance is also completed through a work items screen designed specifically for provider maintenance as reflected in Figure 4C.6-1.



IME Gains Efficient, Interactive and Secure Product Capabilities for Provider Data

- Self service portal allows provider to enroll and maintain provider information
- Fully remediated data allows for holistic view of provider information
- Provider activity is tracked as it occurs using workflows and audit trails

IA MMIS-2 4C6-01



Want to see more? PROVIDER MANAGEMENT Screenshots

available in the Technical Specifications Supporting Information folder of the electronic submittal.



Current Application

Application ID: 3000000221
 Name: KEVIN DEAN SPRINGER
 NPI / API: 1912953597
 Status: Waiting for secondary verification

Application Summary

Application Overview

Application Id: 3000000221 | NPI / API: 1912953597 | Provider: KEVIN DEAN SPRINGER
 Application Type: Electronic | Status: Waiting for secondary verification | Date Submitted: 8/6/2013 2:03 PM

Validation Overview

Fields	Status	Validated By	Date Validated	Reason
Addresses				
Legal	Valid	System	08/06/2013 10:54PM	Please verify the main address with the W9
Physical	Valid	System	08/06/2013 10:54PM	Valid
Mail	Valid	System	08/06/2013 10:54PM	Valid
Pay To	Valid	System	08/06/2013 10:54PM	Valid
Anonymous				
Suite/Office Number	Not Checked			
Institution Address	Not Checked			
Previous Employer	Not Checked			
PCCM	Not Checked			
Certificates				
Certificates	Not Checked			
Demographics				
NPI/API	Valid	System	08/06/2013 10:54PM	Valid
Medicare ID	Not Checked			
SSN	Not Checked			
Licenses				
Licenses	Valid	System	08/06/2013 10:54PM	Valid
Taxonomy				
Primary	Not Checked			
Secondary	Not Checked			

IA MMIS-2 13 400

Figure 4C.6-1. Work Items are tailored to easily navigate and validate data. Designed specifically for Medicaid application reviews. <Data contained in this screenshot is fictitious.>

Communication

The provider portal presents a vehicle for notifying providers of upcoming training announcements, field representatives' names and phone numbers, a hot link to the State's website, and the ability to receive correspondence, and other material that would be useful to providers as approved by the State. This includes such items as electronic Remittance Advices and 1099 information.

Provider Look-Up

Our Provider Search / Look-Up feature makes it easy for a member to locate their preferred provider. As part of the enrollment process, APHP geocodes each provider's physical address at which services are performed, enabling the online provider look-up functionality to map the provider to a specific location. This enhanced feature allows the member that is searching for the provider to obtain the most accurate directions to the provider's location. This is also allows the provider to easily view their demographic information as reflected in Figure 4C.6-2.

Reporting

APHP is equipped with robust reporting capabilities in support of the provider function. A daily provider file audit report that documents the processing of all update transactions for the previous day is produced and delivered at the direction of the Agency. APHP provides the functionality to produce standard production reports as well as user defined, parameter driven reports of data contained in the provider master file.

APHP provides robust standard reporting capability in the key areas of Medicaid program activity, as illustrated in Figure 4C.6-3. Operational reports related to the day-to-day Provider management activities are easily accessible from a centralized dashboard. Historical and other Provider-related program reports are provided on a State-determined schedule. State-defined timers and triggers to govern and automate reporting production can be incorporated into business rules.





MyDashboard | Check My Claims | Find a Provider | Check My Eligibility | Reference

My Dashboard > Provider Search > Search Results

Provider Map

Adjust Your Search

Modify your search results by adjusting the filters below

Location

Within 25 miles of: 4714 Burrell Drive, Des Moines, IA 50301

Provider Information

Gender: Female(2)

Provider Search Results

Your search for General Practitioners within 25 miles of Des Moines returned 3 results.

Displaying 1 - 3 of 3 Records

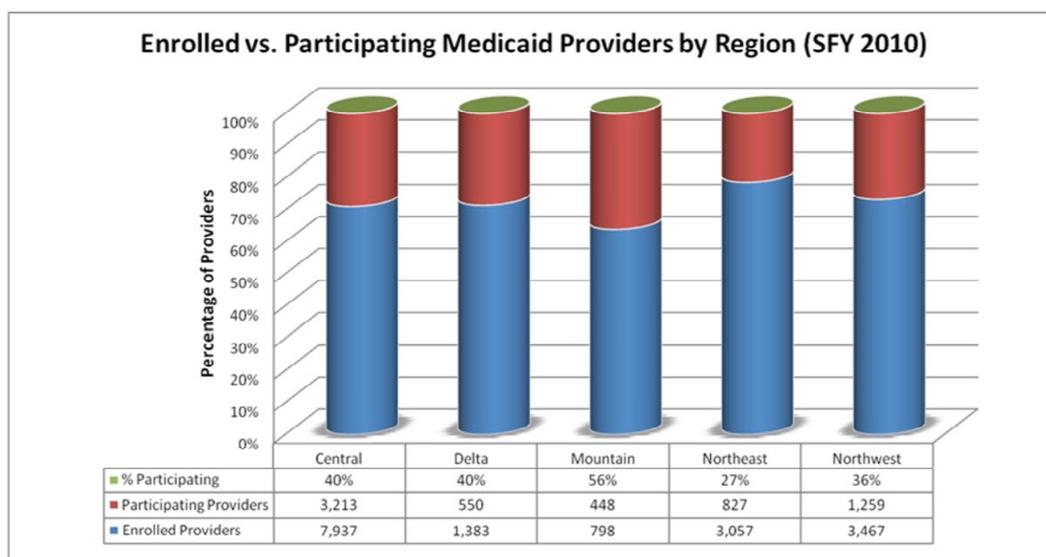
Select up to Four Providers to compare

name	Specialties	Sub-specialty	Dist.	Location	Gender	Languages
<input type="checkbox"/> Dozier, Chris	Family Practice		2.2 mi	Dozier Family Clinic 4940 Hazelwood Ave, Des Moines, IA 50301 Hours: Mon: 8:00 AM-5:00 PM	Male	English, Spanish
<input type="checkbox"/> PATEL, Dagmar	Independent Medical Examiner, Family Practice		8.2 mi	First Stop Immediate Care Clinic 908 Dupont Rd, Des Moines, IA 50301 Hours: Mon: 8:00 AM-5:00 PM	Female	English, Tamil
<input type="checkbox"/> McLean, Christy	Registered Nurse, Family Practice		11.2 mi	McLean Medical Clinic 2932 Breckenridge Ln Ste 1, Des Moines, IA 50301 Hours: Mon: 8:00 AM-5:00 PM	Female	English

IA MMIS-213 402

Figure 4C.6-2: Provider Look-Up is designed for easy searching and viewing of provider information. <Data contained in this screenshot is fictitious.>

Enrolled vs Participating Provider by Region As Of: 3/24/2013 3:15:43 AM



IA MMIS-213 403

Figure 4C.6-3: Dashboard designed to easily view and monitor different aspects of the provider data.



Response to Attachment L Requirements

For each Attachment L requirement narrative response we provide a cross reference of the requirement number and the page of the matrix provided in Tab 4G: Worksheets for Submission.

Att. L Req. Tab 4G - PMR-1 Att L - 8

APHP’s provider management component maintains key demographic data on providers such as provider first and last name, business or corporate name, “Doing Business As” names, and addresses. In addition to demographic data, the provider record contains data necessary to adjudicate claims such as taxonomy (provider type, specialty and subspecialty), group affiliations, rates, and other information. The accuracy of provider data is critical in support of claims processing, management reporting, surveillance and utilization review, managed care and other operations within the Medicaid program.

PMR-2 Att L - 8

APHP’s Provider Management Att solution provides to IME automated workflows and real-time access to information.

Enrollment - APHP provides an easy to use self-service portal that simplifies the enrollment process who desire to enroll in the Medicaid program. The enrollment applications are automated and use standard interfaces for receipt of the application and produce result messages (“approved, denied, need more info”) as the application is moved through the workflow. Status and updates for the application are tracked, reported, and displayed through the audit trail.

Data Management / Maintenance - Updates to provider records, whether initiated through the APHP Portal or through data exchanges and interfaces, are available and accessible through user interfaces. APHP delivers a single, compiled source of provider data that is controlled and verified to support accurate, up-to-date processing, accessible to authorized users via a secure, Web-based portal.

PMR-3 Att L - 9

Our solution is designed upon the MITA 3.0 FM15 Manage 1099 benefit plan that allows for a generation of the 1099 data regardless of how many benefit plans or programs in which the provider participates by creating one base record (NPI/API +Tax ID). The provider’s earnings with the payments at a practice location level allow the easy consolidation of payment information to that provider to produce accurate 1099 information. APHP stores financial data and has the systematic capability to track, consolidate and report this information prior to the 1099 processes executing within the system.

PMR-4 Att L - 9

We understand the inner complexity of the IME structure and acknowledges the critical nature of maintaining accurate provider data for the Agency and other IME contractors. As we understand the importance of access to pharmacy services to Medicaid members, we work closely with the POS vendor to provide accurate and complete provider data through a standard interface. APHP supports multiple provider identifiers within the provider record. DEA number along with NPI, UPIN, TIN, SSN, legacy ID, and others, are maintained as part of the provider’s source record. Per State-defined configurable business rules, DEA numbers are required for Pharmacy Providers and optional for other provider types. APHP identifies providers that are include pharmacy-specific indicators for different specialties such as chains and compounding pharmacies.

PMR-5 Att L - 9

APHP supports provider management functions including the following:

Provider Enrollment – Through the worker portal the work item functionality provides multiple automated and manual steps to assist APHP workers in reviewing and processing submitted provider applications to a final status. The process of enrolling providers is managed by business process checklists that define required procedures, documents and verification steps that are configured for different provider types or benefit programs.

Provider Reenrollment - We understand the complexities involved in the provider enrollment process. We appreciate that reenrollment periods are critical and that gaps or issues in the process could cause a disconnect that reduces provider counts, potentially reducing access to Medicaid members. Through our provider portal, APHP brings an automated and online functionality to support seamless provider reenrollment activities that are vital to retaining participating providers in the Medicaid Program.



EFT Enrollment – As part of the provider enrollment process, providers indicate their preferred method of payment, including Electronic Funds Transfer (EFT). The APHP provider database facilitates electronic payments to Medicaid payees by maintaining indicators and the bank account and routing information necessary for payment by EFT.

EDI Enrollment and Testing - APHP has the ability to configure interfaces with external entities including providers and billing agents to support the submission of electronic claims. Once providers are ready to convert to electronic submission, we provide assistance needed in determining the best method of submission, enrollment in EDI, testing, claims submission and troubleshooting of technical issues.

Remittance Advices – APHP can create, issue, or reproduce Remittance Advices (RAs) through the user-friendly APHP Portal, in hardcopy, or in standardize electronic format, in a non-technical language. These RAs are available for providers to download should they choose to do so.

Managed Care Reporting - Using APHP reporting capability, the Agency will be able to get a comprehensive view of the Managed Care program and will be able to make changes to the program as necessary to improve access to care.

PMR-6 Att L - 9

The Service Oriented Architecture (SOA) model of APHP includes an Enterprise Service Bus (ESB) architecture that creates the ability for secure data exchange between the MIDAS MMIS and trading partners, state agencies, or other Agency designated outside entities, including the Health Information Network for the state of Iowa.



4C.7 MEDICALLY NEEDED PROGRAM

2.7.7 Medically Needed Program

The Contractor shall perform operational requirements for the Medically Needed Program. The medically needed function consists of processing claims for members eligible for the medically needed program, tracking medical expenses to be applied to the spend-down and providing reports of spend-down activity.

Medically Needed Program operational responsibilities are included in Attachment L – Operational Requirements Matrix.

APHP supports various levels of member fiduciary responsibility across co-pays, coinsurance, and spend-down for the medically needed. Spend down and other member liabilities are captured and assessed when considering cost of care to the member prior to claim adjudication and payment of Medicaid funds.

Our Processes and Controls

As part of the member eligibility load processes, we accept spenddown amounts from the State eligibility data. Spenddown amounts are carried at the individual member record within APHP. Claims and other allowable spenddown expenses are systematically applied towards the member’s financial responsibility amount. Once the spenddown requirement is met, an automated workflow informs the State eligibility system of updated eligibility information and fund code information indicating that the member is Medicaid eligible.

APHP provides the business operation with flexibility in the administration of the medically needed program. Specifically, the benefit plan construct allows us to define covered services and services that are not typically covered by Medicaid but should be applied towards the member’s spenddown amount. The accumulation frequency also provides greater flexibility in administering spenddown policy. Based on policy, spenddown accumulation may be defined as weekly, monthly, quarterly or other defined period. Additionally, the accumulation may be limited to the member or extended to include the family. This inherent flexibility supports the existing spenddown program and provides the necessary financial structure to support the emerging healthcare plans.

Authorized APHP workers may use the APHP worker portal to enter appropriate expenditures, including non-medical or non-covered expenditures, to be applied to the member's spenddown amount. APHP uses a unique claim form with specialized procedure codes to capture this data, and stores them in the APHP claims history databases. Editing rules identify the member as part of the medically needed program, determine if the claims are appropriate for spenddown based on the Agency's policy, and invoke the appropriate spenddown logic.

APHP allows receipts or other documentation to be imaged and linked to these claims, which provides additional documentation and justification for the application of the expense to the member's spenddown amount. Claims for medical expenditures are received from providers and the Agency's Income Maintenance (IM) workers on the member's behalf. Medical claims are applied to the spenddown amount and denied for payment if the member's spenddown amount has not been met. Guidelines agreed upon with the Agency are used to help verify that the correct order of deduction is applied to the claims used by the accumulator when manual intervention is required. These processes control the payout of Medicaid funds by helping to verify that any spenddown is appropriately applied prior to any Medicaid payment. Once the member's spenddown has been met, medical claims are adjudicated against the member's benefit plan for payment (if a covered service). The APHP applies appropriate expenditures to the spenddown amount before claims are processed and paid by Medicaid.

Real time status of the current spenddown amounts per member is available to both Agency and contractor staff. Information is made available to applicable members via the APHP portal if desired by the Agency. Providers are able to submit inquiries regarding member spenddown requirements through the provider self-service portal, and members, using the APHP member portal, are able to view all associated medically needed data, including certification periods and claims used to meet spenddown.



Automated Processes Deliver Benefits in an Accurate and Timely Manner

- APHP uses commercial preferred practices using a coinsurance and/or deductible logic to support spenddown management for the medically needed
- APHP has systematic tracking of certification periods and spenddown requirements
- Providers, members, staff and contractors have immediate access to medically needed data including certification periods, spenddown requirements and accumulations

IA MMIS-2 4C7-01



Response to Attachment L Requirements

For each Attachment L requirement narrative response we provide a cross reference of the **requirement number and the page** of the matrix provided in Tab 4G: Worksheets for Submission.

Att. L Req.	Tab 4G Page
<i>MNR-1</i>	Att L - 8

Upon receipt of notification from the State's eligibility system, the member is associated with a medically needy benefit plan that identifies the certification period and the spenddown amount that must be met by the member. Within the benefit plan for that member, we define an accumulator that is used during claims adjudication to track and apply verified expenditures to the spenddown requirement for their defined certification period, systematically deducting the appropriate amounts until the member has no further liability. Once the member's spenddown requirement is met, the eligibility system is updated and the member is Medicaid eligible.



4C.8 CLAIMS ENTRY AND RECEIPT

2.7.8 Claims Entry and Receipt

The Contractor shall perform operational requirements for Claims Receipt and Entry. Claims receipt and entry supports the IME claims receipting, entry, and reporting processes. This includes maintaining electronic images, receipt of all media types, and the interaction with the Electronic Data Interchange (EDI) for provider enrollment and claim transactions, and communication to providers regarding claims entry and receipt transactions. Claims Entry and Receipt operational responsibilities are included in Attachment L – Operational Requirements Matrix.

Document receipt and entry into the system is the important first step in a well-controlled claims processing operation. APHP provides multiple channels of claims receipt, including paper submissions, direct entry into the APHP portal or secure Electronic Data Interchange (EDI) transmissions. Hardcopy documents received are processed so as to maintain integrity in the document's chain of custody from the time of receipt to the point of scheduled document destruction. Direct entry of data is immediately validated, checking for incomplete data and required information. EDI transmissions submitted through the APHP platform also have automated checks and controls for validity and required information. Regardless of the method of submission, each transaction goes through the same basic processes and rigorous controls prior to processing and adjudication. Edits and audits are applied to all claims regardless of claim media through configurable rules and business policies captured within APHP. Our solution maintains complete traceability of all claims from receipt to final disposition enabling the Providers, Agency staff, and supporting Contractors of the IME to access historical and real time data on claim status and disposition via the APHP user interface.



Controls Tailored to Meet the Needs of the IOWA Medicaid Enterprise

- Multiple channels of claims receipt with automated controls to maintain accuracy of data received.
- Controls to apply edits and audits consistently regardless of claim media.
- Complete end-to-end traceability from claims receipt to final disposition regardless of claim media.

IA MMIS-2 4C8-01



**Want to see more?
CLAIMS MANAGEMENT
Screenshots**

available in the *Technical Specifications Supporting Information folder* of the electronic submittal.

Our Processes and Controls

The claims entry and control function of the MMIS accepts claims and other transactions via paper and electronic media. Paper documentation may be received via mail or courier service and is securely scanned and processed through the IME mail room.

Paper Claims and Attachments

Documents received are prepared for processing by mailroom staff. Mail is sorted based on type, such as claim, correspondence, checks or misrouted mail items. Sort criterion is determined by specific business needs agreed upon with the Agency. Documents are then batched and identified through system-generated bar-coded batch header sheets. The batches are scanned into our production control system. Mailroom staff is trained to recognize and reject claims billed on incorrect forms or on copies of original forms (paper claims). If a claim fits conditions to go through the RTP process, these transactions are controlled by them being logged, pulled and returned with a letter of explanation on a daily basis in the format desired by the provider.

Claims and claim attachments that are prepped for scanning are fed into the scanning equipment and then imaged via APHP's Kofax solution. This scanning tool helps verify that quality requirements are met by having quality control analysts verify captured claim images. The documents receive a unique control number immediately upon scanning. The assigned control number resides with the document for the life of the image and is linked to the APHP claim number for audit purposes. The claim number is used to maintain control of the transaction and is used to retrieve information and images from entry into the system, through final adjudication and when eventually archived.

After scanning and imaging is complete, Optical Character Recognition (OCR) software captures data from the claim form, reducing the level of effort required to process paper submissions. The software uses well defined business rules and confidence levels for correct capture of data. If there are certain fields that are not recognized through the OCR process, they fall for manual review and correction. After this process is complete, the imaged claim and claim attachments are uploaded into OnBase, and in parallel, the actual claim data is





converted into a standard 837 file format and sent to APHP for adjudication. The claim and claim attachment images can be retrieved from OnBase by clicking an electronic hyper link in the claim using the APHP portal.

Please reference Section 4C.4 Mail and Courier Service for a more detailed explanation of mailroom processes regarding the receipt of paper claims.

EDI and Portal Submissions

Electronic claims are submitted via EDI (EDI 837) or by using the APHP self-service portal. EDI allows for receipt of claims in batches from a provider, clearinghouses, or other authorized provider representatives.

Using an electronic method of submission, providers receive a real time response providing them with a submission confirmation allowing tracking of the claims. Providers have the ability to submit attachments, scans, and other documentation in support of the claim via EDI or as an upload in the APHP portal.

Claims that are unable to be submitted electronically or translated via OCR may also be entered into APHP via Direct Data Entry (DDE). The entry window is intuitive and user friendly, presenting a format very similar to standard paper forms as shown in Figure 4C.8-1. Authorized users key claims directly into the portal for processing. Regardless of method of entry, all claims go through certain standard checks for the validity of the entered data prior to being adjudicated for payment or denial.

An extensive system based reference library of standard edits in APHP, used in conjunction with Agency specific business rules, control the accuracy of this data entry process. If automated editing processes do not make the required data entry correction, the claim suspends for authorized users to address the remaining issues. An integrated and highly configurable workflow tool within APHP routes the claim to the appropriate staff and corrections are made. Operational processes also look for patterns of problems so that staff can proactively suggest edit and audit updates appropriately.

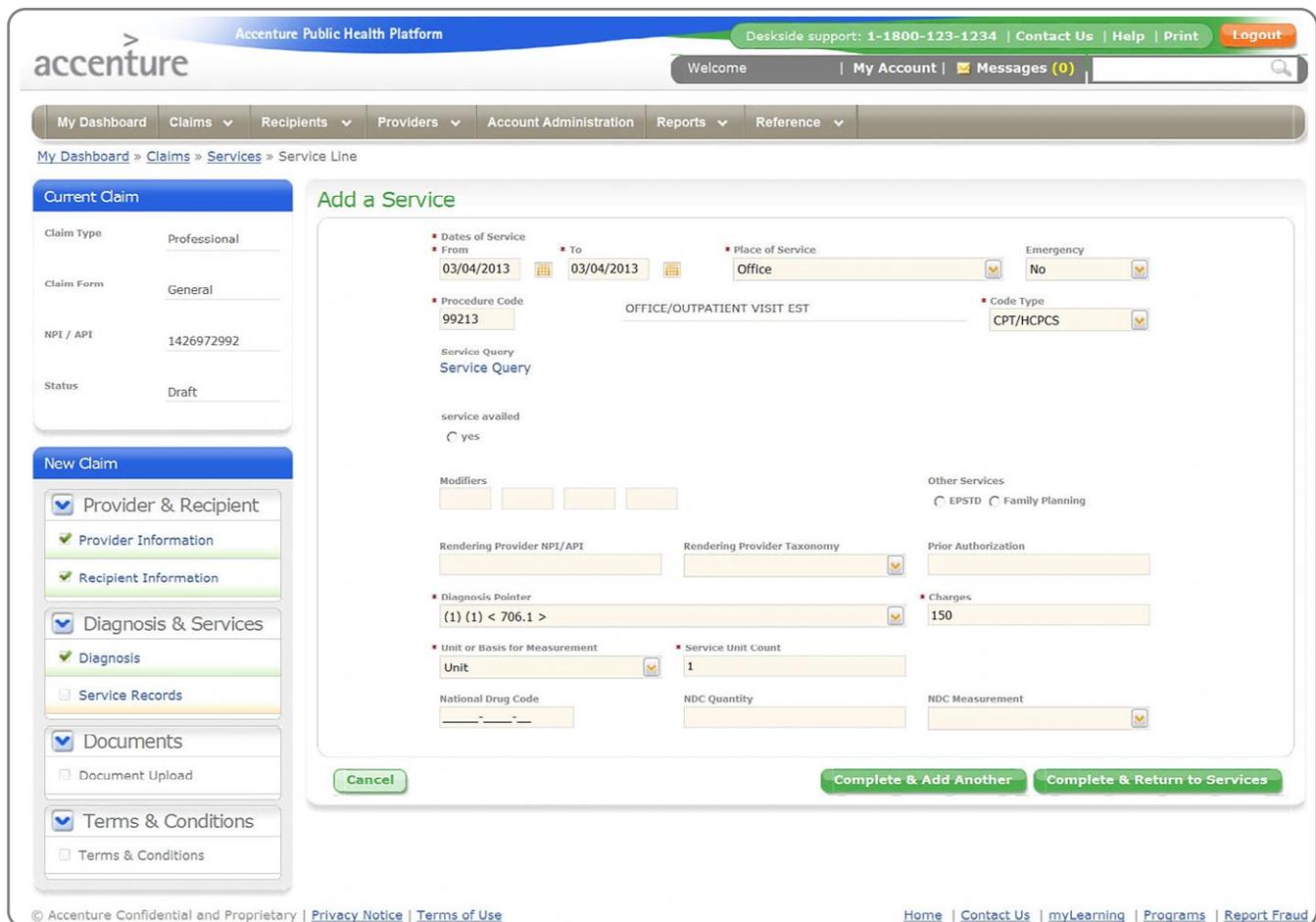


Figure 4C.8-1. User friendly interface makes claims entry easy for the provider.



Response to Attachment L Requirements

For each Attachment L requirement narrative response we provide a cross reference of the requirement number and the page of the matrix provided in Tab 4G: Worksheets for Submission.

Att. L Req.	Tab 4G Page	
<u>CER-1</u>	Att L - 9	We accept all form of claims for processing by APHP including hard copy, EDI and direct data entry through our APHP portal. Paper claims are screened, sorted, batched, scanned and imaged before entering the system for adjudication. The data capture process creates an EDI 837 transaction or CML file that is ingested into the claims system for additional processing upon completion of rules verification. EDI transmissions are received from approved providers or trading partners, verified, and then batched for periodic release into the system for processing.

<u>CER-2</u>	Att L - 9	Our team supports the HIPAA X12 5010 transaction set and will work to obtain written agreements from new providers wishing to submit claims via electronic media using the HIPAA-approved industry standard transaction. We perform HIPAA validation against the transaction to validate compliance with the mandated CMS code sets in place at the time of processing.
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New providers wishing to come on board with electronic submissions sign written trading partner agreements which are entered into APHP and are retrievable at any time by authorized users.

<u>CER-3</u>	Att L - 9	APHP receives electronic claims transactions through the integrated EDI component or by using the APHP self-service portal. The claims receive a unique control number upon entry into the system. The assigned control number resides with the claim, for life, and is linked to the system claim number for audit purposes. The claim number is used to maintain complete control of the transaction from entry into the system, through final adjudication and when eventually archived. Control is established through automated processes within APHP. Claim transactions are monitored through a series of operational dashboards and historical reports.
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Operational dashboards allow authorized users access to transaction statistics in near, real time providing a window into the operation. Accessibility of the information via the portal enables timely dissemination of information and consistency in data presented. Operational dashboards are supported by system generated historical reports. APHP provides the ability to tailor reports to present specific views of historical data required for trending and control.

<u>CER-4;</u> <u>CER-5 (a-e)</u>	Att L - 9	Paper documentation is received in the IME mailroom and scanned a processed according to the established procedures for each document type. All documents received are sorted based on type, prepped by removing anything that interferes with scanning processes, batched and identified through system-generated bar-coded batch header sheets. The batches are entered into our production control system.
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Once claims and claim attachments are logged by the mailroom and scanned for completeness, the documents are staged for the imaging and data capture process of explanation on a daily basis in the format desired by the provider.

Claims and claim attachments that are prepped for scanning are fed into the scanning equipment and then imaged via Kofax. This scanning tool helps to verify that quality requirements are met by having quality control analysts verify captured claim images. The documents receive a unique control number (Document Control Number or Transaction Control Number) immediately upon scanning. The assigned control number resides with the document for the life of the image and is linked to the APHP claim number for audit purposes. The claim number is used to maintain complete control of the transaction and is used to retrieve information and images from entry into the system, through final adjudication and when eventually archived.

After scanning and imaging is complete, OCR software captures data from the claim form, reducing the level of effort required to process paper submissions. If there are certain fields that are not recognized through the OCR process, they fall for manual review and correction. Specific fields go through a "data perfection" process to validate the indexed claim data prior to release and creation of the claim record in the APHP system.

After this process is complete, the imaged claim and claim attachments are uploaded onto OnBase, and in parallel, the actual claim data is converted into a standard 837 file format and sent to APHP for adjudication. The claim and claim attachment images can be retrieved from OnBase by clicking an electronic hyper link in the claim using the APHP portal.



Please reference Section 4C.4 Mail and Courier Service for a more detailed explanation of mailroom processes regarding the imaging of paper claims.

CER-6 Att L - 9

During training, our mailroom and claims teams are trained on key control points that might be on the critical path of the end to end claims process. We understand that the Agency has specific criteria required that define a complete claim. Claims that do not meet these minimum criteria are subject to the Return to Provider (RTP) process.

As claims are received, they are reviewed for required elements prior to entry into the document management system. These claims must include, at a minimum:

- A member identification number
- A provider identification number
- Valid provider or representative signature
- Valid procedure code
- Valid diagnosis code
- Other elements as determined by the Agency

If required information is omitted or if a claim is billed on an incorrect claim form, the document is RTP. Returns are logged, pulled and returned with a letter of explanation on a daily basis in the format desired by the provider. These RTP scenarios are controlled through a system based logging process that creates audit history of the image control number that correlates to the letter that is sent to the provider. This control is critical such that if a provider calls into inquire about claim status, the provider help desk provides the appropriate level of details and the disposition of the claim (in this case a letter being mailed out to indicate missing information on a specific date. This control also helps with trending analysis for targeting specific provider types or a group of providers that may require additional training or coaching for claims submission.

CER-7 Att L - 9

As part of our mailroom processes, all paper claims are screened to help verify that they are properly submitted on the correct claim form and that it is an original. Staff members are trained to recognize and reject paper claims billed on incorrect forms or on copies of original forms. If a paper claim fits conditions to go through the RTP process, these transactions are controlled by being returned with a letter of explanation on a daily basis in the format desired by the provider. Quality assurance processes identify trends for these types of coachable errors and we will collaborate with the Provider Services contractor to identify opportunities for additional provider outreach or training.

CER-8 Att L - 9

We log all paper claims returned to the provider to verify initial receipt. We apply a controlled process to the return of documentation to providers when necessary. When a document is returned, it is first logged for future reference, and for audit purposes, or for responding to provider inquiries. The documents are returned by paper or by electronic means depending on the desired workflow process. When returning to the provider, a customized letter is sent explaining the reason for return and suggestions for successful resubmission. Our mailroom operation works with the Provider Contractor and the applicable Help Desks to communicate returned claim patterns, to help avoid future RTP situations.

CER-9 Att L - 9

Claims are input into APHP through Direct Data Entry (DDE) in batches or as individual claims. Authorized users' key claims data directly into the system for processing. Field level validations are immediately applied to check, at minimum, provider identification numbers, member identification numbers, procedure codes and diagnosis codes. Front end data entry software interfaces with the APHP solution to allow external authorized users to input claim data as well.

CER-10 Att L - 10

Regardless of entry, all claims go through certain standard checks for the validity of the entered data. Internal procedures agreed upon with the Agency help verify that data is entered into the system in a timely manner and quality controls capture and correct data entry errors.

Claims correction functions within APHP include the correction of data entry errors. An extensive library of standard edits in APHP used in conjunction with the agreed upon Agency specific business rules control the accuracy of the data entry process. Examples of some standard system checks are shown in Table 4C.8-1.



Table 4C.8-1. Several standard system checks help to verify that data entered is free from errors.

Standard System Check	
✓	Verification of fields designated as critical by the Agency
✓	Verification of the member identification number
✓	Verification of the provider NPI
✓	Data validation for valid field amounts such as numeric fields contain only numeric characters and date
✓	Field relationship edits, including span dates of service edited against units of service, span dates of service edited to periods more than one month long or dates more than one year old, and edits that check valid modifiers for specific procedure codes
✓	Other relationship edits, including procedure code or diagnosis codes to sex or age criteria and procedure to provide type
✓	Logic checks applied to necessary imbedded codes and check digits
✓	Reference table edits used to incorporate provider, eligibility, local procedure, diagnosis or other local use codes for data validation and field population from database information

The business operation Quality lead is responsible for developing quality plans that support a proactive strategy of issue prevention. We use sampling to review manual data entry performed by each of the claims data entry staff. We analyze issues to identify trends and conduct training to prevent errors from reoccurring. Claim transactions adjudicate against automated business rules. Claims that fail the automated process are routed via defined workflows for manual intervention by authorized users. Approved standard operating processes also instruct the operations staff to look for patterns of recurring issues so staff can proactively suggest edit and audit updates accordingly. Please reference Section 4C.2 Internal Quality Assurance for a more detailed explanation of our approach to quality procedures.

CER-11 (a-f) Att L - 10 A PHP transactions generate an audit trail which shows every action that has been systematically or manually applied during any stage of the claims processing cycle, including any adjustments and financial transactions. The audit trail gives specifics on when the action occurred, what user performed the action, and other necessary information for researching transaction history. A PHP enables authorized users to create user-defined reports on specific claims types, processing location, age, or other attributes for use in data analysis. This user based query supports the configured audit and control reports that are native to the A PHP solution. A PHP also produces input control listings reflecting claim status and includes such items as unprocessed claim and claims in suspense. Operator statistics, including volume and speed is available through Kofax.

CER-12 Att L - 10 Paper documents such as claims, attachments, adjustment requests, correspondence or other documents received into the mailroom are scanned and imaged using Kofax, then uploaded to OnBase for electronic storage and retrieval. Electronic images are accessible by authorized users via the portal. Original paper documents are stored in the secure mailroom archive room until the quality of the image has been verified and for no less than 90 days from the original transaction control number date. Logs of original claim batches will be used as control points to validate the original documents are kept for the minimum duration.

CER-13 Att L - 10 Authorized users may access images stored in OnBase at their convenience. A PHP functionality also supports the ability to print electronic copies of documents for distribution. Paper documents are stored in the secure mailroom archive room, until such time that they can be shredded, for retrieval by IME team members. OnBase has an e-form that users can submit to request the paper documents, the documents are then delivered by the courier to the requesting unit.

CER-14 Att L - 10 Paper claims that are submitted by providers to our mailroom go through the mailroom process and the subsequent optical character recognition (OCR) process. Once the OCR process is complete for each claim, the OCR solution routes claims that do not meet data entry translation thresholds for manual review. This review is carried out through an online correction process to modify specific fields that do not meet minimum configured requirements to pass the OCR process. For claims that are not able to be carried out through the OCR process and require full manual data entry via a Direct Data



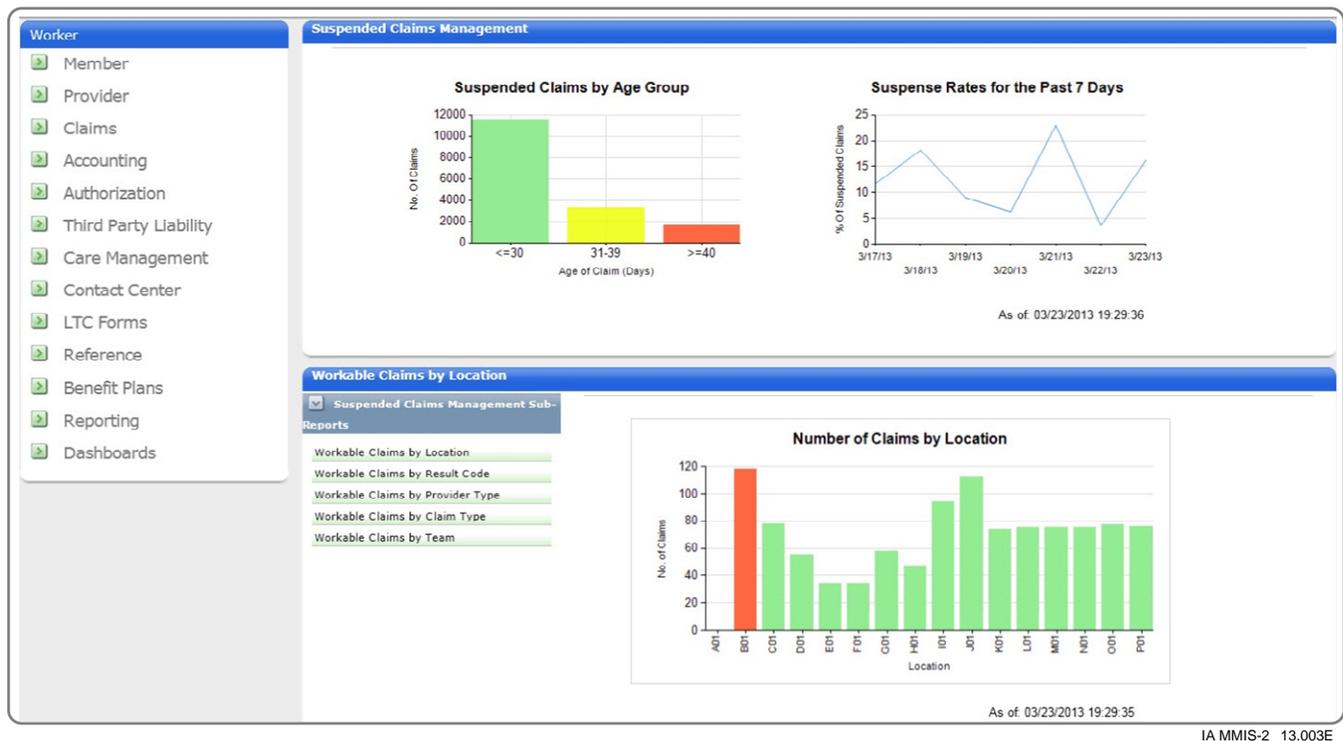
Entry (DDE) process, front end validation is carried out on fields that have required formats and field lengths. If a claim from either process is suspended during the subsequent adjudication process for edits related to initial data entry or translation, our claims staff is trained to manually update the applicable fields through an online user interface to modify the necessary data to clear the claims suspense.

CER-15 Att L - 10

Quality procedures help verify that images are legible prior to entry to the APHP claims processing engine. Visual checks for proper alignment and contrast settings as well as servicing and cleaning scanner equipment are steps that are taken to help verify image quality. A complete quality control plan will be submitted to the Agency for review and approval. Please reference Section 4C.2 Internal Quality Assurance for a more detailed explanation of our approach to quality control.

CER-16 Att L - 10

We provide the Agency with claim inventory reports that document the number of claims in each of the claims suspense area each day. With the integrated reporting solution in APHP, we quickly and easily generate claims processing reporting information. APHP provides real time information on claims processing status including suspense location, backlog volume, and other key performance metrics as shown in Figure 4C.8-2. Dashboard reports are available online based on user's role-based security. The accessibility and flexibility of APHP reports provide the Agency operational transparency and improved control of program funds.



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Figure 4C.8-2. APHP Operational Dashboards give an instant overview to inventory counts and locations of suspended claims.

CER-17 Att L - 10

Accenture will collaborate with the Provider Services Contractor in marketing of the EDI concept to providers and will work to obtain written agreements from new providers wishing to submit claims via electronic media and confirm existing EDI agreements remain in effect. We will work closely with the Provider Services contractor to help verify that the provider community is well aware of the benefits and importance of EDI. We will identify opportunities to educate providers on the EDI concept and work with the Provider Services contractor to provide communication and training. APHP has the ability to provide data for analysis on paper claim submissions which identifies volumes and trends for targeted marketing campaigns and communication to the appropriate providers.



New providers wishing to come on board with electronic submissions sign written agreements which are entered into APHP and are retrievable at any time by authorized users. Agreements from existing providers transition to the APHP system and are retrievable in the same manner.

CER-18 Att L - 10

Our processing cycles provide automated and manual controls to balance incoming transactions as they pass through APHP. The EDI component of APHP uses control totals to confirm that transactions sent to the system are received and that an appropriate response is sent back to the provider or clearinghouse.

When EDI claims are received, they are “batched” for periodic release into the system. As electronic claims are transmitted to the APHP claims processing engine, the system keeps track of each batch. Once inside the claims processing engine, batch control processes take over to provide balancing and control reports. Balance and out-of-balance reports are used to confirm that batches are entering the system correctly. APHP provides the ability to further define control reporting.

CER-19 Att L - 10

The EDI solution verifies that the provider number on the claim is valid and the APHP claims processing engine edits against provider eligibility. If a claim is submitted via EDI using an invalid provider number, the transaction will be rejected. If a provider was not eligible on the date of service, reimbursement is typically denied based on configuration of the agreed upon adjudication rules in the APHP platform. EDI claims that meet the required provider criteria such as claim type and format for the submitting provider are accepted into the APHP platform for processing and disposition.

CER-20 Att L - 10

When a claim is submitted through electronic media, the provider receives feedback providing the status of the claim and information to track the claim. If the transmission is accepted, a notification is sent back to the submitter indicating acceptance. If the submission is rejected, the submitter is notified as to the reason for rejection with instructions to correct and resubmit. In either case, audit trails are kept of what was accepted and what was returned.

CER-21 Att L - 10

Our team uses the services of Edifecs for assistance in readiness testing starting six months before we go live. This allows all current submitters to test prior to coming to our EDI solution. We engage these services for a full year, and six months after we go live, we will bring the initial testing with new EDI trading partners in house. This gives our operational team the opportunity to work with new submitters individually to address their testing needs.

The APHP portal supports the testing of provider claims submission systems by allowing providers to submit electronic claims test files into an environment that processes the claims through the adjudication cycle without impact to production environment data. We assist in sending test files, fixing errors in electronic claim files, and working towards achieving approval for the submission of electronic transactions. Transmission assistance is provided to providers, billing agents, clearinghouses and software vendors. During ACD we are available to field questions to identify and troubleshoot technical problems that arise in readiness testing. We allow only those providers passing testing standards to submit EDI claims. By implementing these testing procedures, we verify that only clean and valid data is submitted into the production environment. During run operations, we have a dedicated EDI help desk to take questions from provider or other trading partners wishing to setup and test an EDI submission protocol with or APHP system. This help desk will be available to providers during the hours of 8am to 5pm Central Time.

CER-22 Att L - 11

We understand the importance of being available to assist providers in support of EDI transactions. We provide trained staff for an EDI Helpdesk call center in exclusive support of Iowa Medicaid trading partners during convenient business hours. Our team is available from 8:00am to 5:00pm Central Time to field questions to identify and troubleshoot technical problems experienced by providers, billing agents, clearinghouses and vendors, including issues with file submission, report receipts, password resets and log-in issues. We use the existing Interactive Voice Response (IVR) and call center technology to configure a specific 800 number dedicated to receiving calls from these groups related to EDI transactions. We have an escalation process for help desk issues to help verify that all calls are resolved appropriately and in a timely manner. Additionally, we have the ability to transfer misrouted calls to the correct contractor staff as necessary to promote swift issue resolution.



CER-23 Att L - 11

EDI help desk staff is trained in identifying when additional assistance is required for providers. We have the ability to track calls received and identify trends in call types to help develop targeted communications to specific provider groups. This helps to resolve or prevent issues through proactive call campaigns or live training as necessary in tandem with the Provider Services contractor. Should the assistance available over the phone prove insufficient to resolve the problem, we work closely with the Provider Services contractor to help verify that providers are given the requested assistance. We supply the Provider Services contractor with educational materials to assist in site visits as determined on a case-by-case basis as well as follow up with providers to confirm that their issues have been resolved.

CER-24 (a-g) Att L - 11

A dedicated EDI helpdesk is available to all trading partners who require assistance in submitting transactions to the APHP solution. We acknowledge that the assistance required includes but is not limited to the following:

- Assist providers in determining the best method of electronic transaction submission.
- Enroll providers for electronic transaction submission.
- Provide transmission assistance to billing agents, clearinghouses and software vendors.
- Test submission software with the Agency trading partners.
- Identify and troubleshoot technical problems related to EDI transactions.
- Provide confirmation of electronic transaction submission.
- Provide assistance to support direct data entry of claims and other transactions through the web portal.

We understand the importance of reducing paper submissions to reduce overall cost and improve overall quality. We will work closely with the Provider Services contractor to help verify that the provider community is well aware of the benefits and importance of EDI. Through analysis of volumes and trends in paper claims submission, we help the Provider Services contractor develop targeted marketing campaigns and communication to the appropriate providers. We provide the necessary support to help drive up the electronic submission rate. Once providers are ready to convert to electronic submission, we provide all assistance needed in determining the best method of submission, enrollment in EDI, testing, claims submission and troubleshooting of technical issues.



4C.9 CLAIMS ADJUDICATION

2.7.9 Claims Adjudication

The Contractor shall perform operational requirements for Claims Adjudication. The Claims Adjudication function supports the processing, payment and reporting of Medicaid claims for the IME. Claims Adjudication operational responsibilities are included in Attachment L – Operational Requirements Matrix.

Our Team understands that the critical function of an MMIS is to process and pay claims accurately and in a timely manner. Successfully performing this critical function helps the IME meet the needs of both the providers and members as service demands increase and budgets decrease. To support our innovative technology solution, we also provide a staff of resources that have extensive knowledge in claims processing, specifically in the administration of Medicaid benefits and reimbursement. The flexibility of APHP, and the resources to support it, lends itself to the progressive environment of IME. As such, our technology and resources are structured to be flexible to meet changing Federal and State mandates and requirements.

We bring established delivery methods and technical experience to implement APHP which aligns with MITA principles to give Iowa the ability to progress upwards within the Medicaid Information Technology Architecture (MITA) maturity model. The use of technologies such as Service Oriented Architecture (SOA) and the automation of business processes using integrated workflows and rules engines transform service delivery for the IME and remain responsive to the demands of government and legislative oversight well into the future.

APHP also integrates with external systems to achieve cost-saving service delivery and respond to changing requirements. We integrate with other IME contractors such as Member Services, Provider Services and Revenue Collections, and essentially plug into the current footprint of IME operations. The flexibility provided by APHP accelerates integration of policy changes that results in lower costs to maintain and higher performance overall. APHP provides the capability for expansion which takes the IME well into the future. Future Iowa systems, solutions, contractors, and Medicaid programs are able to interoperate using the APHP framework as the MMIS.

The claims processing engine is designed for high volume transaction processing, with a focus on systematic processing. Claims and transactions entered into the MMIS from the claims entry screen will include claims that are recycled after correction, claims that are released to editing after a certain number of cycles based on defined edit criteria, online entry of claim corrections to the fields in error, online forcing or overriding of certain edits on provider, member and reference data related to the suspended claims. APHP automates claims adjudication, expedites implementation of new benefit plans, maximizes processing accuracy, and simplifies changes to existing policies and business rules.

Our Processes and Controls

APHP provides to the Agency accurate and timely adjudication of claims. We accomplish this through our APHP COTS claims processing engine, Quantum Choice, which includes pre-packaged adjudication rules for federally mandated and optional benefits. Agency-specific business rules are configured, not coded, shortening implementation time, allowing the Agency to introduce change more quickly. The combined out-of-the-box rules capability in both the claims processing and business rules and workflow engines allow configurability of adjudication rules, process flows and work queue management as one seamless process.

APHP supports real-time claims processing and adjudication for individual claims submitted via the portal, shown in Figure 4C.9-1, from both providers and internal workers. APHP also supports batch claim processing from provider uploads via the portal and from clearinghouse/billing agent file submissions



APHP Meets IME Needs for a Configurable, Flexible, and Efficient Claims Processing System

- Configurable edits, audits and business rules to maximize automation of claims processing
- Systematic communication without manual intervention
- Accommodate all media types, giving providers options for claims submission
- APHP provides end-to-end configurable claims processing and integrates adjudication rules, process flows and work queue management to maximize flexibility

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Want to see more?
CLAIMS MANAGEMENT
Screenshots

available in the *Technical Specifications Supporting Information* folder of the electronic submittal.



The screenshot displays the 'Current Claim' and 'Service Line 1' sections. The 'Current Claim' section includes fields for Claim Type (Professional), Claim Form, Claim Number (20131000P000001), Billing (1598768640), Referring Facility, Member ID (59000181N), Status (Approved), DOS From, DOS To (10/8/2013), Clean Date, Total (250), and # Service Lines (1). The 'Service Line 1' section shows a 'Summary' tab with sub-tabs for Diagnosis Pointers, Supporting Service Information, COB Results, and Adjudication Information. Below this is a table of 'Result Codes' with columns for Result Code & Description, Status, Override Status, and Do Not Clear. The table lists three items: QC1524 - Service capitated (Approve), QC1013 - Using payment contract timely filing setting (Approve), and COR0005 - Current correspondence cycle not found (Deny). Below the table is an 'Adjudication Details' section with a table of items, values, override values, reasons, and dates. The table lists items such as Individual Eligibility ID (MMCBING00101), Benefit Network Level (In Network), Provider Network ID (Humana MCO Providers), Vendor ID (FHC), Covered Benefit ID (Mandatory LTC Medicaid Services), Payment Contract ID (Humana MCO Capitated Services), Fee Schedule ID (Humana Capitated Services), FFS Equivalent Fee Schedule ID (APHP Facility FFS Physician Services), and Primary Care Physician ID (1629296538). Red callouts highlight specific features: 'Links are embedded to allow easy access to information' points to the Member ID field; 'Easy to view each rule claim set on' points to the 'Result Code & Description' column; 'Each detail will provide benefit plan, fee schedule, member information' points to the 'Adjudication Details' table.

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Figure 4C.9-1: Worker Portal is designed to easily view and adjudicate claims.

We understand successful management of claims adjudication requires collaboration between IME and our team. We identify Agency specific requirements and implement rules with the goal to maximize the automation of claims processing by harnessing the processing capabilities of APHP. Our analysts work diligently with IME to help guide through the initial configuration setup for the most efficient processing methods.

APHP is designed to make edit resolution easier for processing personnel. Staff is trained to take advantage of the features available within the solution to perform the required resolution. Provider, member and reference data are readily available for consideration while resolving suspended edits. In addition, we plan to rebadge the current vendors Claim adjudication and adjustment teams during Takeover and then carry those resources through transition to APHP

The editing process allows authorized users to override or deny service, an action that permits a transaction to continue on immediately in the adjudication process without the need for waiting for nightly batch runs. Updates to reference data such as codes are easily achieved through APHP with minimal impact and fast implementation. Edits are date sensitive, enabling dual processing based on date of service or discharge.

Claims control is established through balancing processes within APHP. Our processing cycles are supported by both automated and manual controls to balance incoming transactions as they pass through APHP. As an example, the EDI component of APHP has processes to confirm that transactions sent to the system are received and that an appropriate response (HIPAA compliant message) is sent back to the provider or clearinghouse/billing agent.

Once claims are received and batched, reports are created to quickly address out-of-balance situations to help verify that batches are released into daily adjudication. Hard copy claims are batched and tracked through the scanning process. Electronic claims submissions are manually and systematically monitored on a daily basis to determine if an error has occurred. Daily reconciliation reports are run to see that batch transactions are processed and response is delivered. As hard copy and electronic claims are transmitted to the APHP claims processing engine, the system keeps track of each batch. Once inside the claims processing engine, batch control processes take over to provide balancing and control reports. Balance and out-of-balance reports are used to confirm that batches are entering the system correctly.

Response to Attachment L Requirements

For each Attachment L requirement narrative response we provide a cross reference of the requirement number and the page of the matrix provided in Tab 4G: Worksheets for Submission.



Att. L Req. Tab 4G Page CAR-1 Att L - 11

APHP is capable of adjudicating claims against standard and global edits, as well as user defined edits. User defined edits give the flexibility to apply business defined criteria restrictions or plan accumulators to specific benefit plans, providers or members. Using targeted criteria expedites adjudication and emphasizes automation over manual resolution.

Editing is applied to claims throughout the adjudication process. Edits are used to help verify the integrity of claims submitted and to reduce the potential for erroneous payment. Edits involve the satisfaction of claim data against predetermined criteria. Areas that are subject to editing include but are not limited to data validation, member data, provider data, reference data, pricing, prior authorizations, utilization and duplicate claim processing. Audits validate claim data against other claims in history. Audit validations include checking for duplicate services, checking for exceeded service limits, or checking for exceeded "once in a lifetime" service limits, just to name a few examples.

Claim transactions that fail configured edits may suspend for manual resolution as defined by business rules. Claims are routed to internal or external reviewers based on the established workflow for the associated edit. Locations or work queues are assigned based on the complexity of the edit, the time involved to resolve, or the type of review needed. Staff is assigned specific queues to address suspended claims for resolution and some claims may require multi step manual resolution by specialized or lead claim resources. Resolution may result in manual denial, overriding of the edit or audit to allow for payment, or the application of manual pricing. Data from manually resolved transactions is stored for further analysis. This analysis provides insight into the impact of existing edit processing and guidance for new edits or rules that may reduce the number of claims suspended for manual review.

APHP applies claims pricing systematically and supports the business needs of the IME through configuration of benefit plans and various payment methodologies. Configurable fee schedules use criteria and plan accumulators to edit claims and verify that payment is calculated accurately.

A claim is considered to be finalized after all edits and audits have been resolved and pricing has been applied. The transaction is given a paid or denied status and all finalized transactions are reported to the provider on the remittance advice.

CAR-2 Att L - 11

Claims that enter APHP for processing are assigned a disposition of paid, denied or suspended. Some suspended claims are sent to the appropriate staff for resolution.

This resolution can be either a correction to the error, an override of the edit "forcing" the claim to pay, or coverage denial. Once resolved, these claims are released back into the system for further processing. The online, real-time adjudication inherent to APHP allows the user to resolve all edits presenting on a transaction in a single session thereby reducing the total processing time leading to final payment.

In addition to resolved claims, others types of suspended claims, such as those for member eligibility, are recycled back into the adjudication process based on Agency defined criteria.

CAR-3 Att L - 11

The APHP Framework consists of a core claims COTS product which natively delivers comprehensive claims payment processing services. Upon completion of the claims payment process, which is automated via the APHP automated workflow and process engine, a claims payment file is created for payment issuance. APHP's core claims product supports claims payment processing for providers and other entities who choose to receive payments via Electronic Funds Transfer (EFT). Our open architecture and systems interoperability allow authorized data exchange between APHP and State approved entities, allowing us to transmit financial data electronically from the MMIS directly to the Agency or the entity responsible for producing EFT.

CAR-4 Att L - 12

APHP maintains control over all transactions during their entire processing cycle. We monitor, track and maintain positive control over the location of claims, adjustments and financial transactions from receipt to final disposition. All transactions are assigned a unique control number immediately upon entering the system. This assigned number resides with the transaction from the time of initial receipt all the way through final disposition, payment and archiving. The control number is used to track a transaction at any point in the claims adjudication process in order to maintain complete control. When a claim is submitted through electronic means, the provider is presented the control number as part of the submission confirmation. The control number allows the provider to monitor and track the claim through the self-service portal at any time. Depending on the users' role, the transaction inquiry displays the current suspense location as well as a history of locations through which the transaction has passed.



If a hardcopy document submission is required, the provider prints a barcode cover sheet to include with the document. The barcode links the hardcopy document with the electronic claim submitted and eliminates the need for manual association of related claim items.

CAR-5 Att L - 12

APHP applies audit trails to every transaction in the system. The audit trail captures users and activities, retrievals, queuing, workflow actions and more. APHP is capable of displaying the most recent changes made to a transaction and historical changes in report format. The ability to view before and after data on a transaction provides verification of the integrity of the data. Other reports which show claims processing activities are available for generation at a frequency agreed upon with the Agency.

CAR-6 Att L - 12

Inventory controls are monitored by the assignment of the control, which occurs immediately to a claim or transaction upon entering the system. This unique number tracks the claims and transactions from initial receipt to final disposition, payment and archiving. All transactions that enter the system, including paper claims, electronic claims, adjustments, attachments, and non-claims transaction documents such as applications, consent forms and prior authorization requests show every action that has been systematically or manually applied. The audit trail gives specifics on when the action occurred, what user performed the action, fields changed if applicable, among other information usable when researching the transaction history. APHP's reporting dashboards give authorized users instant access to inventory counts by location as well as information the age of claims within locations, as shown in Figure 4C.9-2.

CAR-7 Att L - 12

We control attachments required for claims adjudication. When a provider sends attachments such as Third Party Liability (TPL) or Medicare Explanation of Benefits notifications, sterilization, abortion or hysterectomy consent forms, or Prior Authorization (PA) treatment plans and emergency room reports, with either an electronically submitted claim via the portal or actually attached to a paper claim, all attached documents are associated to that claim's parent control number so that the attachments are immediately linked and viewable with the claim as associated documents. When the provider submits a claim via the APHP portal, they are given the option to upload attachments through APHP which also associates attachments to the claims control number. Through this option the provider indicates the type of attachment that is being uploaded. Should a provider send related documentation after the initial receipt of a claim, they have the ability to print a bar code cover to affix to the attachment when mailing. This helps verify that the documents are correctly associated with the original claim.

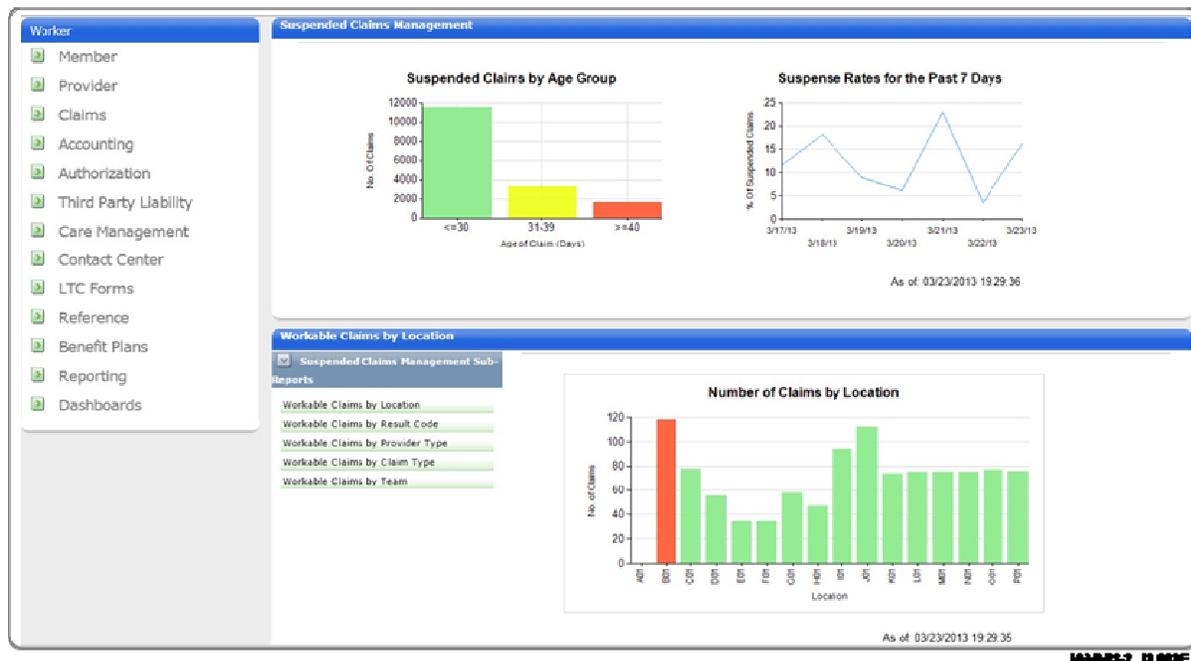


Figure 4C.9-2. Drill down reporting of inventory counts and age of claims are instantly viewable by authorized users in the APHP portal.



CAR-8 Att L - 12

All transactions entering the APHP system are controlled through balancing processes. Batch control processes help verify that claims are tracked through all points, from document preparation to imaging, from imaging to export files, and from export from imaging to import into APHP. Electronic transmissions are balanced by the incoming file header counts against actual transaction counts. The EDI component of APHP is equipped with processes to confirm transactions sent to the system are received and appropriate responses are sent back to the provider. Once in APHP, balancing and control reports are used to confirm that batches are entering the system correctly. We are able to quickly address out-of-balance situations to help verify that batches are appropriately released into daily adjudication. APHP provides the ability to fully customize control reporting. Operational reports are used to track the adjudication process and maintain control over transaction activities. APHP is capable of providing real-time information on claims at any status or in any location such as claims backlog, key entry backlog, pending file status and key performance metrics. Additional controls confirm that received claims are appropriately assigned a final disposition of paid, denied or pending and that the expected numbers of claims submitted into the financial cycle are paid out. The payment cycle produces control totals of claim counts and reimbursement amounts after every processing step, as well as payment registers and summaries. These reports may be used to reconcile the payment cycle to adjudication processing prior to generating payment files, electronic fund transfers, and printing checks.

CAR-9 Att L - 12

All claims that enter APHP are assigned a unique control number used to maintain control over the entire life cycle of the transaction. APHP provides for real-time adjudication and online suspense resolution through final disposition of the claim to the point of payment or denial. When claims are submitted by electronic means, providers are given an immediate response related to the claim status. A history of the claim is accessible through Claims Status Inquiry which shows all of the processing steps that have been applied to the claim. If the claim is suspended for manual review, the dedicated claims staff resolves the claim suspense edits based on approved standard operating procedures and Agency policies to enable the claim to either pay or deny based on configured business rules and policies in the adjudication engine of APHP.

CAR-10 Att L - 12

Claims for services that require prior authorization are edited against the PA file to verify approval and accurately increment/decrement the services used. Claims that fail PA edits can be routed for review to the Medical Services unit or can be denied, based on defined, configurable business rules. Please reference Section 4C.12 for a more detailed explanation of APHP Prior Authorization management.

CAR-11 Att L - 12

Claims are edited against member data, provider data, reference data and relevant fee schedule data. Member data is applied during claims processing to check data that is specific to an individual. A member's specific eligibility defines the period for which a member is eligible for services. A member's enrollment is specific to the types of services that the member is eligible to receive. Claims edit against member data, both eligibility and enrollment, to support the specific policies of the programs in which the member is enrolled. Coverage rules for programs are applied to the detail line of the claim. This allows for submission of services covered under different programs, using different benefit plans, and utilizing different payment methodologies to be submitted on a single claim.

Provider, benefit structure and fee schedule configurations determine the allowable reimbursement for all claims. Once the member is identified as eligible for the date of service and type of services submitted on the claim, the APHP claims processing engine edits against provider eligibility. If a provider was not enrolled or eligible on the date of service, the claim typically denies unless IME policy requires other measures to be taken. Fee schedule data is used to price the claim. APHP defines fee schedules across all providers or specific to individual providers, networks (groups) or benefit plans. APHP supports the concurrent use of services by multiple benefit plans utilizing varying payment methodologies. The flexible pricing structure minimizes the need for state defined modifiers and plan specific billing procedures simplifying claim submission and processing. During adjudication, APHP systematically applies the appropriate fee schedule based on the services rendered and the date of service submitted on the claim.

CAR-12 Att L - 12

APHP supports real-time claims processing and adjudication for individual claims submitted via the portal from both providers and internal workers. Submitters receive a real time response providing them with information allowing tracking of the claims. They also have the ability



to submit attachments, scans, and other documentation in support of the claim through an upload in the APHP portal. The online, real-time adjudication inherent to APHP allows the user to resolve all edits presenting on a transaction in a single session thereby reducing the total processing time leading to final payment.

CAR-13 Att L - 12 APHP provides an immediate status of the transaction. APHP also supports batch claim processing from provider uploads via the portal and from clearinghouse/billing agent file submissions. Claims are assigned a unique control number immediately upon entry to the system. If the claim is submitted through electronic means, the provider or trading partner receives an immediate message providing them with necessary tracking information. This number is used to retrieve information and images from entry into the system, through final adjudication and claims history and archival process.

CAR-14 Att L - 12 Although all edits, audits and warnings within APHP have a unique number assigned to it, there is also an English description associated with each. This English description is provided to users utilizing the system in order to expedite activities such as claims resolution or claims research. This function negates the need to constantly look up the meaning of the codes associated with these functions.

CAR-15 Att L - 12 APHP maintains English descriptions of all business rules residing within the MMIS. Through the worker portal, APHP provides users with the ability to view all applicable business rules such as edits, audits and other rules in a single screen, making it easy to see how the system interpreted policy, for error review and resolution.

CAR-16 Att L - 12 See response to CAR-1.

CAR-17 Att L - 12 APHP has the flexibility and scalability to run payment cycles on demand. Preferably, payment cycles are run weekly per Agency guidelines. Supplemental payment cycles may be run as authorized by the Agency. The payment cycle collects and reports all finalized transactions and generates a file for the interface to the Agency's financial institution. The output of the payment cycle generates remittance advice to providers which report paid, denied or suspended claims as well as adjustment, voids or gross financial transactions. Once the check-write process is completed by the financial institution, the appropriate financial information such as check number, warrant information and check amount are associated to the transactions which are maintained in the claims history database.

CAR-18 Att L - 12 Adjustments can be performed on an individual transaction, such as when a provider corrects a claim, or as a mass adjustment for a selected group of claims, such as when a new or revised policy or rate change needs to be applied. As needed in certain situations, highly trained analysts manually adjudicate these adjustments to help verify proper processing in accordance with Agency policies. Once an adjustment to a previously adjudicated claim is processed, some transactions may result in a net recovery due from the provider or a supplemental payment to the provider. APHP supports multiple configurations to support recovery, cutback and credit balancing as a result of adjustment processing. An adjustment resulting in additional payment to a provider could be configured to issue a supplemental payment during the next payment cycle.

CAR-19 Att L - 12 Capitation scheduling and processing is a key feature of the APHP claims engine component. Non-emergency medical transportation is defined as a benefit plan tied to a specific fee schedule. The configurability of APHP allows a different capitation schedule to be set based on different criteria, so that capitation payments for non-emergency medical transport does not have to adhere to the same schedule as medical claim capitation payments. Encounter data is received, identified and processed in the same way as other transactional based information.

CAR-20 Att L - 12 Provider, benefit structure and fee schedule data determine the allowable reimbursement for all claims. Once the member is identified as eligible for the date of service and type of service submitted on the claim, the APHP claims processing engine edits against provider eligibility. APHP defines fee schedules across all providers or specific to individual providers, networks (groups) or benefit plans. In addition to global fee schedules, APHP also applies data from modifier tables and uses code depreciation functionality to appropriately price services subject to professional or technical component fee reductions or multiple surgery reductions.



CAR-21 Att L - 12

Reimbursement methodology is systematically applied by APHP based on the agreed upon business rules. Rules are configured to suspend claims with special circumstances and an integrated workflow tool routes to work queues when manual review and research is required. When an exception applies, our solution enables staff to execute procedures to override normal processing of special claims. Once adjudicated, the adjudication detail provides the operations staff member with information that is used to identify all of the rules applied during the processing of the claim.

As needed, our operations staff researches and develops additional special payment circumstances and determine the proper payment amounts for these services through controlled documentation and standard operating procedures. Where applicable, configuration changes to support these payment circumstances are performed via front end user screens within APHP. All requests for these scenarios are reviewed by the Agency for feedback and approval.

CAR-22 Att L - 12

We provide the Agency with imaged claims, adjustments, attachments, non-claims transaction documents and electronic transactions as requested, within the guidelines of State-directed data retention policies. The APHP solution provides an on-demand method of retrieval of claims data through via the APHP Worker portal. Immediate availability of claims, member, provider and other key program data gives the Agency and approved IME contractors the ability to efficiently manage the Iowa Medicaid program.

CAR-23 Att L - 13

Claims control is established through balancing processes within APHP. Our processing cycles are supported by both automated and manual controls to balance incoming transactions as they pass through APHP. Once claims are received and batched, reports are created to quickly address out-of-balance situations to help verify that batches are released into daily adjudication. Once inside the claims processing engine, batch control processes take over to provide balancing and control reports. Balance and out-of-balance reports are used to confirm that batches are entering the system correctly. APHP provides the ability to further enhance and tailor to control reporting to meet IME needs.

Every APHP generated transaction is associated with an audit trail, viewable via the worker portal, which shows every action that has been systematically or manually applied. The audit trail provides accountability by presenting details on when the action occurred, what user performed the action, fields changed if applicable, among other information key to researching the transaction history. Edits and audits are configured with an individual disposition status based on business need. The disposition drives the claim to be routed to the appropriate group or work queues via configurable workflow capabilities within APHP. Disposition status is viewable through APHP and is reported on the provider's remittance advice.

CAR-24 Att L - 13

APHP has the ability to recognize Medically Needy members within the member's benefit plan and member record and associate claims that are to be applied to spenddown based on business rules. Claims, or partial claims that are not applied to the Medically Needy spenddown amount are processed as normal for payment to the provider. Medical claims are applied to the spenddown amount and denied for payment if the member's spenddown amount has not been met. Once the member's spenddown has been met, medical claims are adjudicated against the member's benefit plan for payment (if a covered service). APHP applies appropriate expenditures to the spenddown amount before claims are processed and paid by Medicaid.

CAR-25 Att L - 13

Based on defined business rules, APHP has the ability to recognize and process Medicare crossover transactions for Medicaid liability on individuals that are dual eligible. Crossover claims are adjudicated according to Agency standards using defined rules that encompass provider, member, claims type and payment processing.

CAR-26 Att L - 13

We maintain claims history, as well as lifetime procedure information, which is made available to authorized users as needed for inquiries, audit processing, and other required activities. This information is made available to all authorized users through a services call, "Claim Status Inquiry", via the APHP portal. Authorized users of this module can print claims and entire claim records through an easy to navigate user portal. Historical data is also available for access via the APHP portal through an easily retrievable process to review claims older than 60 months. Users access individual claim records as well as use APHP reporting capabilities to run specific user queries to pull historical data sets for analysis and review.



CAR-27 Att L - 13

The complexity of Medicaid includes proper allocation management by funding source to support a structure of multiple programs that require the use of various reimbursement methodologies. Leveraging a commercial COTS claims engine, the ability to facilitate a wide variety of payment methodologies exists natively in APHP. For example, using the fee schedule configuration capabilities, pricing and payment by DRG, RBRVS, REV, APC, % of, and other methodologies are supported. APHP supports multiple pricing methodologies through use of global and assigned fee schedules. Accumulators and other configurable parameters help create a collection of allowable services known as a benefit plan. Benefit plans are configured to apply appropriate payment methodology using specific fee schedules in accordance with the agreed upon Agency policy for each program. APHP's claims processing engine calculates the price for each service based on the appropriate program and benefit plan in which the member is assigned. Prior to pricing, the claim is subjected to audits to enforce service limitations and check that the service has not been paid previously. Final pricing calculations are performed and include cutbacks due to member liability, spenddown and third-party liability.

CAR-28 Att L - 13

APHP supports line item pricing on medical claims, total bill and split bill on Hospital claims and specific pricing by provider and/or facility as necessary. Each service is applied a price during claims adjudication using the assigned fee schedule for the service. Fee schedules are defined using configurable rules and limitations in a variety of ways. Fee schedules may apply across the entire provider population, or may be specific to individual providers or networks (groups), claim type or provider type, as well as benefit plans. Payment is calculated based on the rules as defined for the date of service submitted on the claim, and since members may be assigned to multiple benefit plans which leverage separate fee schedules, it is not uncommon that due to the pricing at the claim line level, multiple fee schedules are applied to a single claim. Using the claim status inquiry feature from the APHP portal allows authorized individuals access to the adjudication details at the claim line by line view. This facilitates the easy audit trail use to clearly identify which fee schedule was used to price each claim. Direct links to the specific fee schedule from the claims detail enhance the research process.

CAR-29 Att L - 13

APHP program, benefit plans, provider and fee schedule configurations determine the allowable reimbursement for submitted claims. Once the member is identified as eligible for the date of service and type of service submitted on the claim, the APHP claims processing engine edits against provider eligibility. If a provider was not eligible on the date of service, reimbursement is denied unless otherwise specified by the Agency. APHP is flexible and highly configurable and supports single, multiple and ranking of fee schedules across all providers or specific to individual providers, networks or benefit plans. The fee schedule appropriate to the date of service submitted on the claim is applied for pricing.

CAR-30 Att L - 13

Our claims processing staff are skilled at analyzing and identifying adjudication rules which may need updating. As situations arise during the resolution of claims, we identify root issues, propose updates to business rule edits, and continuously monitor and audit overall claims processing trends to improve Medicaid Program administration using APHP. We recommend processes that can be automated based on our claims processing experience that allows for quick absorption of our clients policies and programmatic approaches.

CAR-31 Att L - 13

We will work with the Provider Cost Audit and Rate Setting Units as well as the Agency to bring a stable, scalable and flexible application that allows for quick updates to fee schedules that support the use of per diems, DRG rates, APC rates, and other rates and rules.

Reusable components within the application reduce the level of effort, time and associated costs required to configure and implement changes. Updates to fee schedules are performed through a user-friendly interface by authorized users as seen in the sample Professional Fee Schedule shown in Figure 4C.9-3.

CAR-32 Att L - 13

Member liability is applied during claims processing in order to assess a total cost of care to the member prior to any payment of Medicaid funds. APHP leverages robust functionality to accurately manage the deduction of multiple member liabilities on a single claim. Using the same system logic that supports member deductible, coinsurance and co-pay, APHP accurately applies all member liabilities according to the agreed upon Agency guidelines.



Code Type	Starting Procedure	Ending Procedure	Modifier	Payment Method	Payment Value	Effective From	Effective Through
HCPCS	E1296	E1296	NU	Flat Rate	\$595.00	January 1, 2011	
CFT	90460	90460		Flat Rate	\$15.00	January 1, 2011	
CFT	33401	33401		Flat Rate	\$1,500.00	January 1, 2011	
HCPCS	L1830	L1830		Flat Rate	\$98.00	January 1, 2011	
CFT	98940	98940		Flat Rate	\$65.00	January 1, 2011	
CFT	11200	11200		Flat Rate	\$250.00	January 1, 2011	
CFT	50360	50360		Flat Rate	\$100,000.00	June 1, 2010	
CFT	94760	94761		RDAYS without GPCI	\$0.11	June 1, 2010	
CFT	43834	43834		Flat Rate	\$1,010.00	June 1, 2010	
CFT	80076	80076		Flat Rate	\$200.00	June 1, 2010	
CFT	84460	84460		Flat Rate	\$50.00	June 1, 2010	
HCPCS	H0835	H0835		Flat Rate	\$75.00	June 1, 2010	
CFT	54161	54161		Flat Rate	\$125.00	June 1, 2010	
CFT	06201	06201		Flat Rate	\$33.10	June 1, 2010	
CFT	32491	32491		Flat Rate	\$1,063.12	June 1, 2010	
CFT	58000	58000		Flat Rate	\$251.71	June 1, 2010	
CFT	90371	90371		Flat Rate	\$116.40	June 1, 2010	
CFT	90433	90433		Flat Rate	\$21.17	June 1, 2010	
CFT	90445	90445		Flat Rate	\$30.19	June 1, 2010	
CFT	90647	90647		Flat Rate	\$20.17	June 1, 2010	

Figure 4C.9-3. Fee schedules within APHP are easily configured, reducing effort and cost to make changes to existing fee schedules or add new ones.

CAR-33 Att L - 13

APHP captures and stores benefit plan and contract assignment information for each member, and assigns effective start and end dates to each to establish the history of the plan assignment. APHP also allows for grouping of family members by Subscriber. This enables tracking of limitation configurations, such as cost sharing, across family members to verify federal limits are not exceeded. The APHP claims adjudication processes apply benefit limitations as each claim line is processed.

CAR-34 Att L - 13

APHP applies third-party liability information of the member during claims adjudication, thus reducing the liability assessed to Medicaid. Third-party liability details are stored in the Coordination of Benefits (COB) area of the member record. Member data applied during claims processing signals to APHP if there is any third party coverage, thus avoiding Medicaid payment when a third-party payer is liable for the service. APHP carries comprehensive information about the TPL, including but not limited to Plan name, coverage span dates, services covered, member liability, and demographic and contact information for the TPL. Please reference Section 4C.6 Third Party Liability for a more detailed explanation of third-party liability.

CAR-35 Att L - 13

APHP employs editing rules to determine if a claim received on behalf of a member should be applied to their spenddown requirement. Editing suspends the claim for manual resolution when there is a need to adjust the spenddown accumulation based on priority and competing criteria to apply towards the spenddown amount. Adjustments to the spenddown accumulators apply incurred expenses towards spenddown requirements in the appropriate order. See section 4C.7 for our approach to Medically Needy.

CAR-36 Att L - 13

APHP member management supports the assignment of multiple benefit plans based on eligibility rules. A member's specific eligibility defines the period for which a member is eligible for services. Claims edit against all member data, both eligibility and enrollment, to price according to the specific policies of the programs in which the member is enrolled and associated benefit plans are assigned. Coverage and pricing rules for programs are applied to the detail line of the claim. This allows for submission of services covered under different programs and utilizing different payment methodologies to be submitted on a single claim and pay accurately according to the agreed upon Agency guidelines.



CAR-37 Att L - 13

APHP processes against all forms of total liability during claims adjudication in order to assess a cost of care to the member prior to any payment of Medicaid funds. We will accept client participation (CP) amounts from ISIS and will offset claims payments by the CP amounts on the member record.

CAR-38 Att L - 13

Our team brings talented staff to support claims processing and resolution. APHP supports the varying levels of complexity for edit resolution and business processes and determines the appropriate routing of suspended claims. Our claims processing team is led by an Iowa experienced Claims Operation Manager. This person is responsible for managing the claims operations as well as working with other contractors to help support resolution of any issues and communicate to all involved. Team members are authorized to resolve basic data validation edits while some resolutions such as manual or special pricing, medical review or other more complex edits are generally routed to senior staff. Some cases may require routing to Agency or other IME contractors for review according to business needs. We work closely with the Agency and incumbent staff for the continuity of business knowledge. Our staffing preference is to re-hire as many current Incumbent contractor employees as appropriate. We have extensive experience in making available opportunities for incumbent staff. We have extended offers of re-hire to more than 30,000 people from over 130 clients; of these, 98% accepted our offer of employment and more than 95% remain employed with us after two years. In all cases, qualified staff are re-trained and provided the appropriate tools to verify they are performing based on the agreed upon Agency guidelines.

CAR-39 Att L - 13

Edits set up in APHP capture claims requiring special consideration, such as claims from providers designated for prepayment review, across all claims containing procedure or diagnosis codes designated for prepayment review and/or specific provider payment holds. Once the edit is triggered, the claim is suspended for resolution. Automated business processes determine appropriate routing for resolution and forward the claim to appropriate staff, supported by the highly configurable integrated workflow and process engine.

CAR-40 Att L - 14

APHP automatically recycles claims based on defined business rule criteria. Once identified, APHP processes claims transactions after a predetermined number of days based on specific Agency policy which is configured using the integrated workflow and process engine.

CAR-41 Att L - 14

APHP is a web based, real-time claims processing solution for MMIS. Upon failing an edit during the initial claims adjudication process, claims are routed to internal/external reviewers based on the established workflow within APHP for the given edit. Edits/audits are assigned a location or work queue based on complexity, time to resolve or type of review. Our Operational or other IME contractor staff is assigned specific locations for resolution. Transactions that require manual resolution may result in manual denial, manual pricing, or the overriding of an edit/audit to allow for payment. Reviewers have immediate access to resolution manuals and instructions (standard operating procedures), clearly documenting how to proceed with adjudication online, via the same APHP worker portal in which resolution activities take place. Updates to instructions are applied in real time, helping minimize impact to claims adjudication and ensuring that all reviewers are using the most current resolution guidelines agreed upon with the Agency.

CAR-42 Att L - 14

We will work with the Agency to receive approval before establishing any new claim adjudication rules or changing the disposition status of existing claim adjudication rules in the system. Robust reporting capabilities within APHP allow the generation of standard and ad-hoc reports that detail the services that denied and/or the edits used to override payment. This enables our team to work directly with the Agency and other IME contractors to analyze adjudication rules, establish new rules or make minor modifications to current rules. APHP also has the capability to test the impact of new rules or changes to existing rules prior to implementation against a model production environment. The impact analysis helps the Agency decide to approve changes prior to introducing them into the system. APHP supports the Agency's full evaluation of the impact of new policy additions by supporting scenario testing and the resulting impact analysis to the Agency and supporting contractors. Leveraging the speed to value approach of a highly configurable COTS product based MMIS, the amount of time needed to configure a policy change and actually verify its validity to the program is drastically reduced by the APHP solution.



CAR-43 Att L - 14

Standard operating procedures for adjudicating claims and resolving error codes are available for reference via the APHP Worker Portal to the document repository. These documents are accessible by staff online as they complete real-time resolution of suspended claims. As policies and business strategies of the Agency evolve, and as changes are made to the claims processing guidelines, these documents and manuals are maintained and updated to detail the steps used in manually reviewing and resolving each error code.

Updates to edits, audits or other business rules are easily configured in APHP via the Worker Portal in a timely fashion with no hard coding required. Aside from the manual error resolution manuals, our solution includes a configuration manual that maintains all edits and disposition codes that is updated to audit and track changes of modification and changes to dispositions for each configured business rule and edit in the claims module. As needed, updates to the web based resolution manual are communicated across the operations staff via banner messages that display upon user and staff login to APHP.

CAR-44 Att L - 14

APHP applies third-party liability (TPL) information of the member during claims adjudication, which reduces the overall liability assessed to Medicaid. Third-party liability details are stored in the Coordination of Benefits (COB) area of the member record. Member data applied during claims processing signals to APHP if there is any third party coverage, thus avoiding Medicaid payment when a third-party payer is liable for the service. APHP carries comprehensive information about the TPL, including but not limited to Plan name, coverage span dates, services covered, member liability, and demographic and contact information for the TPL. We recognize that the Revenue Collections contractor is responsible for the identification of TPL and we will work with that contractor to coordinate communications to help avoid a Medicaid payment when third party liability exists. Please reference section 4C.6 for a more detailed explanation of Third-Party Liability.

CAR-45 Att L - 14

Accenture is responsible for maintaining the MMIS rules engine. Just as outlined in the CMS "Seven Conditions for Enhanced Funding" documentation that further defines the MITA principles, APHP is designed to leverage rules engines for business rule execution, automation of business processes, triggering of communication and alerts, and overall program administration. Designed using a Services Oriented Architecture (SOA) framework which leverages the power and configurability of the integrated COTS products' native rules engines, APHP does not require the use of an additional single "rules engine." The APHP design for MMIS helps eliminate the extensive labor and time that may be needed to maintain, change or add new rules. Each of the integrated COTS products provide web based configuration pages that are accessible from the APHP worker portal. Using the native configuration tools from each product confirms accurate interpretation of the rules configuration and eliminates any need for rules replication or compiling of rules during claims adjudication and processing. This attribute sets APHP apart from all other MMIS solutions available to IME.

The rules engines integrated within APHP are accessible through a simple web interface in the APHP portal system. This accessibility allows proper maintenance of the rules engines by designated users. Any configurations made to the rules engines are done via the worker portal and do not have to be hard-coded.

CAR-46 Att L - 14

Standard claims processing procedures allow for the overriding of edits and audits based on the agreed upon Agency guidelines. APHP provides for real-time updates to edit and audit rules to help verify that users access the most recent criteria for resolution. The action of overriding an edit/audit creates an entry into the transaction audit trail. The use of override codes is monitored and reports may be used to identify potential abuse. Monitoring of overridden claims helps us identify training needs and to make recommendations of adjustment to processes where needed.

CAR-47 Att L - 14

Edit processes, including CCI editing, are applied to claims upon entry to the APHP system. Edit and audit criteria are easily defined and applied systematically to improve operational efficiency. If a claim fails a system edit, the claim is suspended for resolution. Basic data validation edits are resolved by front-end operational staff while more complex resolutions, such as manual pricing, are generally routed to senior staff. Additions, changes or deletions to edit criteria are updated in real time, via the APHP worker portal, to help verify that users access the most recent criteria for resolution. As an added control to quality, access to current standard operating procedures for the claims staff are made available online as reference documents to assist in processing suspended claims for manual review and pricing.



CAR-48 Att L - 14

Timely filing limitations are easily configured at either a global level or for a specific benefit plan within APHP. Based on the agreed upon business rules, adjudication decisions are made and edits are applied using submitted claims data, submitted attachments and historical claims data. When an exception is made during the processing of a claim for reasons such as third-party filing delays, retroactive member eligibility, or other reasons as agreed upon with the Agency, the failing edit is systematically overridden if data supports the exception. Other exceptions to timely filing requirements are granted after the original claim denial and an adjustment are performed to process the claim for payment.



4C.10 ENCOUNTER MANAGEMENT

2.7.10 Encounter Management

The Contractor shall perform operational requirements for Encounter Management. The Encounter Management function provides for the acceptance and reporting of encounters by IME’s managed care contractors. Encounter Management operational responsibilities are included in Attachment L – Operational Requirements Matrix.

We understand Managed Care is one of the tools Iowa uses to help manage costs and improve the member’s health care outcomes. Our current economic conditions demand organizations fully maximize the quality of care provided for every healthcare dollar spent. The Agency needs the ability to measure outcomes, quality of care and cost impacts compared to fee-for-service programs to determine the effectiveness of each Managed Care program. The APHP solution easily interfaces with encounter data sources and makes the data available for analysis, reporting and exchange with other HMO stakeholders quickly and efficiently.



The Agency Benefits from Comparative Data Analysis across FFS and Managed Care Plan Transactions

- Comparison of encounter payment through shadow pricing
- Reports and dashboards available for view of Managed Care Plan participation
- Creation of Benefit Plans for each Managed Care Plan to monitor member and provider utilization

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Our Processes and Controls

We recognize the need to process encounter files and verify that the data is of the highest quality possible. During the ACD Phase of the contract, we meet with the Agency to identify the specific encounter edits to enforce and their associated error tolerance level. Table 4C.10-1 discusses the four specific criteria of our process edits.

Table 4C.10-1. Quality assurance processes help mitigate risks and promote data quality early in the process and throughout it.

Criterion	Description
Completeness	Each encounter record must contain values in the required fields. Errors are set for missing fields. Optional fields are also evaluated and reported on to provide the Agency with an overall data profile report for each submitted encounters file.
Accuracy	Each field, required or optional, is evaluated for a valid, or legal, value. Errors are set for invalid or illegal values received. Our data profile report for each submission includes counts on the accuracy of the data items submitted.
Consistency	An additional quality check we perform is to compare this month's submission to the previous month's submission or average submission amounts to determine if the variance is outside a specified range. This quality check identifies submissions that do not contain all the expected encounters or contain other volume anomalies, which trigger our team to contact the submitter to verify the counts.
Timeliness	The system's operational processes include monitoring for files submission from the submitting entities. An alert is generated if the expected submitter is late in submitting their file and escalates to the appropriate contact.
Duplicate Checks	Encounters will be processed within the MCO benefit plan. This allows our claims system to process the transactions and perform auditing against the members account including duplicate billing for limitation services (i.e. once in a lifetime benefits).

Improving Encounter Submission

We strive to improve the quality of current encounter submissions by collaborating and working with HMOs, the Iowa Plan contractor, PACE, and transportation brokers by adopting and submitting encounters to the Agency in the industry standard EDI X.12 formats. The adoption of this standard has a number of advantages for all parties including eliminating proprietary file format and reducing overall system maintenance costs.

Response to Attachment L Requirements

For each Attachment L requirement narrative response we provide a cross reference of the requirement number and the page of the matrix provided in Tab 4G: Worksheets for Submission.



Att. L Req. Tab 4G Page
ER-1 Att L - 14

Through the APHP solution the system accepts encounter data received from participating HMO's, Iowa Plan Contractor, PACE, and the transportation broker. Encounter data is processed through the claims engine and aligned with a unique benefit plan that includes business rules to confirm no payments are made for the submitted transactions.

The processing of transactions within a designated benefit plan enables insight into member participation and utilization. The IME can quickly view by the member services reports if there is under or over utilization.

ER-2 Att L - 14

Our automated interface capability processes encounter data received and accumulates the error statistics (both warnings and failures) to determine if the encounter file can continue processing. If the file passes the edits thresholds, we import the data into APHP. Any file that exceeds the Agency's error tolerance rate is rejected back to the submitter. As part of normal processing, we return error details of the encounter file to the submitting entity. Based on the operational procedures established during the Implementation Phase of the MIDAS MMIS project, submitters correct errors and resubmit based on the criteria and timelines established.

ER-3 Att L - 15

The APHP solution categories encounters as a type of claim, therefore we store encounter data in the claims data mart. This approach supports reporting and analysis in the same manner as claims data. The IME will benefit from the ability to perform federal and analytical reporting on encounter data as well as comparative analysis and business rules across programs.

ER-4 Att L - 15

During the Operations Phase, our team monitors inbound and outbound file processes. Included in the operational activities is the requirement to process encounter data files from the HMOs, the Iowa Plan Contractor (currently Magellan Behavioral Health Care), PACE, and the transportation broker. Our automated processes are triggered by the availability of the file on the Secure File Transfer Protocol (SFTP) site. In the first step of processing the solution reviews the file and determines what transactions (i.e. individual records within the file) cannot be processed. The solution continues to process the remaining records and notifies the submitter of the errors (both warnings and failures), this provides a reconciliation of the full set of transactions within the file.

These statistics determine if the encounter file is below the acceptable error tolerance and if it can continue processing. If the file passes the edits thresholds, the data is imported into APHP claims processing systems where the fee-for-service equivalent is determined and add the record to the encounter history. Encounters are then extracted from the claims database and loaded into our dimensional data store (DDS) where authorized Accenture and Agency users can report and query on the approved encounter data.

Any file that exceeds the Agency's error tolerance rate is rejected and sent back to the submitter. As part of normal processing, we return to the submitting entity the error details of the encounter file. Based on the operational procedures established during the Implementation Phase of the MIDAS MMIS project, submitters

ER-5 Att L - 15

Our team understands and shares the Agency's interest in utilization review and quality of care. The proposed solution is designed to provide data that supports analysis for better outcomes. The encounter data is made available in the APHP reporting platform to support the Agency's ability to analyze the performance of the HMOs, the Iowa Plan Contractor (currently Magellan Behavioral Health Care), PACE, and the transportation broker. For example, the Agency may want to analyze the following:

- Calculate the cost of services reported on the encounter claim had they been paid on a fee-for-service basis
- Evaluate the access to care and the quality of care members receive for health and transportation services
- Comply with the IME program requirements and plan performance
- Evaluate capitation rates and risk adjustments
- Create performance benchmarking

The APHP operational data store (ODS) contains submitted encounter data. These reporting capabilities provide the Agency and other approved entities access to encounter data to support the required reporting and analysis capabilities.

ER-6 Att L - 15

The standard interface protocol checks for accuracy of data submitted to MIDAS from managed care entities and the transportation brokers. As reflected in ER-4, the solution implements standard processes around inbound interfaces files to validate data integrity and validity. As part of normal processing, error details of the encounter file are returned to the submitting entity. Based on the operational procedures established during the ACD Phase of the MIDAS Project, submitters correct errors and resubmit based on the criteria and timelines established.



ER-7 Att L - 15

Encounter data files are extracted from the claims processing engine and loaded into the dimensional data store (DDS) where we and Agency users can report and query on the approved encounter and transportation broker data. Microsoft SQL Server Reporting Service (SSRS) is used to generate automated reports and query responses. Using the DDS reporting platform, reports are produced containing information on managed care and transportation broker encounters. SSRS also provides the ability to produce data files for analysis of HMO and transportation broker encounter information or for data exchanges with other Agency stakeholders.

SSRS provides the end user the ability to use "drag and drop" functionality to design reports for analysis of the encounter data. Providing a COTS tool such as SSRS allows users to build additional reports to help answer requests from Agency staff quickly and efficiently from their desk top and further analyze operations management quickly.

APHP also offers the capability to create a data file for an interface partner. Files created from the DDS can use Microsoft's SQL Server Integration Services (SSIS) to create files using the COTS provided scripting capabilities within the tool.

ER-8 Att L - 15

The first validation of each encounter data submission is the attestation provided on the 42 CFR 438.606. We accept and log the HMO, the Iowa Plan, PACE, or transportation broker attestation for each encounter. The 42 CFR 438.606 is required for every encounter data submission because it certifies the content of the encounter data. The certification must attest and be signed by an officer of the HMOs, the Iowa Plan Contractor (currently Magellan Behavioral Health Care), PACE, or the transportation broker. Control of receiving and processing encounter transactions is critical to supporting the Agency's encounter module. We also validate the encounter file satisfies Federal Managed Care regulation 42CFR438.606 and includes an attestation for encounter data submissions. Submitted encounters are processed within five days of receipt.

ER-9 Att L - 15

APHP supports the receipt of encounter data through standard X12 837I, P and D formats. APHP's EDI solution applies configurable edits and validations against the encounter (e.g., MCO, physician, member ID numbers; diagnosis and procedure codes) to verify only valid provider, member and service related information is submitted. During the ACD Phase, our team collaborates with the Agency to identify and document front end HIPAA validation for encounter data, which will be processed against the encounter file to verify and validate the data so the Agency is confident the information is technically correct. Over the course of the IME contract, the Agency may add, change or delete encounter data validation edits to fit the needs of the Agency and the Iowa Medicaid Program. The advantage of the APHP solution is these edits can be configured and modified as business needs evolve.

Once an encounter enters the claims engine, APHP has the capability to only apply select criteria against the encounter allowing it to process similar to a claim, but with encounter specific rules. The received encounter data is stored and the encounter receives shadow pricing which indicates the Medicaid payable amount for the reported service. The business rules for encounters are configurable and can be easily modified as business needs change.

ER-10 Att L - 15

Each HMO, the Iowa Plan Contractor (currently Magellan Behavioral Health Care), PACE, and the transportation broker receives an Encounter Submission Report. The main purpose of generating the Encounter Submission Report is to provide the errors reported from the processed encounter data through the APHP encounter edits for each plan. These reports are made available to the Agency and each plan via APHP or through other forms of electronic delivery for analysis regarding the acceptance rate and quality of submissions.

ER-11, ER-12, ER-13, ER-14 Att L - 15

Our team recognizes the need to work with the supporting HMOs, the Iowa Plan and the transportation broker to maintain and report on the effectiveness of the Iowa Medicaid Program. We create detailed processing reports for each submitter that provides the submitter with edit warnings and failures. The report allows the submitters to see the exact field in error and the associated error code. The submitters use this information to correct and resubmit the data.

Once a file is accepted, the accepted file is imported into the APHP claims processing systems. Encounters are then extracted from the claims processing engine and incorporated into our Dimensional Data Store (DDS) where our staff and the Agency can report and query on the approved encounter data. We will maintain clean



encounter data history for five years from the date of submission. The data is available for access by the Agency or approved users; i.e. auditors, as needed.

During processing, the APHP flags encounter data containing Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screening claims. The encounter data is edited for specific procedure codes that indicate an EPSDT screening was performed. Based on the procedure code on the encounter claim, APHP counts EPSDT screenings and retains for inclusion on the annual CMS-416 report. APHP also includes the EPSDT counts on the HMO Encounter EPSDT Counts Report. The Agency may also elect to use this data to monitor performance of HMOs, the Iowa Plan, and the transportation broker as part of a quality improvement/feedback loop.

ER-15 Att L - 15 Encounter data files that are to be produced on a production schedule to interface with external partners or for loading into the data warehouse, are produced and sent to the appropriate stakeholder through our secure file transfer protocol (FTP) solution. The APHP solution produces and sends encounter data reports to the Agency contractors as requested by the Agency. APHP supports ad-hoc requests for information through our ODS and DDS reporting data stores.

ER-16 Att L - 15 The APHP solution will create T-MSIS files for reporting on a quarterly basis, or as needed, when mandated by CMS. As the T-MSIS requirements evolve and become ratified APHP will support these new standards.

The data source for the T-MSIS reports is the DDS that is part of the APHP reporting solution. As part of the encounter data processing operational procedures, the DDS is updated with the encounter data once the encounter file has passed the appropriate edits. We accept, test and integrate into the quarterly T-MSIS encounter records processed by our claims engine and subsequently loaded into the APHP DDS.

ER-17 Att L - 15 The APHP solution extracts the encounter data from the IME MMIS and sends the encounter information to update the data warehouse for monthly reporting. We collaborate and communicate with the Agency during the Implementation Phase to agree to a format to meet the Agency's needs.

ER-18 Att L - 15 Our solution is standards based upon HIPAA compliant EDI X12 formats. Encounter claims are accepted and processed in standard X12 834 and 270/271 transactions. We can accept and process data in different formats.

ER-19 Att L - 15 Our solution is designed to accept and process encounter data received from the Agency and external entities. Encounter file integration is held to the same controls as any other interface. APHP can be configured to meet the agreed upon specifications to accept and process the encounter files as described in this section of our proposed solution. This includes tracking each file submission and report as requested by the Agency.

Using our experience with systems implementation and application maintenance, we collaborate and openly communicate with the various sources of encounter files and develop a standardized process for encounter submissions that accommodates the receipt of data.



4C.11 REFERENCE MANAGEMENT

2.7.11 Reference Management

The Contractor shall perform operational requirements for Reference Data Management. The Reference Management function provides a consolidated source of information used extensively throughout the MMIS to define applicable code sets, define edits and audits, and define fee schedules and pricing methodologies. Reference Management operational responsibilities are included in Attachment L – Operational Requirements Matrix.

IME wants an extensive, flexible, and expandable Reference Data management capability that provides access to real-time information and fully supports claims processing. The claims engine within the APHP solution organizes reference data and business rules into components. Through this functionality the configuration analyst (BA's) are able to create and manage benefit plans and the necessary data, rate setting, business rules required for health care administration.

Out of the box, APHP is pre-packaged with benefit plan configurations and core reference data that complies with federally mandated standards. Benefit plan configurations are pre-populated with reference data required to correctly administer benefits and make payments to Providers as illustrated in Figure 4C.11-1.

APHP accepts reference data for service, procedure and diagnosis codes and payment methodologies, including Outpatient Prospective Payment System (OPPS), and Diagnosis Related Group (DRG). Reference data is received either regularly scheduled or on-demand, via standard data transmission protocols or flat files. The claims engine supports comprehensive reference data management. Procedure codes (CPT, NDC, HCPCS, UCR, and RUG) diagnosis codes (ICD-9 and ICD-10) and payment method code sets such as DRG, RBRVS, etc. as reflected in Figure 4C.11-2. Modifications to service, diagnosis / procedure codes or payment parameters are made via configuration changes, with no programming required, thus dramatically reducing the time required to implement new processing and payment rules. Our MITA-aligned APHP solution provides a web-based user interface for access to business and performance information. Reference data is available to a user through single-click accessibility from the portal.



The IME Benefits from a Reduction of Manual Effort to Maintain Reference Data

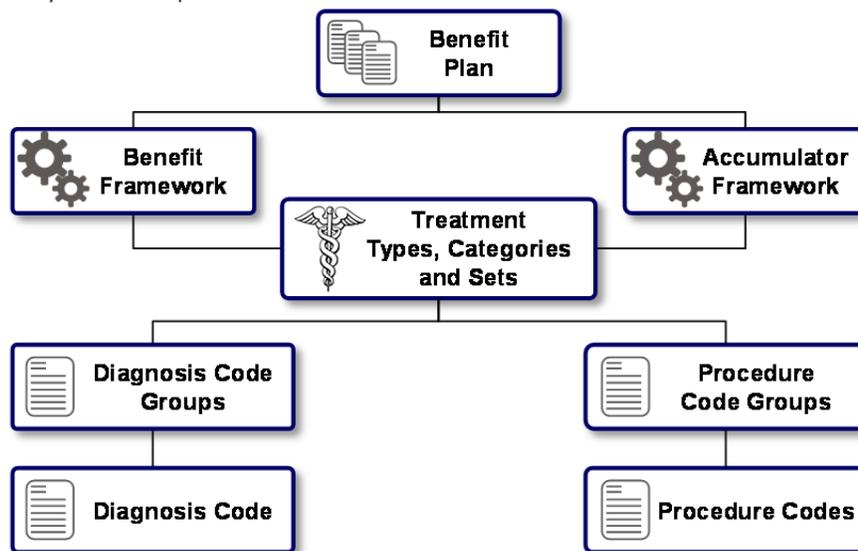
- Innovative system providing flexible data and rule updating capabilities for authorized users
- Codes, rules and plans are grouped into components for ease of use
- Creation and management of Benefit Plans, Fee Schedules and Business Rules will be completed by Business Analysts

IA MMIS-2 4C11-01



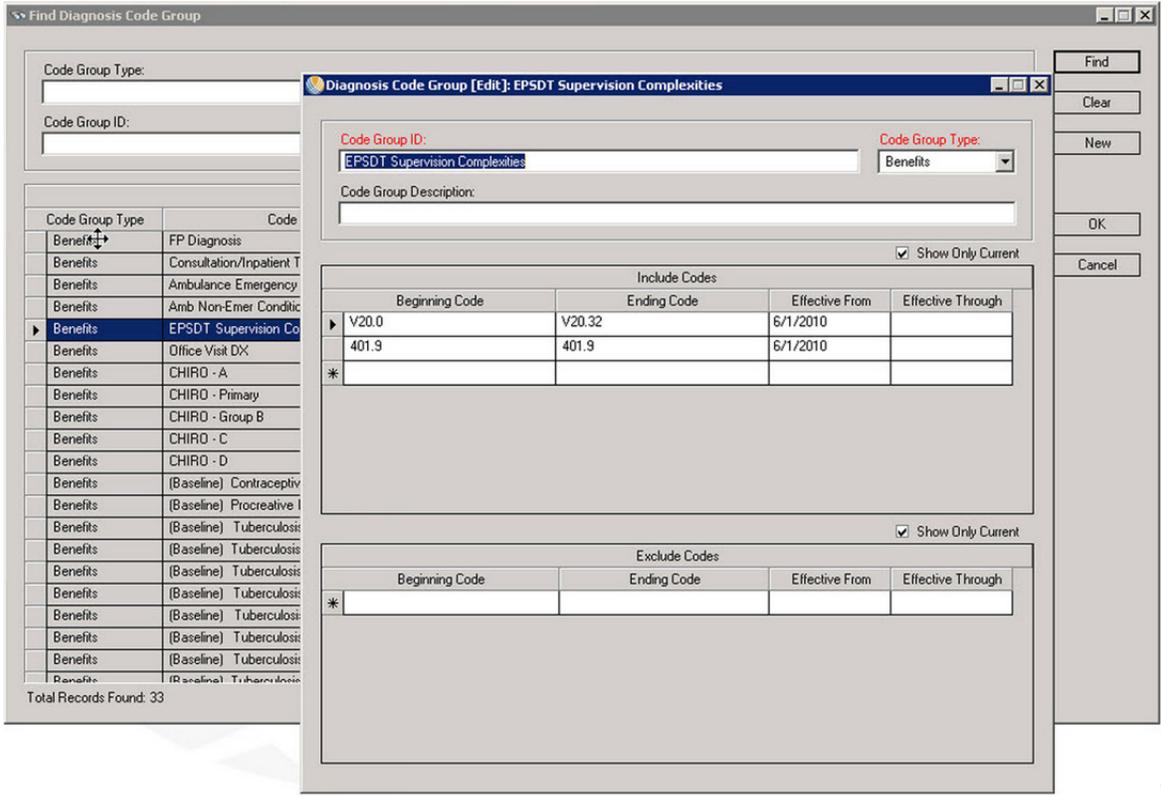
Want to see more? **REFERENCE DATA MANAGEMENT Screenshots**

available in the *Technical Specifications Supporting Information folder* of the electronic submittal.



IA MMIS-2 13 079

Figure 4C.11-1. APHP provides configurability at each hierarchy level for improved control over benefits administration.



MMIS-213080

Figure 4C.11-2. APHP's claims engine configuration console allows access to reference data for management of benefit plans.

Response to Attachment L Requirements

For each Attachment L requirement narrative response we provide a cross reference of the requirement number and the page of the matrix provided in Tab 4G: Worksheets for Submission.

Att. L Req.	Tab 4G Page
RFR-1	Att L - 16

APHP provides an integrated COTS claims engine that includes a module for reference data management. This integrated module and its content supports standard functions for Medicaid operations and offers flexibility to implement and manage IME specific medical policy.

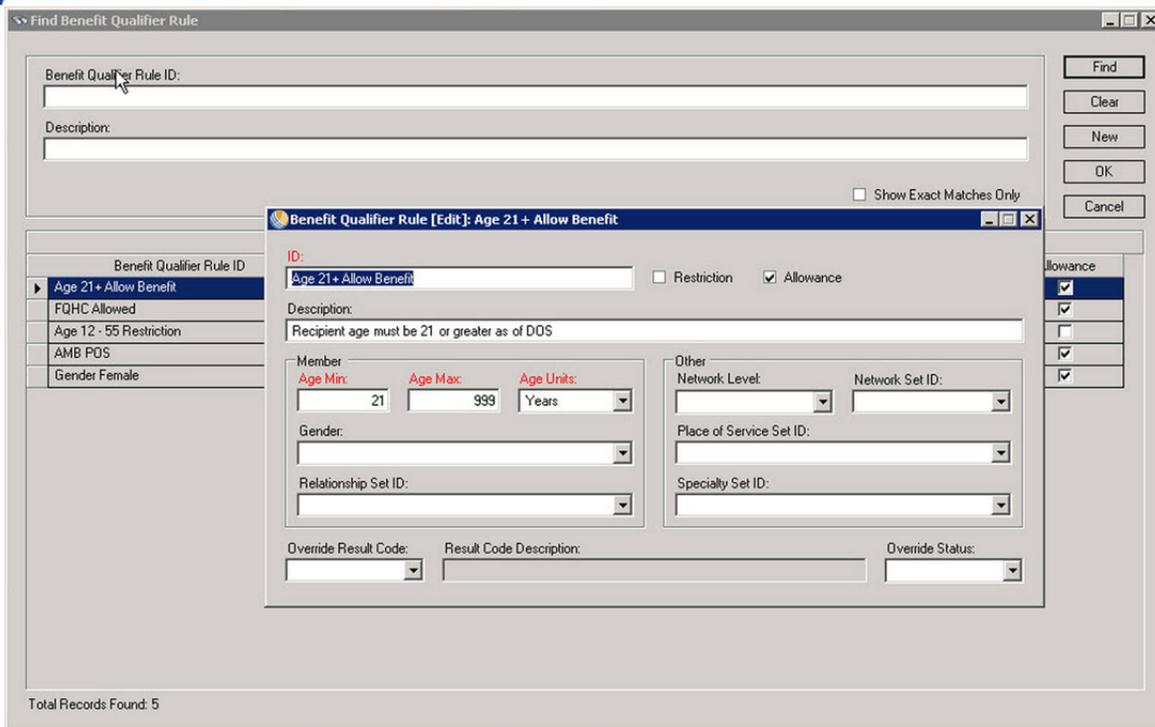
The reference management contains rates and pricing information, and is used to determine allowable payments to providers, control edits and audits, and support other MMIS functions as well as reference tables that are used in the prior authorization and claims adjudication processes. As illustrated in Error! Reference source not found., authorized users can configure and view benefit plan rules through easy-to-use Web interface that comprehensively support benefit plan administration.

The APHP reference data module is configured to meet the Agency's requirements through the ACP phase. Once deployed into the Operations environment, our staff then designates testing environments to allow authorized users to configure changes and review the impact of the new configurations prior to implementing these changes into production. Testing and collaborative review of testing results amongst program.

RFR-2	Att L - 16
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Through the claims engine IME will have the ability to perform coding and pricing verification during claims processing through calls to the appropriate reference files such as procedure and diagnosis codes, fee schedules, and other drivers of provider and other agency reimbursement, and contracts for capitation program. Additionally, with the APHP solution IME has the flexibility for maintaining configuration for multiple fee schedules and various reimbursement methods such as flat rates, percentage of bill, usual and customary (UCR), and Resource Based Relative Value Scale (RBRVS), etc. The APHP benefit plan configuration methodology allows reusability of base procedures, diagnoses, criteria, and accumulator structures as well as associated reference data files.





IA MMIS-2 13 081

Figure 4C.11-3. APHP provides user-friendly screens to view and configure business rules.

RFR-3 Att L - 16

APHP accommodates changes to reference parameters and file capacity. The claims engine within the APHP solution approaches the organization of all reference data within a top-down, bottom-up approach as reflected in Figure 4C.11-1 above. Customization of table structures and reference file layouts are not required as creation and maintenance of the Medicaid programs is completed by a configuration analyst. Our solution’s framework can adapt to these changes through a front end configurable interface as opposed to labor intensive, expensive back end code development.

The configuration of the benefit plan as an initial component is done for base diagnosis and procedure codes. Individual codes are grouped into procedural groups and diagnosis codes to develop treatment sets. The procedures, codes, diagnostic grouping, procedural grouping and treatment sets are configured in the benefit plan. Subsequently, the client, group, and benefit contract are built top-down. The multi-layer architecture allows flexibility in maintaining reference parameters and file capacity to support claims processing functions for information used in adjudication and pricing claims. APHP uses the claims processing rules engine, benefit plan information, and reference files in claims processing to drive all editing. Reference data and business rules within APHP will be configured to reflect whether spanned dates of service are allowed for a given service detail and accordingly. The claims rules engine configured to perform the appropriate pricing calculations against units of service, spanned dates and daily limitations.

RFR-4 Att L - 16

APHP is configurable to support the data requirements of other MMIS applications. The solution provides support for claims data by providing reference data for provider files, procedure codes, diagnosis codes, drug NDC, result codes, and DRG files. In addition, APHP maintains reference data for fee schedules, eligibility records and prior authorizations.

The APHP reporting data store receives all drug claims data from the POS vendor. This data is accessible to support the production of reports to analyze individual drug usage. APHP stores current as well as historical data so that trending can be performed. DUR, retrospective DUR and utilization review is configured for the ICD-9 and ICD-10 code sets as required and can be accessed for reporting and other required analysis.

RFR-5 Att L - 16

APHP maintains and operates reference tables needed to process claims and encounter data including required enhancements. Reference data is date specific,



invokes a comprehensive audit trail when added, modified or deleted, and the reference tables store current and retired pricing information.

Through the claim engine the APHP solution supports comprehensive reference data management. Procedure codes (CPT, NDC, HCPCS, UCR, and RUG) diagnosis codes (ICD-9 and ICD-10) are contained in APHP. The claims engine integrates real-time use of industry standard tools within the claims pricing process for accuracy on calculations of key functions such as DRG and APC derivatives, Lab Panel vs. ATP, and POA validation and impact to the DRG classifications.

Unlike traditional MMIS solutions where pricing methodologies are commonly hidden within custom code solutions, the APHP solution centrally manages claims pricing through a configurable online user interface for Professional and Institutional fee schedules.

Both fee schedule types are based on procedure code or service codes, and code ranges that may have different payment methods and values assigned within one or multiple fee schedules. Fee schedules are further enhanced by criteria configurations that utilize provider, member, and benefit plan claim attributes to identify appropriate pricing, as well as inclusion of modifier tables as extensions configured to adjust the payment parameters defined in the core fee schedule.

RR-6 Att L - 16 APHP is able to provide reporting of information from the reference data files for current code, historical code, and updates. The reference data is reported for IME through APHP's central reporting data store. Ad hoc reports and additional details are added for standard reporting functions. Through the reporting dashboard IME will have the ability to customize reports involving monitoring, metrics, quality assurance, or management.

RR-7, RR-8 Att L - 16 APHP provides and maintains customary charge data for provider's Medicaid customary charges through the physician fee schedules. The physician and institutional fee schedule management feature accommodates pricing methodologies such as flat fees, percentage of billed amount, capitation, RBRVS, per Diem, and DRG. The fee schedule also utilizes the RBRVS conversion factor, if applicable, for geographical prices indices. APHP is configurable for modifier pricing and code depreciation, and also supports service calls to external pricing entities for re-pricing at industry standard levels.

The APHP contains a Fee Schedule to provide and maintain prevailing Medicaid charge data for pricing files for procedures and other in scope services. Pricing data within APHP will be configured to reflect whether spanned dates of service are allowed for a given service detail and accordingly, the claims rules engine configured to perform the appropriate pricing calculations against units of service, spanned dates and daily limitations.

RR-9 Att L - 16 Through the accumulator framework functionality within the claims engine business rules (edits) are applied to procedures, drugs, diagnoses, DRG and APC codes. The APHP solution comes pre-packaged with federal and state mandated benefits. As part of the ACD (analyze, configure, and deploy) phase we will review and validate the standard benefits in order to configure the additional limitations as necessary. Benefit limitations are able to be configured at a procedure or diagnosis code grouping(s), or at a specific code level.

RR-10 Att L - 16 The APHP fee schedules use configurable criteria to drive to specific reimbursement methodologies including state specific rates and manual pricing. Fee schedules can include additional attributes or code sets as needed to manage state and federal payment rules. Fee schedule templates are reusable and can be copied and tailored to expedite the creation of new payment methods.

RR-11 (a-c) Att L - 16 The claims engine maintains revenue codes and provides online update and inquiry access to authorized users, including but not limited to: coverage information, restrictions, service limitations, automatic error codes, pricing data, and effective dates for each item, and an English description of each revenue code. The revenue code listing is contained within the procedure code sub-area of enterprise administration. Within this area, the user has the ability to define the coverage effective from and through date.

As reflected in above requirements the solution accommodates multiple pricing methodologies and action codes for institutional fee schedules, global payment value, assignments and fee schedule modifier tables.



Effective and termination dates can be configured by reference file staff to document spans of validity for each data file.

RF-12 (a-g) Att L - 16

APHP is built upon the MECT standards, as reflected in RF1.8 the claims engine maintains current and historical reference data used in claims and encounters processing. Reference data is date specific, and the reference tables store both current and retired or historical pricing information. APHP will meet requirements for procedure codes and modifiers that include at a minimum the following elements in the Table 4C.11-1.

Table 4C.11-1. We acknowledge the seven subsets of requirements for maintenance of historical reference data.

Element	Contractor Responsibilities	Existing Capabilities
A.	APHP will maintain current and historical reference data for date-specific pricing segments including a pricing action code for each segment showing effective dates and end dates.	✓
B.	APHP will meet Agency-specified restrictions on conditions for a claim to be paid such as provider types, member age and gender restrictions, place of service, appropriate modifiers, aid category, and assistance program.	✓
C.	APHP will maintain current and historical reference data for pricing information such as maximum amount, fee schedule amounts and RVS indicators with unlimited segments showing effective dates and end dates.	✓
D.	APHP will maintain current and historical authorization codes with unlimited segments showing effective dates and end dates.	✓
E.	APHP will maintain current and historical reference data for English descriptions of procedure codes.	✓
F.	APHP will maintain current and historical global indicators for codes that include reimbursement for pre- and post-procedure visits and services.	✓
G.	APHP will maintain current and historical global indicators for other information such as accident-related indicators for possible TPL, federal cost-sharing indicators and prior authorization required.	✓

RF-13 Att L - 17

APHP is configurable to maintain procedure information that sets adjudication limitations and medical policy restrictions for automatic pricing of medical procedures according to the effective date. APHP is not limited to set the restrictions on the procedure or diagnosis code itself, as has been standard practice by MMIS solutions to date. Leveraging a building block design approach from the APHP benefit administration component, the procedure and diagnosis codes, in and of themselves, become attributes within the configuration of any given benefit plan.

The APHP difference by design, not setting the restrictions on the procedure itself, promotes flexibility and the reuse of the same procedure under different programs without cumbersome and expensive configuration or back end programming or coding routines. Specific medical policy and pricing rules are applied to support the various types of Medicaid and State-funded programs through simple and reusable configurations within APHP. APHP may be configured to set adjudication limits and medical policy restrictions for automatic pricing of medical procedures according to the effective date.

RF-14 Att L - 17

APHP reference rules for claims processing is also part of the core rules engine that supports claim adjudication. Our solution is configurable to identify specific situations based on claim data when prior authorization and pre-procedure review approval is required through APHP at the benefit plan, service code or service code grouping level.

Authorization requirements are configured into the APHP through business rules. It is through this configuration that operations influence the rules (edits) and route claims requiring prior authorization or pre-procedure review by the appropriate team as required by IME guidelines. This means the rule can also auto-deny services as well.



RFR-15 Att L - 17

APHP restricts the use of procedure codes to those providers qualified to perform them through the configuration of attributes that are shared between the reference data and the provider data. The enrollment process for APHP assigns a specialty (provider type) and sub-specialty, if applicable, to the enrolling provider based on submitted information. The APHP claims adjudication module uses the coded provider type/specialty (i.e. taxonomy) restrictions within the reference configurations to restrict procedure codes to the appropriate providers. APHP restricts providers at different levels based on a treatment set or the framework level. APHP may be configured for user-control of these restrictions.

RFR-16 Att L - 17

APHP accommodates variable pricing methodologies for identical procedure codes based on provider specific data. The APHP solution contains an embedded fee schedule administrative feature for institutional fee schedules, professional fee schedules, global payment value assignments, and fee schedule modifier tables. The overall set of schedules support variable pricing methodologies for specific procedure codes and provider types. The type of reimbursement is configurable with the Fee Schedule Administration capabilities of APHP. The APHP integrated claims and payment engine supports a variety of reimbursements such as RBRVS, flat fee, modifier pricing, and geographic pricing. Each procedure is configured to have a one-to-many set of multiple fee schedules to allow processing of various pricing methodologies. The core foundation of the benefit plan is encapsulated with fee schedules to support the reimbursement of like services based on IME business rules.

RFR-17 (a-h) Att L - 17

Through the claims engine the APHP solution is configurable to maintain the previous and current diagnosis data set of diagnosis codes using the ICD-CM required by HIPAA and DSM coding systems. We understand that DSM is in the process of revision and not expected for release until 2014 at the earliest. As such, our configuration is based on DSM-IV which is the most current version. The APHP solution is capable of maintaining the previous and current diagnosis data set of medical diagnosis codes utilizing ICD-CM used by HIPAA and DSM coding systems.

The system is configurable to maintain relational edits of data attributes for medical diagnosis codes such as age, gender, place of service, prior authorization codes with effective dates and end dates, inpatient length-of-stay criteria, descriptions of diagnostic codes, and effective dates and end dates. The relational edit feature supports the extension and restriction of benefits. The benefit plan has a benefit framework that allows reuse of base codes. The effective segments are adjusted for State or federal levels.

RFR-18 Att L - 17

APHP maintains and operates reference tables needed to process claims and encounter data including required enhancements. Reference data is date specific, invokes a comprehensive audit trail when added, modified or deleted, and the reference tables store current and retired pricing information.

Through the claim engine the APHP solution supports comprehensive reference data management. Procedure codes (CPT, NDC, HCPCS, UCR, and RUG) diagnosis codes (ICD-9 and ICD-10) are contained in APHP. The claims engine integrates real-time use of industry standard tools within the claims pricing process for accuracy on calculations of key functions such as DRG and APC derivatives, Lab Panel vs. ATP, and POA validation and impact to the DRG classifications.

Both fee schedule types are based on procedure code or service codes, and code ranges that may have different payment methods and values assigned within one or multiple fee schedules. Fee schedules are further enhanced by criteria configurations that utilize provider, member, and benefit plan claim attributes to identify appropriate pricing, as well as inclusion of modifier tables as extensions configured to adjust the payment parameters defined in the core fee schedule.

RFR-19 Att L - 17

The claim engine contains a unique functionality that allows a data upload feature known as the Code Importer. This functionality consumes and takes advantage of third party industry standard files for CPT/HCPCS, ICD-9 & 10, UCR, RBRVS and other code updates, and inherent with the APHP solution claims engine Microsoft framework uploads from Excel, Word, Access and CSV files are easily enabled.

The Code Importer function also allows users to make one change that automatically triggers update functionality throughout the system. For example, the Code Importer function allows staff to import procedure code updates globally across all applicable areas within the benefit and payment contract tables.



Reference data can also be updated manually depending on the volume of the change. Updates to data adhere to the defined stages of analysis, design, build, and test prior to their release into a production environment.

RFR-20 Att L - 17 APHP maintains online access to all reference files with inquiry by the appropriate code. APHP provides an interoperable framework for easily fitting into IME's current environment while providing the foundation for future expansion of reference data management. General reference data information such as rate, UR, exception control, text, and NDC may be accessed online for inquiries by code.

RFR-21 Att L - 17 The APHP Portal provides online access to reference data for authorized users through a secure user interface, including the capability to search on key terms and locate their usage within the configured business rules.

RFR-22 Att L - 18 APHP updates rates and provider fee schedule rates with each fee having an associated effective begin and end date through manual, on-line modification of fee schedules and systematic mass updates for files received from the Rate Setting Contractor. The update process is inclusive of impact analysis within a test environment, implementation in the production environment and quality review. APHP performs updates related to policy changes by CMS for HCPCS and diagnosis codes, AMA for CPT, and fiscal agents for DRG updates. The import process of each file assigns an effective date for implementation for audit and historical data access purposes. The imported files are quickly verified in production to promote immediate use for the claims adjudication process.

RFR-23 Att L - 18 APHP administers complex payment methodologies that support defined Agency guidelines and allow for multiple provider-specific reimbursement rates with begin and end dates. APHP's user interface provides the capabilities to load per diems, level of care per diems, case mix, percentage of charge rates, and rates based on level of care, preferred provider agreements, managed care agreements, volume purchase contracts or other cost containment initiatives with begin and end effective dates. APHP maintains per diem rates for hospitals with Medicaid-certified rehabilitation units as specified.

RFR-24 Att L - 18 Online inquiry and update capability is important for Agency staff, supporting IME contractors, and staff supporting the MMIS processes (such as claims processing and adjustment review). Authorized users perform online queries via the APHP portals. Online or manual updates to reference data provide an easy, non-technical method of modifying information data to reflect program changes. Data updates entered online are edited for correct formats, valid values, and completion of required fields.

The online change is executed in real-time in the test environment. The change is then promoted to the production environment after verification and has an immediate effect on transaction processing using a controlled, workflow driven approval process.

RFR-25 Att L - 18 Control in the maintenance and operation of any system module is critical to trace root causes of issues and confirm activity is performed as required. APHP has a robust audit capture capability and produces an audit trail report in the media required by the Agency. This audit feature shows before and after images of changed data that can be stored as supporting documents in the system, the ID of the person making the change and the change date.

The reference data is documented through version control in the APHP solution and each version of the stored reference data file is searchable for online queries through the APHP worker portal. The versions represent changes which have audit trails documenting who made the change, what change was made, and the date/time of change. Audit trails are shown for standard changes, errors in changes and suspended changes.

RFR-26 Att L - 18 Through APHP, authorized business analyst and associated users enter reference data, pricing data, procedure codes, and benefit plan configuration. APHP validates and prevents overlapping dates or invalid code modifiers. Batch updates also provide similar edits to prevent overlapping dates and erroneous code modifiers. APHP prevents erroneous reference data. APHP generates error reports informing users of errors. A process will be implemented to route notifications of these error reports to the appropriate user or work group.



RFR-27 Att L - 18

The ability of the APHP solution to accommodate multiple reimbursement methodologies is one of many examples of how we help enable the IME handle complex policies to effectively operate the Iowa Medicaid program. The solution accommodates reimbursements methods including, but not limited to, DRG, APC, fee schedules and per diem. APHP fee schedule administration functionality is configured for a variety of reimbursement calculations such as flat rates, percentage of bill, UCR, RBRVS and reimbursement for services submitted in UB04 (837I) format.

RFR-28 (a-j) Att L - 18

APHP is configured to maintain multiple and complex pricing files. It contains a flexible and scalable solution to implement pricing that varies by attributes such as procedure, modifiers, provider type and specialty, and place of service. The solution pricing process is designed to review billed amount, allowed pricing, and actual paid for the claim. In addition, APHP interfaces with an external pricing application to support DRG derivation and APC processing. Through the claims engine the APHP solution is configured to maintain pricing files for the entities below in Table 4C.11-2.

Table 4C.11-2. APHP has existing capabilities to meet responsibilities for maintaining each attribute of pricing files.

Element	Pricing File Entities	Existing Capabilities
A.	Customary	✓
B.	Fee schedule	✓
C.	Per diem rates	✓
D.	DRGs	✓
E.	APCs	✓
F.	Capitation rates for managed care plans	✓
G.	Administrative fees for primary care management, medical home and others as designated by the Agency	✓
H.	Maximum allowance cost (MAC), estimated acquisition cost (EAC), average wholesale price (AWP), Medicaid average wholesale price (AWP), Veteran Health Care Act 5193 and Federal Upper Limits (FUL) pricing for drugs	✓
i.	Multiple rates for long term care providers	✓
j.	Encounter rates for federally qualified health centers & rural health centers.	✓

RFR-29 Att L - 18

APHP maintains and updates the DRG-based prospective payment file for inpatient hospital services. In addition, the solution manages updates to the base rates periodically as authorized by the Agency. In APHP, the reference data is adjusted to apply an economic index to the base rates as authorized by the Agency. APHP is configured for DRGs assigned by grouper programs that are set for claim data with common attributes such as ICD diagnoses and procedures. Additional data such as age, gender, and complications within DRG files are processed efficiently by the solution. APHP processes updates at the Agency's discretion. The APHP solution has the ability to process these payment files from a variety of sources and file structures through a file interface or import process.

RFR-30 (a - d) Att L - 18

Our solution maintains and updates DRG and APC data sets. APHP maintains and updates unlimited occurrences for entities contained within the DRG and APC: price by code, high and low cost outlier threshold, high and low length-of-stay outlier thresholds, and mean length of stay. Our business analyst staff and program leadership will collaborate and communicate with the State to remain current with product releases and updates subject to change control process. In addition, two sets of DRG's will be maintained; one for ICD-9 related DRGS's and one for ICD-10 related DRG's. Both of these versions would be maintained and updated.

RFR-31 Att L - 18

APHP maintains the fee schedules in the reference file and update on an annual basis or as authorized by the Agency including applying an economic index to the fee schedule rates. APHP is configured to work with multiple fee schedules and resources such as institutional fee schedules, physician fee schedules, global payment values, and modifier tables. The APHP fee schedule management feature is used to modify or adjust payment to a provider. As an example, remote providers are reimbursed based on an index multiplier allowance which allows a higher payment. The reference data in the



APHP solution applies a conversion factor for geographic adjustments of work, practice expense and malpractice fees to allow the full allowable rate for a given service.

RFR-32 Att L - 19 Our APHP solution supports multiple reimbursement methodologies for the following list of providers required by the IME (along with other providers as applicable). Reimbursement methods configured in the APHP solution include flat rates, percentage of bill, UCR, and RBRVS among other configurable fee schedules.

The quality assurance process tests data transfer for reimbursements as well as related documents and functions that process the payment to providers. The APHP solution is configured to reimburse on a fee schedule multiple provider types listed in in Table 4C.11-3.

Table 4C.11-3. Our team’s solution is configured to reimburse on a fee schedule multiple provider types.

Element	Provider Type Supported	Acknowledged
1	Ambulance providers	✓
2	Ambulatory Surgical centers	✓
3	Audiologists	✓
4	Chiropractors	✓
5	Community Mental Health Centers	✓
6	Dentists	✓
7	Durable medical equipment and medical supply dealers	✓
8	Hospital-based outpatient programs	✓
9	Independent laboratories	✓
10	Maternal health clinics	✓
11	Nurse midwives	✓
12	Orthopedic shoe dealers	✓
13	Physical therapists	✓
14	Physicians	✓
15	Podiatrists	✓
16	Psychologists and screening centers	✓

RFR-33 Att L - 19 The provider fee schedule for optometrists, opticians, and hearing aid dealers uses the general provider reimbursement methodologies discussed in this section of the proposal. In addition to reimbursement on the basis of a specific pricing method, the solution selects the appropriate configured fee schedule entries to price professional service plus the cost of materials. The reimbursement methodology is flexible and is configurable to include costs of material at a fixed fee or at product acquisition costs. The ability to configure a system, whether through rules, data tables, workflow or other parameters – enables APHP to implement changes rapidly in a controlled environment, while reducing the costly effort of back end custom code development and testing required in legacy systems.

RFR-34 Att L - 19 Capitation payment scheduling and processing is a key component of the APHP claims engine and supports the configuration of multiple rates through the capitation payment functionality. APHP configures capitation payment schedules and vendors as the pay to person for the managed care providers, contractors and the non-emergency transportation broker. The configurability of APHP allows a different capitation schedule to be set based on business requirements, not system limitations such that, capitation payments for non-emergency transport, for example, does not have to adhere to the same schedule as medical claim capitation payments.

RFR-35 Att L - 19 Normal editing processes (business rules) are applied to claims upon entry in APHP and continue to apply throughout the adjudication process. Edits are used to help verify the integrity of claims submitted and to reduce the potential for erroneous payment. Maintenance of these edits and audits occur by the Business Analyst staff performing appropriate impact analysis and working with impacted resources across the IME to execute the changes as approved by the appropriate governance and change processes.



Edits involve the comparison of claim data against predetermined criteria. APHP edits include data validation, member data, provider data, reference data, pricing, prior authorizations, utilization and duplicate claim processing. Audits validate claim data against other claims in history. APHP integrates with industry standard Correct Coding Initiative (CCI) tools within the claims adjudication process. This additional feature provides logic that edits for consistency, payment limitations, procedure unbundling, mutually exclusive procedures, incidental procedures, and investigational procedures. Audit validations include checking for duplicate services, checking for exceeded service limits, and checking for exceeded "once in a lifetime" service limits.

APHP adjudicates claims against standard or global edits as well as user defined edits. User defined edits give the flexibility to apply business defined criteria restrictions or plan accumulators to specific benefit plans, providers or members. Using targeted criteria expedites adjudication and emphasizes automation over manual resolution. Service frequency and quantity limitations are implemented through the configuration of a member's benefit plan or plans. APHP is capable of a vast number of different benefit plan configurations. The design of the APHP benefit plan component is an intuitive and innovative model based on applying reusable benefit building blocks.

RFR-36 Att L - 19

The APHP claims adjudication process uses configurable rules that adjudicate and systematically provide final disposition for the greatest percentage possible of claims.

Once entered into APHP for adjudication, claims are processed through a hierarchy of edits and audits based on criteria established in the reference data sets as well as the rules engines and benefit plan administration modules. The reference data for each edit and audit will include the appropriate code which reports the description of errors found (as applicable) on the Explanation of Benefits (EOB) sent to the provider and member. The comments and code descriptions are configurable based on the intended audience of the EOB.

Each edit or audit is configured with an appropriate disposition result code which classifies the claim as paid, denied or suspended. Claims which fail an edit or audit result in a suspended status. APHP will not suspend every claim that fails an edit or audit, because a claims analyst may not be able to resolve the issue. We only suspend claims where specific manual adjudication procedures are defined. Maintenance of these edit and audit disposition codes occur by the Business Analyst staff performing appropriate impact analysis and working with impacted resources across the IME to execute the changes as approved by the appropriate governance and change processes.

An integrated workflow functionality routes suspended claims to the appropriate staff for resolution. Then the APHP workflow management system will route the claim to the appropriate work queue or department based on the result code, load balancing requirements, or specialization of the staff. Locations are set up to sort claims by the manner of submission within each claim type as well as define the function that should be performed on the claims entering that location. The appropriate workflow criteria will be fully customizable based on Agency requirements and will be updated with new configurations as business needs change and evolve. We collaborate with the Agency to define error-specific resolution procedures that will be available online to anyone requiring access to resolve claim suspense. Through the worker portal, APHP provides users with the ability to view applicable business rules (such as edits, audits and other rules) in a single screen. This makes it easy to see how the system interpreted policy, thus aiding in error review and resolution.



4C.12 PRIOR AUTHORIZATION

2.7.12 Prior Authorization

The Contractor shall perform operational requirements for Prior Authorization. The Prior Authorization function supports authorizations and tracking of authorizations in accordance with IME medical and utilization limit policy.

Prior Authorization operational responsibilities are included in Attachment L – Operational Requirements Matrix.

Our approach promotes user-friendly interfaces and work tools, automates workflows and communications, provides real-time access to PA-related information and status, and facilitates expedient turnarounds and workload management. Reporting through Dashboards provides users and management easy access to PA processing statistics, so that workloads and issues can be managed easily

Our Processes and Controls

Our APHP workflow solution provides the ability to route and track progress through a workflow for submitted PA requests, including those related to document imaging or electronic transactions (portal). The authorization process follows a basic workflow pattern designed with input from the Agency and the Medical Services contractor. This workflow can then be configured to add/repeat/ reuse across other business scenarios for prior authorization. Core workflow designs look and act similar (data storage, communication, and tracking) to make it easier to cross-train users in different areas of business support.

Through the APHP Provider portal, providers use easy-to-navigate PA submission screens to submit requests. Figure 4C.12-1 illustrates our user friendly, easy to navigate PA submission portal page.

IME Benefits from Easy-to-Use, Online, Standardized Submission Screens and Attachment Processing

- Improved provider experience and prior authorization request package completeness
- Requests for more information are reduced
- Bottlenecks in processing are cleared easier or even completely removed by enhanced automation and workflows
- Promotes user access to real-time data for improved communications

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Want to see more? PRIOR AUTHORIZATIONS Screenshots

available in the Technical Specifications Supporting Information folder of the electronic submittal.

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Figure 4C.12-1. Prior Authorization submission is facilitated by APHP’s easy-to-navigate screens and functionality. <Data in screenshot is fictitious>





The functionality is designed to encourage providers that have opted to use paper submission in the past to utilize the portal. Features include:

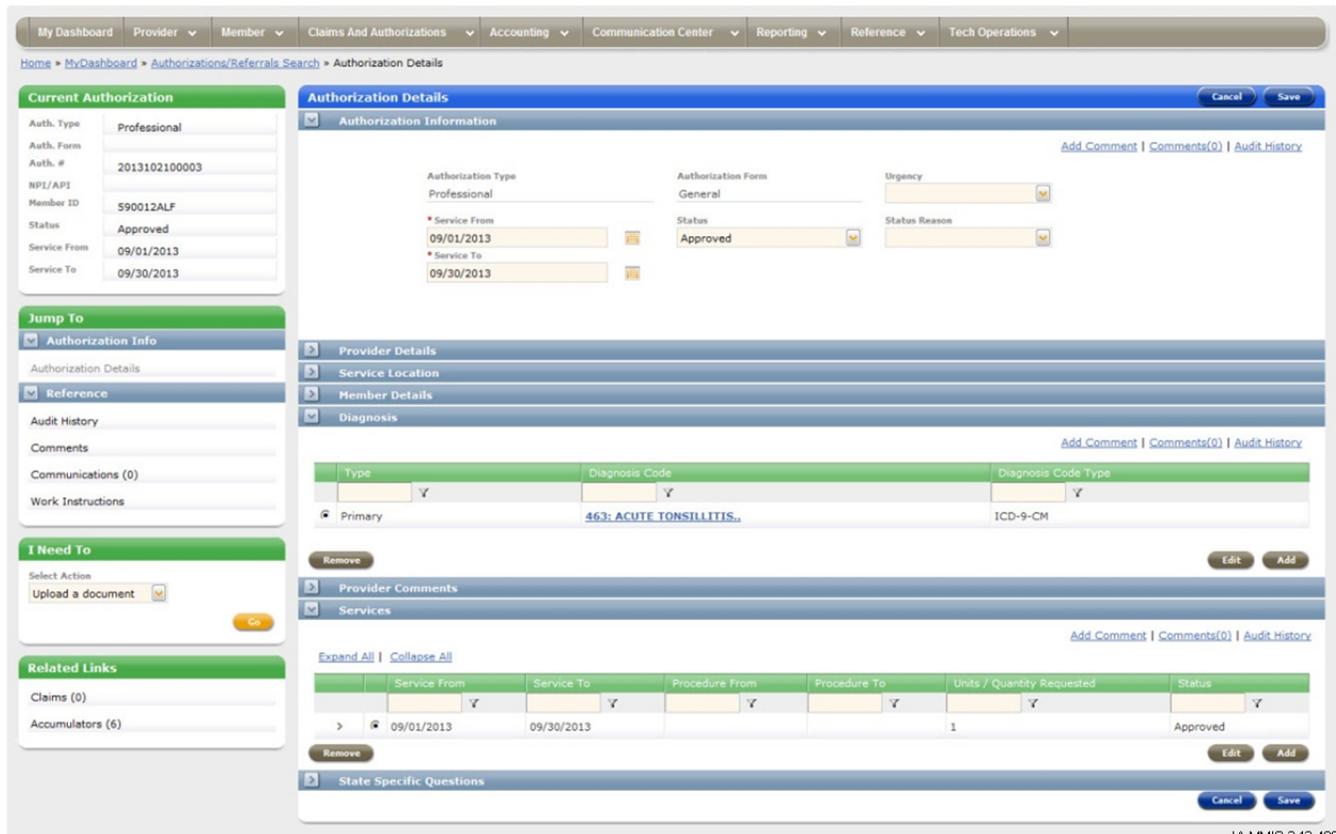
- On-line help features to improve provider user self-service
- Single-click access to system codes presented in every-day language, enhancing providers' learning curve
- Easy to learn, intuitive web pages, configurable to meet a variety of preferences and roles to simplify navigation
- Single-click access to relevant links and functionality presented to simplify user tasks and tailored to user roles with a "breadcrumb trail" navigation aid
- Ability to open multiple tabs and windows simultaneously
- Job Access With Speech (JAWS) compatibility for compliance with the Section 508 Amendment to the Rehabilitation Act of 1973

We deliver reliable, accurate and timely operations by subjecting incoming PA requests to a range of configurable business rules and automated workflows that:

- Confirm that only valid data is entered on the PA record
- Identify duplicate requests and automatically route to authorized staff for review
- Route to appropriate authorizers, helping to eliminate misdirected/lost requests
- Generate timely notifications and letters to providers, members and case workers, as needed
- Accurately specify and apply policy coverage to services, rendering reduced processing turn-around

Based on user-configurable rules, PA requests are automatically routed to the appropriate authorized staff for review and approval, shown in Figure 4C.12-2. These adaptable business rules can be easily changed, when approved, by trained users to support the evolving needs of the Iowa Medicaid program.

APHP maintains the status of PA services by interfacing with the claims processing function to verify approval and to accurately increment/decrement the services used. APHP delivers a PA solution that provides work tools that improve worker experience, promoting quicker PA approval turnarounds:



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Figure 4C.12-2. Worker Portal prior authorization screens are designed for a worker to easily review and approve.



- Necessary real-time information at requestor’s fingertips
- Single-click access to criteria and codes
- Automated checking for overlapping or duplicate PAs
- Auto-generated correspondence
- No paper/files to maintain

Once the PA has a final disposition, the authorization is stored for use in future claims processing. During the claims adjudication process, the prior authorization record is decremented and reflects the outstanding amounts and/or units available, the adjustment and/or void of prior authorized services to the record.

Our user-friendly, easy-to-navigate worker portal pages are designed to help Agency staff, and other authorized users, to perform the necessary steps required to complete the PA request. Through the portal, authorized users have easy access to criteria such as:

- Medical necessity
- Procedure and/or diagnosis codes
- Date ranges, units
- Times and quantities
- National Provider Identifier (NPI) taxonomy
- Recipient eligibility to perform and receive the requested service

APHP allows workers to be more efficient. For example when looking at a claim, the single-click functionality enables an authorized user to go right to the associated PA and get detailed information without having to launch a separate screen.

Response to Attachment L Requirements

For each Attachment L requirement narrative response we provide a cross reference of the **requirement number and the page** of the matrix provided in Tab 4G: Worksheets for Submission.

Att. L Req.	Tab 4G Page
PAR-1	Att L - 19

We will collaborate and team with the IME Medical Services contractor, as they continue to perform prior authorization responsibilities for medical and dental services. Through the APHP portal and workflows, we provide prior authorization system functionality, files, and data elements necessary to support maintain the prior authorization business process.

PAR-2	Att L - 19
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We maintain the APHP prior authorization system to allow for the loading of authorizations, which allows for tracking utilization of authorized services. Prior authorization approvals are loaded and maintained in the APHP prior authorization module.

APHP captures decisions and approved information for each authorization to facilitate tracking utilization of authorized services. Captured information, as shown in Table 4C.12-1, interacts with claims processing during adjudication to confirm the existence of a PA and authorized available service criteria.

Table 4C.12-1. Information captured on PA requests interacts with claims adjudication to facilitate tracking of authorized service utilization.

Captured data on PA requests	Checked during Claims Adjudication
Identification of the member (or members in the case of a newborn under the mother's eligibility ID)	✓
Status of the request	✓
Services authorized	✓
Number of units requested (and if applicable, consumption frequency)	✓
Number of units approved (and if applicable, consumption frequency)	✓
Service date range	✓
Cost amount requested	✓
Cost amount approved	✓
Provider approved (unless approved as non-provider specific)	✓



PAR-3 Att L - 19

APHP brings real-time capabilities to the Agency's prior authorization (PA) business processes. These capabilities support the maintenance of edit dispositions to deny claims requiring a PA where no PA is identified or active. Prior authorization edits that are applied, both during the entry of the service request and the application of the authorization during claims adjudication, are configurable to mirror applicable claims processing edits. APHP reference data management functions support the configuration and maintenance of edits, audits, PA requirements and other service restrictions that are applied consistently across the system. Editing validates values on entered PAs using current information on benefit plan, provider, member eligibility and reference databases. Claims processing interacts with the PA module during adjudication to confirm the existence of a PA and authorized available service criteria. If no match is found, the business rule logic is configurable to set a denied disposition to confirm that claims are not paid for a service requiring authorization, but for which no active PA is identified.

PAR-4 Att L - 19

Secure delivery channels include the APHP portal, APHP Electronic Data Interchange (EDI) capabilities, HIE, web based services and flat files. The system accepts prior authorizations requests through electronic data interchanges or the health information exchange using standard transaction sets. Once the PA is received business and workflow rules are applied to the PA to determine the appropriate disposition. For PA's that require manual intervention APHP provides reviewers access to real-time information at their fingertips to assist them in making the appropriate determination.

PAR-5 Att L - 19

APHP supports automated workflow management and distribution of PA requests received from providers to appropriate Medical Services contractor staff for review and determination, including those identified as needing manual review. APHP manages work assignment using multiple levels of criteria including, but not limited to: characteristics of the claim or PA record, characteristics of the client, type of claim submission, and edit/audit type.

PAR-6 Att L - 19

Our mailroom operations have the capability to accept and process the volume received via paper in a controlled mailroom environment. We use effective processes for acquiring and managing paper input related to the prior authorizations. Paper prior authorization requests are received in the mailroom, sorted, batched, and imaged. As authorizations are imaged, the system assigns a document control number (DCN) that is permanently tied to that item and the associated attachments, and transferred into the core processing and data component of APHP. Requests, or requests with attachments, are imaged together and assigned the same DCN plus a sequence number. The DCN remains with the transaction throughout its life.

Once imaging is complete, prior authorizations are placed in work queues for data entry. Resulting images from the mailroom process are routed to the appropriate prior authorization contractor through the current workflows configured in OnBase. If the Agency desires, the original paper authorization can be forwarded to the contractor, in addition to routing the image through the workflow. Other routing requirements are supported as the needs of the Agency and supporting contractors are identified. Please reference Section 4C.4Mail and Courier Service for a more detailed explanation of the scanning and imaging of hardcopy documents.



4C.13 THIRD PARTY LIABILITY

2.7.13 Third-Party Liability (TPL)

The Contractor shall perform operational requirements for Third Party Liability (TPL). The TPL function supports the identification and maintenance of health insurance and other third party resources of Iowa's Medicaid members. Additionally, TPL data is used in the processing of claims to support cost avoidance and recovery in accordance with IME policies.

TPL operational responsibilities are included in Attachment L – Operational Requirements Matrix.

Medicaid is typically one of the largest budget items in most states. The Agency needs a MMIS solution that enforces Medicaid as the payer of last resort to preserve the State's limited funds and enable Iowa to provide more services to its Medicaid-eligible population. The Third Party Liability Management program allows the Agency to identify and cost-avoid thereby reducing the state's Medicaid program expenditures. Accenture understands the complexities of Third Party Liability (TPL) programs that require coordination of multiple business unit, contractor and external organization efforts.

Successful TPL programs collaborate with many business partners to collect and share financial liability and insurance information. Because our solution is designed using a SOA framework, it is built on the principle that it must easily interface with other systems. APHP uses industry standard secure data exchange protocols to enable the Agency to receive and share information and services across the Medicaid enterprise in a variety of ways. Our reliable, flexible and configurable data exchange solution supports the Agency in aggregating TPL data from multiple sources.

Upon receipt of this data, our claims engine allows the Agency to store more detailed other insurance coverage information for its members. The APHP claims engine provides a framework to store TPL benefit coverage, plan service limitations, co-pays, co-insurance, and deductibles. The claims engine also stores plan details such as ID numbers, addresses and billing information, allowing the Agency to identify other insurance responsible for payment automatically during claims adjudication so more claims can be accurately cost avoided.

APHP provides easy, online access to other insurance coverage through the APHP Portals. Providers can access member records, including TPL information, to get the information they need to bill correctly the first time, making it easier for the provider and resulting in less erroneous billing to the Iowa Medicaid program. The APHP Portals also provide the IME Revenue Collections contractor with a more comprehensive member record to use during pay and chase activities.

Because TPL business processes require involvement and interaction with multiple parties, they require robust workflow capabilities to instill process consistency, efficiency and discipline. Using the IME's existing workflows integrated with our APHP automated workflow tool, the IME receives intelligently designed workflows to manage TPL processes. This includes the ability to identify and maintain accurate TPL data for the member population, perform automated cost avoidance, support pay and chase activities, track monies owed and collected, support trauma investigation activities and estate recovery activities and perform the premium management processes. Automated workflow supports these processes by automating process steps, such as letter generation and generating work items for prompt resolution of those tasks that require user intervention.

Table 4C.13-1 on the following page highlights the features of the APHP TPL solution and associated benefits to the Agency.



The Agency Gains Enhanced Capability to Avoid Costs and Maximize Recoveries

- Uses insurance information to adjudicate claims quickly and accurately
- Identifies claims and services for billing to other entities to support pay and chase activities, trauma activities and estate recovery activities
- Accurately tracks and reports on TPL monies owed and collected

IA MMIS-2 4C13-01



Want to see more? **THIRD PARTY LIABILITY Screenshots**

available in the *Technical Specifications Supporting Information folder* of the electronic submittal.



Table 4C.13-1. Accenture's TPL solution provides the Agency with a faster, more accurate tool to avoid costs and maximize recoupments.

APHP TPL Features	Benefits to the Agency
SOA-based solution that provides flexible, efficient, real-time system-to system integration	Minimizes the need to replicate the same data in multiple systems
Workflow business rules provide real-time access for claim adjudicators to access vital information such as insurance coverage information from other carriers	Faster and more accurate processing of TPL claims through automated business process workflows
APHP data model allows the capture of source of TPL information	Increased audit trails to capture follow-up data and recoveries
Allows batch files from external sources or real-time web services to accept, validate and store casualty related information	Faster recovery of funds
A solution that identifies claims with trauma diagnosis codes, accident codes and indicators that trigger subrogation casualty case for subsequent follow-up.	More timely recoupment of funds
Our APHP solution includes integrated COTS products and services that allow configuration of the system to auto generate letters	Efficient mailings leading to more efficient follow-up by TPL contractor specialists

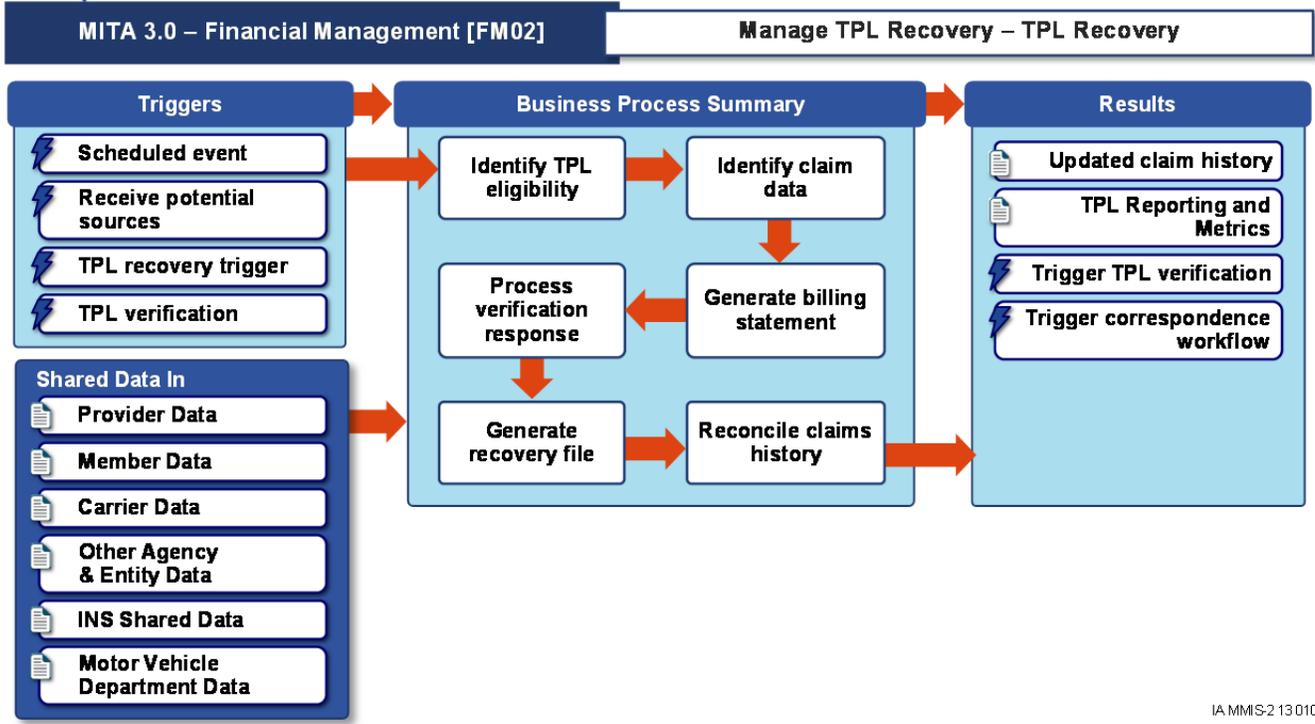
Our Processes and Controls

APHP provides the solution for maintaining a timely, accurate and automated data repository of member third party liability data, including: carrier, group, policy, and begin and end dates, and identification of types of services and coverage provided. APHP collects and maintains third-party resource information for all members. Our workflow business rules provide real-time access for claim adjudicators to obtain vital information such as insurance coverage information from other carriers and Medicare enrollees, including Medicare managed care health plan enrollments. We work closely with the Agency and the Revenue Collections contractor to recommend implementation strategies to support the Agency’s TPL policies. Under the direction of the Agency, we also provide required support for CMS engagements or requirements related to Medicare Secondary Payer (MSP) or, on specific coverage types to cost avoid or recover.

Large payer environments and in particular, Iowa Medicaid, require real-time system-to-system integration. The implementation of our MITA aligned infrastructures with service oriented architecture (SOA) integration capabilities provides the flexible, efficient, real-time system-to-system integration critical to TPL interfaces across the IME. This minimizes the need to replicate the same data in various systems. Key to this transformation is to move from legacy nightly batch data transfers between systems to just-in-time processing of transactions even though the data may reside in more than one system.

APHP supports the necessary interfaces and defined data interface standards to verify the successful automated receipt of input data and the proper distribution of output data between APHP and the Agency’s TPL contractor. APHP supports standard ANSI X12 transaction formats, as well as the ability to configure custom file formats as needed. The Enterprise Service Bus (ESB) provides for secure data exchange between the IME and the Agency’s multiple business partners, as well as other Iowa state agencies. The ESB provides XML and fixed file format interfaces, both inbound and outbound. Our solution keeps an audit trail of changes to member resource information including user ID, date and time and field value changes.

APHP provides the Agency with an extensive set of data integration capabilities using widely deployed, components that support its TPL interface and integration requirements. We provide workflows using the workflow management engine within APHP. The Agency benefits from improved speed to recovery and increased visibility into the volume and status of recovery and cost avoidance activities. Figure 4C.13-1 M shows the interrelationship between data received via interfaces and its real-time application in an operational environment.



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Figure 4C.13-1 M. We capture TPL inputs through our interface tools and update and store documents for retrieval by the subcontractor's TPL specialists.

Response to Attachment L Requirements

For each Attachment L requirement narrative response we provide a cross reference of the requirement number and the page of the matrix provided in Tab 4G: Worksheets for Submission.

Att. L Req.	Tab 4G Page
<i>TPLR-1</i>	Att L - 20

We maintain the Third Party Liability (TPL) system to manage private health insurance and other third party resources to verify that Medicaid is payor of last resort. The TPL Management function in APHP receives and stores accurate, current and historical sources of other insurance coverage information on individuals eligible for Medical Assistance in the State. TPL information is identified either through electronic interface with various sources such as the ELIAS eligibility system, CMS, Iowa's TPL Contractor, the Child Support Enforcement Agency or from information contained on claims, referrals or other channels. APHP also provides for the capture and cross-reference of TPL carrier and employer information, as available from the originating source.

APHP uses coverage information, such as coverage type (i.e., dental, vision, long term care, comprehensive medical, pharmacy drugs, inpatient services only and professional services only), coverage effective dates and plan limits, to enable automatic cost avoidance, pay and chase or pay and report activities, depending on the rules defined by the Agency.

We will collaborate with the Revenue Collections Contractor to support post payment recovery processes. Our solution allows for receipt of recovery information through either file updates or the APHP Portal. Our financial processing and payment management solution maintains financial data at the lowest level of detail and provides for Third Party Resource (TPR) recoveries to be associated to the individual claim level. Once payment is received from a carrier, Medicare or other insurance vendor, APHP prompts the Revenue Collections vendor specialist through the business workflow to disposition the payment across individual claims or claim lines. This activity is supported through the APHP history-only mass claim adjustment process, which provides verification steps throughout to assist the TPL specialist in assigning the monies to the appropriate claim. In addition, APHP supports the entry of gross level history-only adjustments when payment cannot be tied back to individual claims. APHP financial management screens will allow tying of refund or recovery back to the billed claim. Recoveries are available for viewing and reporting within APHP.



TPLR-2 Att L - 20

APHP's configurable workflow tool streamlines operations by automating correspondence and alerts based on defined schedules or process outcomes. This means that APHP can recognize events, such as receipt of a claim identifying TPL without any TPL on the member record or receipt of a claim with trauma procedure or diagnosis codes, to trigger the automated production of correspondence such as TPL and trauma lead letters. APHP software converts flat files of outbound mail data into print-ready copies for spooling to the designated Agency print shop or for distribution through the APHP Portal secure message function. APHP stores both inbound and outbound correspondence in the OnBase Enterprise Document Management System. Correspondence is stored with appropriate Meta data to enable easy retrieval from the APHP Portal or for reporting purposes.

TPLR-3 Att L - 20

APHP maintains MMIS data within the Dimensional Data Store (DDS) to allow easy access to this information by the Agency and authorized users. Because we know that the IME contractors often require member, provider and claims data to support their work with the Medicaid program, our product provides the Agency with standard product member, provider and claims extracts from our DDS. The Agency can configure APHP to send these extracts from the DDS to desired recipients, such as the Revenue Collection contractor, on a defined schedule, including monthly as desired by the Agency.

TPLR-4 Att L - 20

Accenture staff will work closely with the Revenue Collection contractor to support efficient operation of the Agency's TPL processes. Our APHP solution increases TPL business process efficiency by enabling automated updates to member, claims and accounts receivable records through data exchanges with the Revenue Collection contractor. APHP can accept and capture matched data and TPL recovery information from the Revenue Collection contractor files on a schedule defined by the Agency, including weekly. APHP processes coverage updates and captures the source and date/time of the update in the member's coordination of benefits (COB) eligibility information, providing an audit trail for member TPL data updates. The Agency and Revenue Collections contractor users can view these changes to member, claim and accounts receivable records through the portal immediately after file processing.

TPLR-5 Att L - 20

The APHP Portal provides full query, view and update access to TPL information. Based on security permissions, authorized users, including the Revenue Collection contractor, will be able to review and maintain TPL information using the APHP Portal Member Information and Carrier Management functions.

TPLR-6 Att L - 20

Frequently, a non-custodial parent may provide health insurance coverage for children. To discover potential third party resources, APHP can receive data input from local departments of Social Services and Child Support Recovery Units. APHP accepts data files from these TPL sources per the defined schedule and captures the information within the member's record. APHP identifies the source of the TPL information and the date and time received.

TPLR-7 Att L - 20

The Agency's HIPP program, which pays for an insurance policy for Medicaid eligible members where it is more cost effective to pay the premium and/or co-pays and deductibles than paying claims through Medicaid, requires continuous update of member files. APHP captures HIPP plan, coverage, premium payment and TPL information from the State of Iowa Income Maintenance (IM) Social workers through the daily eligibility updates from the ELIAS system. The TPL Plan and coverage information is loaded in the APHP TPL records for each applicable member.

TPLR-8 Att L - 20

APHP receives and processes premium payments according to the federal and Iowa requirements. Our solution manages the premium payments to the member, employer, or insurer by calculating and generating payments and notices of payments (remittance advices) to impacted parties including the member, employer, or insurer. The payments and notices are generated on a monthly basis. Our solution includes the ability to process the payments using the EDI X12 820 (Premium Payments) processing. The payment cycle and processing is configurable and can be designed to meet the States requirements. The payee can also select on their preferred payment method (EFT or check) and the notifications can be sent via paper or through email.



TPLR-9 Att L - 20

APHP creates and issues HIPP remittance advice. It allows accurate response to queries from authorized users and applications. Remittance Advices (RAs) are created, issued, or reproduced through the user-friendly APHP Portal, in hardcopy, in standardize electronic format or in a non-technical language based format. The RA business processes and workflows are triggered by receipt of data sets resulting from the pricing, audit and edit processes. The APHP workflow management engine drives the required manipulation of the data according to business rules and creates the required output data set. The workflow process generates an outbound transaction.

TPLR-10 Att L - 20

Transparency and visibility into the effectiveness of TPL cost avoidance and recovery processes requires both administrative reports for fiscal planning and control and operational reports to measure the TPL unit's productivity, quality and efficiency. Our reporting solution delivers reports to help the IME manage TPL business processes.

APHP contains a centralized reporting data store, tools and reporting functions providing immediate and holistic view of TPL operations, service and performance. We collaborate and openly communicate with the Agency during all phases to solidify requirements for TPL reports. Our APHP reporting solution allows for the rapid creation of reports to be deployed in standard crosstab format or via a web dashboard. Key data can be summarized and stored for historical comparisons and trend analysis.

TPLR-11 Att L - 20

Medicaid covered services include payment of group health plan premiums when a member's enrollment under a group health plan is cost-effective. Medicaid generally considers a healthcare premium payment cost-effective when the costs of a member's Medicaid services are likely to be greater than the cost of paying the premium for a member to receive care under a group health plan. APHP contains a core financial component that captures and applies multiple types of premium payments for those members that are not Medicaid, but are eligible for other benefit plans like AIDS/HIV. The APHP solution allows for the creation of HIPP cases for enrollees that are not Medicaid members because a member's record is based upon a benefit plan, and not if they are enrolled in Medicaid first. Through this flexibility, we can include HIPP members that are part of a different program such as AIDS/HIV or a future ACA plan.



4C.14 PROGRAM MANAGEMENT AND FEDERAL REPORTING

2.7.14 Program Management and Federal Reporting

The Contractor shall perform operational requirements for the Program Management and Federal Reporting functions. The Program Management function supports the IME’s strategic planning, policy-making, monitoring, and oversight activities and to effectively report to the Centers for Medicaid and Medicare or other federal agencies or business partners as needed.

Program Management and Federal Reporting operational responsibilities are included in Attachment L – Operational Requirements Matrix.

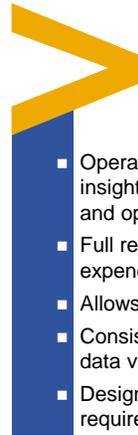
It is essential for Medicaid agencies to incorporate and maintain a dependable accounting system with various financial analysis capabilities to assist with budgetary controls and meet auditing and reporting requirements for both Agency and federal regulations. APHP’s accounting management solution provides comprehensive finance and accounting functionality allowing the Agency to achieve high reliability and performance through quantifiable improvements in service, capabilities, and cost. Our MIDAS MMIS solution design performs in accordance with laws and federal reporting requirements established to meet business needs.

APHP provides access to an extensive out-of-the-box reporting library with the capability to produce additional reports. Ad-hoc reporting capabilities allow the Agency maximum flexibility in meeting ongoing management reporting needs and also providing the federal reports required by CMS. We understand that timely access to complete and accurate reporting is crucial to the administration of Iowa’s Medicaid program. Our IA MMIS solution provides authorized users the ability to access a library of predefined reports and/or easily create their own ad hoc reports.

Accenture’s component for Enterprise Reporting and Analytics provides a full range of tools and services to help workers create, use, and manage reports. It has features that enable the extension and configuration of the reporting functionality. This component has capability to produce reports at the program (Agency), operations (IA MMIS), and service (contractor) level, meeting all CMS reporting and Program Management requirements. Features include access to comprehensive data from IA MMIS and other source systems, real time and historical data available in a single tool, and dashboards for operational and service metrics. This functionality addresses the needs of both Program Management reporting and Federal reporting.

The main objectives of the Program Management business area are to provide management with key information to properly monitor the MMIS and the MMIS contractor performance as well as to administer and manage the Medicaid Program in a fiscally responsible manner. The APHP solution provides the State visibility into operational and program level performance by providing transparency and access to operational and program metrics in near real time.

The federal reporting process involves the categorization of services and expenditures to provide the CMS comparative measures and insights into how the State is spending their Medicaid funds. Federal reports are produced from APHP’s dimensional data store (DDS). The DDS contains claim data down to the claim detail service level. Each paid claim record is processed through a configurable rules engine which assigns an MSIS category of inpatient, long term care, other non-institutional, or prescription drug to the claim header or claim line as specified in the MSIS Data Dictionary rules. The APHP solution also stores the Federal expenditure category as well as multiple State defined expenditure and service categories down at the claim detail service level. This design enables the State to perform ad-hoc analysis by Federal and State expenditure categories. This gives the State the ability to trend and forecast expenditures ahead of the generation of any of the CMS reports.



APHP’s Reports and Dashboards Provide Meaningful Insight into Program and Operational Performance

- Operational Excellence Dashboard providing up to the hour insight into operational metrics, such as claim suspense and open prior authorizations
- Full report library of reports to analyze Medicaid program expenditures, utilization and participation
- Allows for ad-hoc analysis across all expenditure categories
- Consistent, reliable data extract, transform and load (ETL), data validation and cleansing
- Designed to be adaptable to changes in Federal and State requirements

IA MMIS-2 4C14-01



Want to see more? PROGRAM MANAGEMENT and FEDERAL REPORTING Screenshots

available in the Technical Specifications Supporting Information folder of the electronic submittal.



APHP provides a comprehensive view of the MIDAS MMIS operations. APHP enables near real-time reporting functionality through our Operational Excellence Dashboard (OED). The OED provides up to the hour statistics by collecting operational data from across the enterprise into an Operational Data Store (ODS). The ODS is loaded with transaction level business activity metrics. Examples include claim submission statistics, current suspense inventory, PA submissions and call center volumes, to name a few. These metrics and statistics are available to the Agency, through an easy to access and use dashboard, any time of day or night.

APHP produces the federal reports/files/interfaces currently required by CMS. APHP maintains the data sets required by CMS for MSIS reporting. Specifically:

- Inpatient hospital claims
- Long term care claims
- Other, non-institutional claims
- Prescription drug claims
- Eligibility

Financial transactions, adjustments, or other updates to claim data are applied according to the business rules specified by CMS so that the APHP MSIS file captures the corrections in the applicable reporting period.

APHP reporting meets the CMS federal reporting guidelines. The reporting features of APHP enhance and extend common MMIS reporting features because APHP ad-hoc capabilities offer robust flexibility and transparency. APHP has a server-based reporting dashboard that integrates with the rest of the solution and offers useful features including charts, matrices, custom layouts, ad hoc reports, custom report items, and a variety of presentation formats. The reporting dashboard provides navigation ease and allows various aggregations and graphical elements.

Accenture also recognizes the importance of program level reporting to provide the Agency with visibility into how the program is performing. APHP comes with a complete Medicaid program reporting capability. Program level reporting is done against a report data store designed specifically to support program level reporting and analysis. This Dimensional Data Store (DDS) is the database that supports the APHP program level reporting. The APHP DDS provides a wealth of information for program management analysis and produces a growing inventory of management and aggregate reports to support the Medicaid program.

APHP provides Program Management reports to provide insight into the Iowa Medicaid program. Our Program Management reporting solution contains standard reports for program performance, provider participation, service utilization, access to care analysis, enrollment statistics, capitation payment analysis, expenditure reporting, and reimbursement reporting and monitoring. The APHP DDS also enables trending of the various metrics tracked across the program.

Our Processes and Controls

APHP reporting offers search, selection, and drill-down features that leverage the capabilities of the Microsoft SQL Reporting Services (SSRS) toolset, providing the Agency with flexible online access to a reporting library with relevant data vital to strong program management and administration. Whether the Agency is monitoring Medicaid operations or examining Medicaid program metrics, we provide an easy to navigate reporting and dashboard capability within APHP. Our technology offers numerous useful features including ad-hoc report generation, creation of custom report layouts, metric aggregation and reporting output with various visualization capabilities like pie charts, bar graphs, and other drag and drop dashboard controls; all providing presentation formats to provide clear, 'at your finger tips' information. Our reporting data stores collection information across the enterprise and makes that information available to the Agency and other key Medicaid stakeholders.

APHP has a robust and flexible integrated dashboard and reporting system which provides both high-level and granular views of the Iowa Medicaid program. APHP's DDS consolidates data about Medicaid expenditures, participation and utilization. APHP reports data in a variety of ways providing the Agency appropriate insight into program metrics. APHP provides access to an extensive out-of-the-box reporting library with the capability to produce additional reports. Additionally, ad-hoc reporting capabilities allow the Agency maximum flexibility in meeting ongoing management reporting needs.

APHP federal reporting produces the reports/files/interfaces currently required by CMS and provides the scalability, flexibility, and fast configuration capabilities to meet future requirements without costly, time-consuming new coding. Via APHP's user-friendly interface, an authorized user can quickly re-configure a federal report by setting specific parameters and functions to execute the report. The configuration process for building the federal reports uses a suite of Microsoft COTS products. These tools make it quick and easy to change the



format, frequency, or data elements used to create a report. APHP generates federal reports on schedules determined by the Agency and CMS.

Accenture applies multiple control activities to maintain a high quality of federal reporting functions and output. Policy analysis for changes is an important aspect of control procedures. Our program team will review policy changes and determine a change impact analysis. Processes require the review of the Federal Registry and state/Federal legislation for control measures. Such policy changes will be quickly implemented in APHP for federal reporting. The reporting dashboard can be reconfigured quickly without major programming updates that might impede delivery and are costly.

Response to Attachment L Requirements

For each Attachment L requirement narrative response we provide a cross reference of the requirement number and the page of the matrix provided in Tab 4G: Worksheets for Submission.

Att. L Req. Tab 4G Page
PMRR-1 Att L - 21
APHP provides a comprehensive view of the MIDAS MMIS operations. It enables near real-time reporting functionality through its Operational Excellence Dashboard (OED). The OED provides up to the hour statistics by collecting operational data from across the enterprise into an Operational Data Store (ODS). The ODS is loaded with transaction level business activity metrics. Examples include claim submission statistics, current suspense inventory, PA submissions and call center volumes, to name a few. These metrics and statistics are available to the Agency, through an easy to access and use dashboard, any time of day or night.

PMRR-2 Att L - 21
The APHP reporting tool provides all required reports and meets the timeframes and requirements of the Agency. We work with the Agency to understand the reporting requirements. These requirements are input to the operational guides created to be used during operations. It is understood that significant program decisions are made based on the data and analysis provided by APHP's reporting.

Existing reports serve numerous useful functions such as allowing current financial status/activity to be compared with prior period status/activity, historical trends, outline expenditures, utilization, and other activities. The reports help the Agency plan for fiscal budget forecasting, policy changes, and trends in provider, member participation, etc. Both existing and newly developed reports can be executed on-demand or automatically generated on Agency-requested frequencies. Additionally, APHP transmits data based on Agency-defined business rules specifying any criteria, any schedule, and any destination. Also understood is the significance of the program decisions that are being made based on the data and analysis provided by APHP's reporting. Our proposed reporting solution brings together the right tools, people, and processes to produce all required reports and information in the timeframes required and in the manner desired by the Agency.

PMRR-3 Att L - 21
The APHP provides reporting tools that provide "drag and drop" functionality so users can create their own queries, allowing for rapid report building. Using powerful and flexible COTS tools, such as Microsoft's SSRS, allows users to quickly and easily build additional reports as they need to further analyze operations and the program. APHP's reporting capabilities are very broad; therefore we do not foresee any issues in generating special reports that are supported by the existing capabilities and data within the system.

APHP's SSRS solution contains out-of-the-box standard queries and views into the data to allow for easy, ad-hoc creation of reports without having to build a report from scratch. We include prebuilt dashboards for each of the operational areas that allow managers and Agency stakeholders to view how each operational area is performing. These dashboards contain key performance indicators (KPIs), inventory levels, and "work on hand" to aid operational leaders in assigning work and increasing overall efficiencies. The reporting features are easy to use and reports can be generated quickly. The Agency will be able to request special or ad-hoc reports through the service request function of the service management process. We work with the Agency to rank all service requests so they can be worked according to the Agency's priorities.

PMRR-4 Att L - 21
As requested by the Agency, we collaborate with the impacted IME Team contractors to model and report to the Agency financial, access and utilization impacts on proposed program modifications. Accenture personnel are assigned and participate in the Agency's change process for cost, schedule, and impact on system operations. Using our governance and change management process, these requests will be prioritized and completed on a mutually agreed to schedule and



priority. We collaborate with Agency personnel and other impacted stakeholders to fully understand the specific business needs and desired outcomes the Agency wants documented in the reports. The Agency will be able to request program modification modeling through the service request function of the service management process. We work with the Agency to rank service requests to be worked according to Agency priorities.

PMRR-5 Att L - 21

APHP's report balancing process includes review of all process summaries to verify accuracy and consistency between reports before they are delivered to the Agency.

For MMIS processing, APHP applies cross-checks of similar totals and counts. If items do not balance as they should, the system generates an alert. Upper and lower control limits are established to monitor metrics for statistical variances. Historical benchmarks or averages are also incorporated into peer reviews in order to verify accuracy and consistency of report data. Data outside normal control limits will be manually reviewed for accuracy by comparing report output to source system outputs.

PMRR-6 Att L - 21

Accenture works with the Agency to improve reporting. We review requirements and offer suggestions to generate reports that provide valuable insight into Iowa Medicaid program performance. For example, if the State does not have an analytical report covering a salient issue, our solution can provide the Agency overview of different reporting metrics to help determine what best suits the specific reporting requirement.

APHP's reporting modules are a valuable tool to support the administrative and monitoring duties of the Agency. APHP's reporting function supports the Agency in monitoring eligibility and program utilization, evaluating performance indicators, overseeing the program budget, and initiating program changes in response to defined regulatory developments or trends identified through data analysis.

The list below reflects the various reporting modules in APHP. It is our expectation that many of the Agency's reporting needs will be satisfied by existing reports in the reporting modules.

- Member Reporting Module
- Provider Reporting Module
- Program Reporting Module
- Operations Reporting Module
- Federal Reporting Module

Accenture staff collaborates and teams with the Agency during operations in determining what reports are useful and used regularly and what reports are not being used. Accenture, working with the Agency, will make recommendations based on report utilization and reviewing query patterns from ad-hoc users of the system. We actively look for opportunities on improving the reporting process and make recommendations to the Agency.

PMRR-7 Att L - 21

APHP's flexible, integrated design makes adding, changing, and discontinuing report data elements easy and subsequent report updating seamless with no additional cost to the Agency. The data items include, but are not limited to, benefit plans, categories of service, special programs, member aid categories, provider types and provider specialties.

Flexibility and adaptability are the hallmarks of the APHP, providing the Agency efficiency and timeliness in program management reporting. Impact of changes is minimized by APHP's approach to designing and implementing reports. The design approach is to not "hard code" values such that changes to values of data elements affect how the report would behave. This enables the changes to be carried forward in affected reports without additional cost.

PMRR-8 Att L - 21

APHP's reporting design enables the Agency to easily produce ad-hoc reports on request. The solution architecture provides fast access to data there by enabling rapid report generation in flexible formats. The basis of the reporting component is a comprehensive reporting data store which is maintained separately from the claims processing engine of the MIDAS MMIS to give rapid and efficient data access and analysis. By using a database and platform separate from MMIS transaction processing, our design prevents ad-hoc reporting from impacting production claims processing and other transactions. The Agency will request ad-hoc reports through the service request function of the service management process. We work with the Agency to rank service requests so they can be worked according to the Agency's priorities.

PMRR-9 Att L - 21

APHP has a standardized interface that integrates with Medicaid legacy systems or other external entities. We produce and deliver data extracts on the Agency's timeline. We can produce the required reports to external entities based on the Agency-specified timeline. The timeline will be developed during the Analyze, Configure, Design phase and carried over into operations.



PMRR-10 Att L - 21

If a reporting error is detected, Accenture reporting resources work closely with the stakeholders responsible for the metric to understand the source of the report error. Data outside normal control limits is commonly the trigger for these types of activities. If the report data is confirmed inaccurate, reporting impacts will be assessed and incorrect reports are remediated and resubmitted, as necessary. Activities performed in support of data correction, report generation and remediation are performed at the cost of the MMIS Contractor. Quality Assurance documentation is generally reviewed and revised to control any future incidents of the report error.

FRR-1 (a-j) Att L - 21

APHP generates and delivers CMS reports 21, 37, 64, 372, 416, and the Quarterly Ethnicity report plus the SF269, as part of the reporting solution. APHP also produces the MSIS files per CMS requirements in the MSIS File Specifications and Data Dictionary. These reports and files meet the formatting requirements and are produced and delivered on the schedules currently published by CMS. See Table 4C.14-1 for the correlation of existing capabilities of APHP to the production of each required report. APHP provides an interoperable framework with a reporting dashboard that easily fits into the Agency's current environment while providing the foundation for future expansions. CMS Standard reports will be reviewed and agreed upon with the Agency during the ACD phase.

Table 4C.14-1. Each report meets the standards listed in the opening statement and its specific responsibilities specified in this table.

Report	Definition	Existing Capability
CMS 21	Accenture solution produces the Quarterly Children's Health Insurance Program (CHIP) Statement of Expenditures containing information on CHIP expenditures and administrative costs which reconciles actual advances and expenditures for which states are entitled to Federal reimbursement under Title XXI and which reconciles any advance of Title XXI Federal funds made on the basis of estimates provided on the Form CMS-21B.	✓
CMS 21 B	Accenture solution produces the Children's Health Insurance Program Budget Report which is the basis for advances of Federal matching funds for CHIP.	✓
CMS 21 E	Accenture solution produces the required report on enrollment in child health programs that are not part of Medicaid. Alternately, it can also report SCHIP Medicaid expansion programs on the CMS-64.21E Form.	✓
Quarterly Ethnicity Report	Accenture solution produces the Quarterly Ethnicity Report.	✓
CMS 64	Accenture solution produces Quarterly Expense Report -- including all required forms on Medicaid benefit costs and administrative expenses.	✓
CMS 37	Accenture solution produces the Medicaid Program Budget Report on budget estimates for Federal matching funds	✓
T-MSIS Data	APHP will create T-MSIS files for reporting on a quarterly basis, or as needed, when mandated by CMS. As the T-MSIS requirements evolve and become ratified by CMS, APHP will support these new standards. APHP maintains all the data sets currently required by CMS for MSIS reporting.	✓
CMS 372	Accenture solution produces the Report on Waiver Expenditures according to the current lag requirements.	✓
CMS 416	Accenture solution produces Early and Periodic Screening Diagnostic and Treatment Participation Report.	✓
MSIS and CMS Tapes SF269	Accenture solution produces MSIS and CMS tapes within the appropriate timeframe for federal reporting. Accenture solution produces the Financial Status Report, which accounts for all uses of Money Follows the Person Rebalancing Grant Demonstration monies, submitted semi-annually.	✓ ✓



FRR-2 Att L - 22

APHP supports Payment Error Rate Measurement (PERM) for reporting of metrics on error rates of expenditures for Iowa Medicaid to CMS. The APHP reporting data store receives data via an ETL process that also extracts claims in compliance with CMS quarterly claims sample frequency requirements for PERM reporting. The output is in CMS-approved formats and media and is transmitted to the statistical contractor (SC) using CMS-required security procedure.

FRR-3 Att L - 22

The Accenture modifies reports as requested by the Agency and makes the modifications available within Agency-specified timeframes. APHP is designed for flexibility to allow rapid, easy modification of reports. The federal reporting input, output, and business functions may be modified based on changes in policy, data, or implementation. Modifications can be made to standard report features such as selection criteria, printing, exporting, report generation, output, or custom fields or functions. When requesting modifications to reports, the Agency will use the service request function of the service management process. We work with the Agency to rank service requests so they can be worked according to the Agency's priorities

FRR-4 Att L - 22

APHP generates the CMS 64 Variance Reports and CMS 21 Variance Reports for the current and prior three quarters to give a full picture of an entire rolling year of budget and expenditures for CHIP and Medicaid programs. Reports are available for delivery to the CMS Medicaid Budget and Expenditure System within timeframes and formats required by the Agency. Authorized users can easily investigate report details using the online reporting capabilities of the APHP reporting solution.

FRR-5 Att L - 22

APHP will create T-MSIS files for reporting on a quarterly basis, or as needed, when mandated by CMS. As the T-MSIS requirements evolve and become ratified by CMS, APHP will support these new standards. APHP maintains all the data sets currently required by CMS for MSIS reporting.

FRR-6 Att L - 22

APHP prepares and delivers the Quarterly Report of Abortions (CMS 64.9b) to the Agency as part of the Federal Reporting module. The report is part of the APHP reporting solution and meets CMS and State requirements.

FRR-7 Att L - 22

APHP prepares and delivers to the Agency the report on the expenditures under the Money Follows the Person Program. The APHP reporting solution identifies and reports expenditures and related information for Medicaid recipients who transition from institutions to person-based care. The reporting data store can provide data for generating Money Follows the Person (MFP) reports to meet Federal compliance requirements.

FRR-8 Att L - 22

APHP's reporting solution identifies and reports the Federal Financial Participation (FFP) rate for each claim line. APHP provides many measures of enrollment by categories and costs of assistance. Our team will work collaboratively with the Agency to develop useful reports specific to Agency needs on FFP rates. The APHP portal's extensive repository can be configured to generate FFP reports, and users can easily run ad-hoc reports as needed from their desktops.

FRR-9 Att L - 22

APHP's reporting dashboard produces a report of pharmacy drug rebate amounts for inclusion on federal reports. Additionally, Accenture's experienced team works with the Agency to gather and report any Agency-specific information needed.

FRR-10 Att L - 22

APHP is configured to regenerate reports and interfaces such as MSIS with no additional costs to the Agency. The APHP reporting solution has control procedures to identify errors, which can expedite report regeneration. In addition, any mass adjustment of federal report codes can be identified with Accenture's control procedures for federal reporting and impacted reports can easily be regenerated. APHP is scalable and configurable without the administrative costs of paper-based claims systems or the limited features of systems that only focus on claims. APHP will create T-MSIS files for reporting on a quarterly basis, or as needed, when mandated by CMS. As the T-MSIS requirements evolve and become ratified by CMS, APHP will support these new standards. APHP maintains all the data sets currently required by CMS for MSIS reporting.



4C.15 FINANCIAL REPORTING AND MANAGEMENT

2.7.15 Financial Reporting and Management

The Contractor shall perform operational requirements for Financial Reporting and Management. The Financial Management and Reporting function supports claims related financial processing including claim payment processing, adjustment processing, accounts payables and receivables, interface with Iowa's financial accounting system, and generation of claims financial reports such as Remittance Advices (RA's), Explanation of Medical Benefits (EOMB's), 1099's and other benefit expenditure reports.

Financial Management operational responsibilities are included in Attachment L – Operational Requirements Matrix.

It is essential for the IME to incorporate and maintain a dependable Financial Management and Reporting systems that include various financial analysis capabilities to assist with budgetary controls and meet auditing and reporting requirements for both State and Federal regulations. Through the claims engine and report manager the financial management functionality provides a comprehensive solution that allows IME to achieve high reliability and performance through quantifiable improvements in service, capabilities, and cost. APHP's Financial Management component supports funds management including various accounting services such as:

- Creation and management of accounts payable and receivable
- Performs or assists with reconciliations of payments
- Supports coordination of benefits including EOB generation
- Management of fund recoveries due to an audit, cost settlement, TPL recovery, etc.
- Financial reporting through standard reports, ad hoc, and dashboards
- Creating premium payment(s), provider payments, reconciliation of checks
- Creation of the Remittance Advice
- Management of payment information and the annual production of 1099's

Access to information is available online, through the APHP Portal for authorized users. This information is accessible to the State's financial systems in a flexible manner that can be adapted to the State's changing requirements over time with minimal system change. Our solution will support compliance with the identified State and Federal requirements, and will support the reconciliation of funding with CMS, to avoid penalties and costly recovery activities, and to provide support for the State's initiatives.

Our solution includes processes that are used to receive, send, track and process financial transactions, coordinate with third parties for other payer liability, pay providers and managed care organizations, pay Medicare premiums and complete other claim, benefit plan and service transactions.

This allows the IME to receive the support that is necessary for the financial management actions and transactions to be automated as much as possible with built-in quality checkpoints. Our web-based access to real-time financial information, reporting and analytics will provide the State a holistic view of their budget, outstanding credit balances (account receivables), and incoming funds (cash receipts).

Financial Management Overview

The Financial Management functionality is based upon MITA 3.0 and includes a robust integration of rules-based components to support much more than a simple claims processing system. APHP initiates automated processes and workflows that:

- Support funds management and automate financial reporting
- Process accounts payable and receivable
- Perform or assist with reconciliations
- Support coordination of benefits including Explanation of Benefits (EOB) generation, shown in Figure 4c.15-1
- Automatically interface with claims processing
- Provide secure access to information



Oversight of Medicaid Program Financials is Enhanced with Real Time Access to Key Information

- Automated EOB/Remittance advice distribution
- Comprehensive capabilities include void processing and stop payments, credit and adjustment processing and electronic fund transfers
- Fund source and payee information available online

IA MMIS-2 4C15-01



Want to see more? FEDERAL REPORTING and FINANCIAL MANAGEMENT Screenshots

available in the Technical Specifications Supporting Information folder of the electronic submittal.



Financial Reporting

We schedule weekly, monthly, and annual financial reports to run in the system. We work closely with the state to set the format, content, and specific schedule to run these reports. Reports show the date for the end of payment cycle and the date the report is generated to confirm compliance with the requirement timeframe.

APHP's capabilities support automatic reconciliation reports between accounts payable and accounts receivable, APHP's automated financial reporting functionality summarized in Figure 4C.15-2.

Through the use of the APHP Report Manager, authorized users have an easy-to-use, Web-based reporting solution that provides faster access to accurate and up-to-date claims, financial, client and Provider information among other key program metrics. Included in components are standard financial reports that assist the State in daily, weekly, monthly and annual financial management.

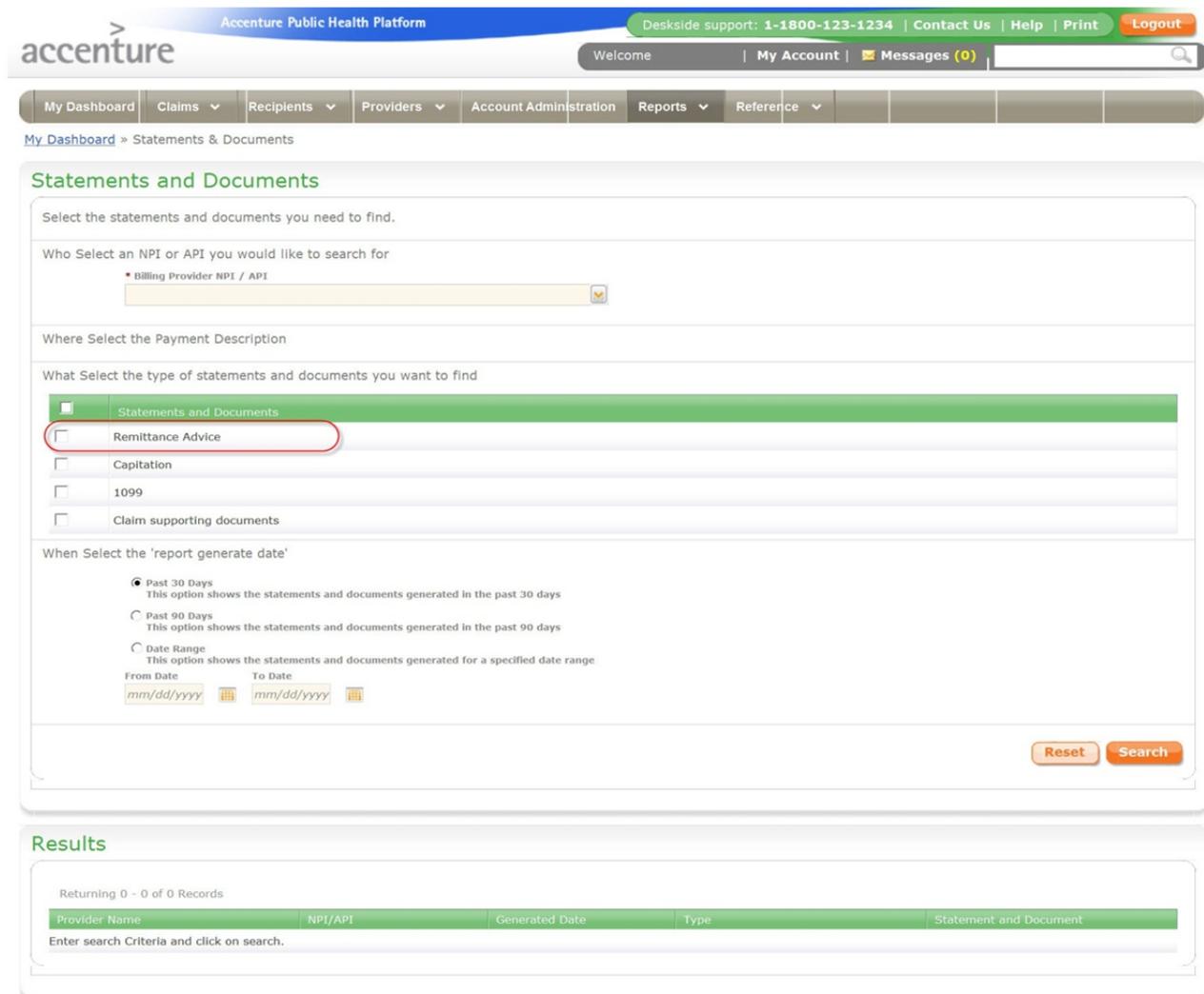
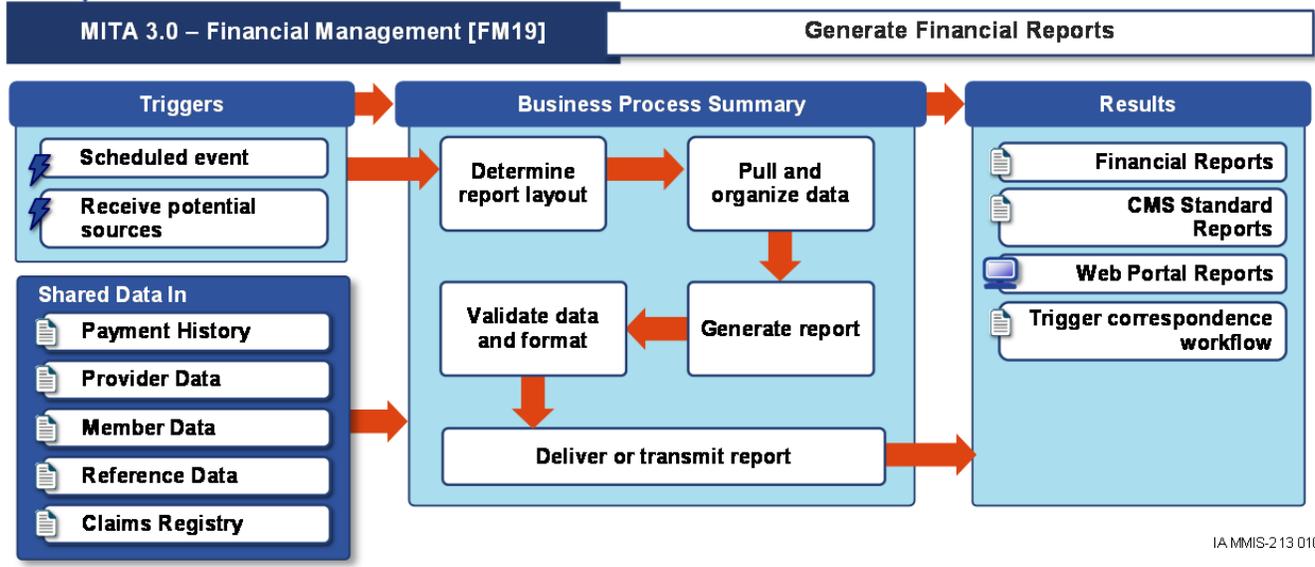


Figure 4C.15-1: APHP's Statements and Documents Feature enables users to research and/or maintain financial records.



IA.MMIS-213 010-D

Figure 4C.15-2. APHP uses automated workflows, configurable rules, standard dashboards, and templates to improve decision-making and automate reports.

Financial Account

An important factor within the APHP financial functionality is the “Financial Accounting” as reflected in Figure 4C.15-3. Through our solution we use this record to maintain specific financial information such as the tax or social security number. This is viewable for approved users within the Financial Module along with the associated base record (provider, member, or carrier).

By diversifying how the solution groups the data in our system the State has the flexibility on how they manage the State funds. Below are examples of what this means for the State:

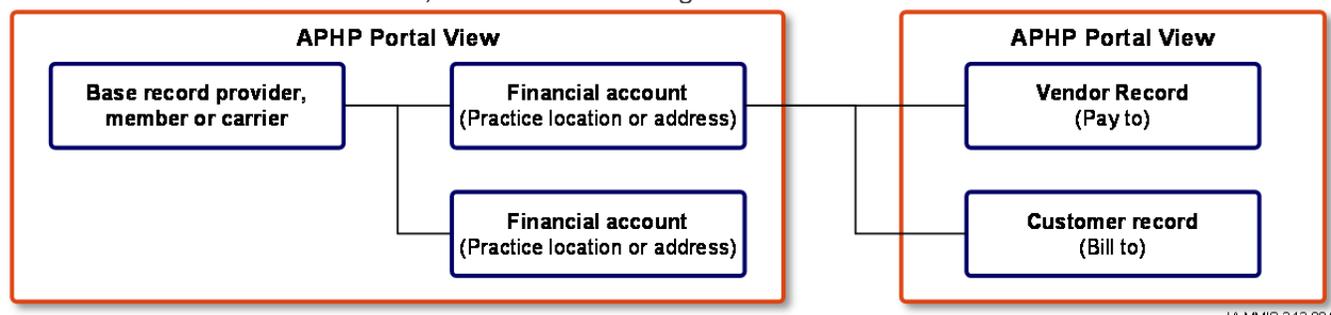
- Allows payment to a specific provider (NPI) at a specific practice location (Tax ID) without impacting their associated addresses
- Separates the payment of a business (Tax ID) from the program (NPI + Taxonomy) it allows the State additional choices on how to implement new federal or legislative changes
- Financial segregation to support the State charts of accounts and fund code reporting structures

Response to Attachment L Requirements

For each Attachment L requirement narrative response we provide a cross reference of the **requirement number and the page** of the matrix provided in Tab 4G: Worksheets for Submission.

Att. L Req.	Tab 4G Page
FMR-1	Att L - 22

The APHP Portal includes a financial management module that supports accounting functionality including the management of accounts payable, accounts receivable, check-write/EFT functionality, and remittance advice. The financial transactions are recorded, posted, tracked and maintained as part of the financial account base records in accordance with GAAP standards, State and Federal regulations.



IA.MMIS-213 084

Figure 4C.15-3: APHP has created a new way to manage the financial information to support future changes.



APHP updates claims history and online financial files with payment information such as the check number, electronic funds transfer (EFT) number, and warrant number/check number, date of payment, payment status and amount paid after the claims payment cycle.

The creation and management of the remittance advices is generated through the automated workflow per configurable business rules or can be manually retrieved via our "Report Manager" tab. The secure Provider Portal also allows authorized users to review payment status and details, including check amounts, as well as view and download remittance advices posted to the portal following the adjudication cycle as reflected in Figure 4C.15-1.

FMR-2 Att L - 22

We understand Wells Fargo is the entity that produces and transmits the electronic fund transfers. Through the Financial Management functionality within the claims engine the payment disbursements process pulls in available transactions created by the accounts payable process and bundles them into accurate and timely payments ready to be paid to providers, members, and other payees.

The amounts to be paid (medical and pharmacy) are input to the claims payment process which interfaces with the accounting modules to create an accounts payable transaction for each amount. Payment and Financial Account information is included within the State specific file to be submitted to Wells Fargo for EFT payments. Additionally a file will be submitted to the print vendor for the print and fulfillment of paper checks.

APHP will produce and handle checks a weekly basis for Residential Care Facilities (RCF) only until such time as the Agency transitions to another solution. This will be handled in the same manner as it currently is being performed for the Agency.

FMR-3 (a-d) Att L - 22

APHP accurately reports claims data for financial management and analysis. We work closely with the Agency to gather requirements and update APHP's rules engine. The APHP Portal contains a reporting dashboard with comprehensive features for federal reporting, program reporting, and other Agency reporting requirements.

Reports are easily setup for content, format, frequency, and media. The reporting dashboard also allows configuration of reports for financial information such as services, eligibility codes, and fund codes. Customized reports can be quickly created for presenting numerous kinds of information including claims data from each processing cycle. The reports can be setup for parameters such as schedule, format, and distribution requirements. The APHP process for populating the data stored that are used for reporting provides report data accuracy

APHP provides an interoperable framework for easily customizing reporting functionality to the Agency's current environment while providing the foundation for future expansion. The solution uses service-oriented architecture that allows flexible configuration of data from multiple sources via an extract/transform/load (ETL) process which loads data from MMIS areas such as provider, member and reference, and from Agency-specified external sources. APHP integrates those multiple data sources to provide information on financial items such as:

- MMIS claims from each processing cycle
- Online entered non-claim-specific financial transactions such as recoupments, mass adjustments, cash transactions and other non-claim-specific financial transactions
- Provider, member and reference data from the MMIS
- Individual claim records for claims not paid through the MMIS

FMR-4 Att L - 23

Through the Mass Adjustment module within the worker portal IME will have the ability to enter a mass adjustment requests based on a variety of criteria. The solution uses native functionality of the re-adjudication filter for assisted claim selection processes. Data can be entered and edited online through the Portal or uploaded from MS Excel spreadsheets.

Mass adjustments can be requested due to rate changes, changes to benefit plans, for cost settlements or to group claims for a particular provider, or other data. The system processes payment adjustment data from external sources. APHP supports the online entry and management of gross adjustment financial data such as debit and credit entry of cash receipts or other non-claim specific financial transaction (premium billing, invoice receipts, expense reimbursements, etc.).

When a request is entered, all of the affected claims are displayed for review, as well as the dollar amounts affected, so that the user can assess the impact of the mass adjustment prior to executing it. Once satisfied, the user can release all or part of the adjustments based on the review. This functionality can also be used by the



Agency as a modeling tool in the impact analysis environment to determine the impact of potential business rules, policies, and rate changes.

FMR-5, FMR-6 Att L - 23

APHP is based upon MITA 3.0, which includes the Payment and Reporting business processes as reflected in Figure 4C.15-1. The disbursement of payment processes within the claims engine payment information is updated in the claims history records and financial files. The payment maintenance process includes respective claims, provider, member and financial history records. This includes the check number, electronic funds transfer (EFT) number, and warrant number/check number, date of payment, payment status and amount paid.

Automated EFT and electronic remittance advices (ERA) for claims processing activity are provided to authorize users via industry standard HIPAA compliant transactions through the flexible architecture within the APHP framework. Common attributes of electronic remittance advices such as payment transfer, total payment, itemized payment, and related services are pre-configured for electronic remittance advices and can be easily changed by authorized users.

APHP has the flexibility to generate EFT transactions on a variable or pre-defined schedule. In addition the solution has the ability to send either paper Remittance Advice notifications or Electronic Remittance Advice (ERA) notifications based on entries in the provider record. The solution will mail paper checks and remittance advices to specific provider groups produced by the current Agency contractor which is understood to be Residential Care Facilities (RCF). This will be handled in the same manner as it currently is being performed for the Agency through support of the framework.

FMR-7 Att L - 23

APHP's enterprise data management feature provides an electronic copy of the check payment register to the Agency following each check-write in the format and with the content approved by the Agency. We collaborate with the Agency during the Implementation Phase to finalize the Agency approved format and content.

This is completed through the development of a state specific report from the general ledger transactions generated by the MMIS and supporting financial packages. APHP cross references the information to support reporting and query requirements so that users can access and view, directly from the portal, detailed payment information including check number, EFT number, warrant number, payment date, and payment amount.

FMR-8 Att L - 23

APHP runs a check-write payment cycle and EFT authorization on a schedule determined by the Agency. APHP's flexible design allows job scheduling to be easily updated by authorized users should the need for special cycles occur.

FMR-9 Att L - 23

APHP will generate and distribute remittance advices to all providers pursuant to the Agency guidelines and timeframes. APHP applies the rules engine and formats the results based on the Agency requirements. The process generates output for remittance advices. The outputs are printed in hardcopy or transferred with standard electronic formats.

FMR-10 Att L - 23

The APHP solution has a pre-packaged MITA 3.0 business process designed upon PE05 Prepare REOMB. Through the reporting functionality APHP generates EOB notices to Members who received services under the plan as described in §11210. Per business rules configuration, EOB Notices will be sent within 45 days of the payment of claims. Members can also see EOBs online via the secure portal.

Our solution sets up EOMB data in an encapsulated format with the appropriate parameters such as Medicaid services received in previous month, date of service, provider, procedure, and amount paid. The flexible document formatting capabilities inherent to APHP allow the user to define the manner in which the EOMB is presented to the member.

APHP generates EOB notices to members based on random and focused sampling requirements as defined by the Agency. The sampling methodology of members is configurable, and can be easily changed from the 1 percent sample currently used by the Agency as needed. The sample set of EOMBs is combined with State specified targeted members or group of claims and then mailed to each appropriate member.

Our solution supports the delivery of EOMB documents to the member through hardcopy mail and electronically via the secure, easy to use message center of the APHP Member Portal. EOMB documents are member correspondence and are accessed by authorized users for review and reprint through the document



management system. APHP provides an interoperable framework for managing Medicaid benefits that will easily fit into the Agency's current environment while providing the foundation for future expansion.

FMR-11, FMR-12, FMR-13 Att L - 23

APHP will make twelve months of EOMB data information available via the user-friendly Member portal. APHP operates print requests at a minimum of three cycles per week of claims history and runs a minimum of five cycles per week of member history requests. APHP also operates print requests at a minimum of one cycle per week for purged claim history requests. The core features of APHP allow updates and viewing of claims history with such attributes as check number, date of payment, amount paid, and the claims payment cycle.

Through the forms management integrated with all of the product components produces required correspondence, letters, and notices to members, providers, liable third-parties and other data trading partners. The APHP will produce Remittance Advices (RAs) and EOMB forms in a variety of media, including hardcopy, or electronic format. Additionally, APHP enables authorized users (providers, workers, members, IME contractors, etc.) to use the self-service portal feature to access claim and financial information, including claims status, check amounts, remittance vouchers, explanation of medical benefit forms, or other transaction information.

FMR-14 Att L - 23

APHP is configurable to provide the Agency of Inspections and Appeals a file of all checks paid out and EFTs. The APHP portal is configured for integration with appropriate internal and external data sources in the service-oriented architecture to generate the records needed for checks paid out and EFTs. The solution is designed for easy, secure generating and processing of interface files. Additionally, the reporting dashboard generates information on checks paid out and EFTs and can be easily customized to Agency requirements. APHP provides an interoperable framework that will fit into the Agency's current environment while providing the foundation for future expansion.

FMR-15 Att L - 23

APHP produces electronic files of monthly billings for entities responsible for the non-federal share of claims. The financial management module of APHP is integrated with the financial repository of data for billing entities and the non-federal share of claims. Our APHP has an interface that easily reports financial transactions for analysis of non-federal share of claims. Trained business process analysts collaborate with the Agency to configure the solution to comply with the State's requirements.

FMR-16 Att L - 23

APHP's documentation subsystem prints billings for entities responsible for the non-federal share of claims as directed by the Agency. Alternately, APHP creates electronic EDI billings or billing interface files for delivery to Agency-specified recipients.

FMR-17 Att L - 23

We understand, from a review of Iowa's policy, that licensed Intermediate Care Facilities for the Mentally Retarded (ICF/MR) certified to participate in the Medicaid program that are not operated by the State are obligated to pay a monthly assessment fee to the Agency.

The Agency deducts each facility's monthly provider assessment fee from their monthly medical assistance payments. APHP is highly configurable and can identify the non-federal share of transactions including those for ICF/MR providers. APHP has the ability to stamp transactions at the claim and line level with the date, federal report code, and State account which allows delineation between federal and non-federal share amounts.

The rules engine will mark the non-federal share of ICF/MR as financial transactions that are not transferred to the accounts receivable system. This consequently prevents collection triggers to the Agency. APHP has the ability to recoup and issue hold harmless add-on payments.

FMR-18 Att L - 24

APHP specifically supports the automation and real time capability for overall program financial management, including the necessary data exchanges and process flows that occur between the MMIS and the Integrated Information for Iowa (I/3). This includes the ability to maintain specific codes and code sets so as to align with predetermined practices that support program cost center appropriateness. APHP will review the code sets as part of the ACD with the financial team to validate our solution captures all of the code sets.

FMR-19 Att L - 24

APHP is capable of extracting information required for billing entities responsible for the non-federal share of benefit expenditures and quickly download the information to a SQL-server based A/R system. The solution uses a SOA design with an access layer, business services layer, and data layer. The extraction process for billing entities is a standard, automated process within the solution.



FMR-20 Att L - 24

APHP manages the billing process for entities responsible for the non-federal share of specified services. It provides transaction processing functionality that allows claim lines to be split across funding sources. At the same time, it applies accurate, prescriptive payments to providers, members and other authorized entities based on IME business rules and defined payment methodologies. The transactions are assigned to accounts based on user-defined account assignments.

The detailed accounting of funding source supports the invoicing of billing entities for the non-federal share of the cost of services provided to members. APHP utilizes a claims engine that natively supports the ability to produce invoices to individuals, organizations or other entities when an overdue balance is discovered. Collection of the non-federal share could be accommodated through invoice generation or the creation of AR directly from the claims adjudication process.

FMR-21 Att L - 24

APHP leverages the EDI component for secure data exchange between the MMIS and external data sources and systems. In preparation for payment processing, the APHP financial management component will perform reconciliations for credit balance and offsets. APHP accepts the Department of Administrative Services Off-set file on a monthly basis and applies the offsets as part of the financial payment cycle. APHP generates a payment file for submission, via established secure interface, to the State's accounting system, which will be reflective of these offsets.

FMR-22 Att L - 24

Through the APHP Portal, authorized users have access to electronic standard and ad-hoc reports as well as graphic dashboards, built from real-time information. Users access report and dashboard functionality within APHP's enterprise reporting module through the report management feature of the APHP Portal. The financial reporting includes reports: Monthly report for return of Federal funds for accounts receivable (AR), Collection activity, balances, and status for all AR by category, and providers who have received collection notices.

FMR-23 (a-i) Att L - 24

APHP generates provider remittance advices in electronic, paper, and pdf format that meets ANSI X12 835 standards. APHP includes the 9 items listed in FRM-23 requirement within the remittance advice identified in Table 4C.15-1.

Table 4C.15-1. APHP offers a flexible solution to meet remittance advice requirements.

Information Included on Remittance Advice	Existing Capability
Our solution provides an itemization of claims that were paid, denied, or adjusted and any financial transactions that were processed for that provider, including subtotals and totals.	✓
The APHP solution provides an itemization of suspended claims.	✓
The solution provides adjusted claim information showing the original claim information and an explanation of the adjustment reason code.	✓
APHP generates the name of the insurance company, name of insured, and policy number for claims rejected due to TPL coverage on file.	✓
APHP provides explanatory message relating to the claim payment cutback or denial.	✓
The solution generates a summary section containing earnings information regarding the number of claims paid, denied, suspended, adjusted, in process, and financial transactions for the current payment period, month-to-date, and year-to-date.	✓
APHP provides an explanation of benefits payment messages for claim header and for claim detail lines.	✓
The solution provides patient accounts and medical records where available.	✓
APHP provides a comprehensive database of fields required to support the Agency. The APHP solution provides the ability to include any of the data in the APHP database on the Remittance Advise, as required by the Agency.	✓



Accenture has experience in managing claims data for X12 formats for 45 Code of Federal Regulations Part 162: ASC X12N 835 and ASC X12N 820. We invest in addressing the needs of future Medicaid financial management, providing the capability for expansion into the future.

FMR-24 Att L - 24

APHP allows authorized users to insert informational messages on remittance advices (RAs) or a supplemental document. The process logs transactions into the APHP solution. The control procedures calculate and assess the impact of each transaction. Users can view the remittance advices and add annotations or attach documents. Communication artifacts are configured to accompany payments with multiple messages available on a user-maintainable message text file that has selectable print parameters such as provider type, claim type, and payment cycle dates. APHP provides flexible framework that allows for future expansion as requirements for RAs and informational messages evolve.

FMR-25 Att L - 25

APHP is capable of suppressing the generation of zero-pay checks and EFTs while still generating associated remittance advices. Zero-pay checks occur when a provider has an outstanding credit balance (whether carry-over from prior cycles or generated in the current cycle), and the reimbursement for the cycle in question is not enough to cover the outstanding credit. Therefore, the offset results in a net zero, or zero paycheck. Our solution allows the insertion of business rules to apply a threshold to the financial process. Thus, if the calculated check amount is zero or less, the check print is suppressed. APHP still reports the transaction to the provider on the 835 transaction.

FMR-26 Att L - 25

APHP provides each provider's 1099 information annually to the State. APHP's process of 1099 preparation and electronic reporting complies with IRS specifications. The solution calculates 1099s based on FEIN or Tax ID and accumulates payments to the same Tax ID on a single 1099. APHP's workflow generates notification to the provider's secure portal inbox when their 1099 is ready. The completed 1099 is viewable in the portal by the provider associated with the Tax ID and approved Agency users. APHP produces quarterly reconciliations of 1099 activity to cash and adjustment reports and individual payment reports. We actively resolve 1099 issues through research and responds to provider inquiries for 1099 postings in a timely manner. Any updates will amend 1099s while retaining the original 1099 input. We comply with IRS B1 and B2 protocols for resolution of mismatched data.

FMR-27 Att L - 25

Through the worker portal authorized users have the ability to manually issue a check by the state and associate to a financial account. As part of the work item an AR is also created that can include the ability for the worker to set when the recoupment begins as directed by the State. An adjustment to the providers 1099 earnings data is included for non-claims payments.

The advancement can be pre-dated and an AR automatically triggered using the pre-dated date related to the AP. APHP uses the automated workflow and process engine to drive business rules and processes. Using the output from a financial process activity, such as "Provider Advance Established", APHP allows for the configuration of a resultant step within the workflow engine. Upon the completion of the first step, the next step in the workflow configuration would be "Create Invoice" such that the provider's advance notice is immediately offset by the action to invoice the provider for the receivable.

FMR-28 Att L - 25

APHP supports user setup of liens and payment assignments directing payments to the provider and lien holder(s). This is accomplished by configuring a provider's withholding to route a percentage or a set amount of the provider's payment to the lien holder identified within APHP as a Vendor or Pay-To person. The withholdings process includes setup of criteria that indicate percentage or amount, frequency, and total amount to be withheld.

FMR-29 Att L - 25

We recognizes the Agency is charged with paying for actual services rendered, so that overpayments -- both planned and unplanned -- must be tracked carefully. APHP identifies providers with credit balances and no claim activity during the Agency specified number of months and generates an audit report of credit account balances on an Agency defined frequency including quarterly. The easy-to-use reporting dashboard is integrated with financial management data, so reporting queries clearly reflect months and providers with a balance greater than \$0, but no claim activity during the specified time period. The reports can be quickly generated and printed or exported.



FMR-30 Att L - 25

APHP generates overpayment letters (invoices) and provides information on recoupment procedures to providers based upon the business rules for the attributes associated to the accounts receivable (AR). The invoice may be delivered electronically or mailed based upon the financial accounts preferred communication method.

FMR-31 Att L - 25

Accenture provides paper, envelopes, check stock and all services associated with printing and mailing Residential Care Facility (RCF) letters and checks, including lien holder provider checks. We understand paper transactions, though typically more expensive than electronic, are necessary and accept these costs.

FMR-32 Att L - 25

APHP Enterprise Reporting and Analytics provides a full range of tools and services to help manage program administration, leveraging the use of contract management and performance measures reporting dashboards. APHP reports financial transactions by source including TPL recoveries, fraud and abuse recoveries, provider payments, and drug rebates.

FMR-33 Att L - 25

The APHP Framework consists of a core claims COTS product which natively delivers comprehensive claims payment processing services. Upon completion of the claims payment process, which is automated via the APHP automated workflow and process engine, a claims payment file is created for payment issuance. APHP's core claims product supports claims payment processing for providers and other entities who choose to receive payments via Electronic Funds Transfer (EFT). Our open architecture and systems interoperability allow authorized data exchange between APHP and State approved entities, allowing the transmittal of financial data electronically from the MMIS directly to the Agency or the entity responsible for producing EFT.

FMR-34 Att L - 25

APHP provides functionality to support county billing based on the IME's need to collect the non-Federal share of specific services. Invoices generated from the financial management component within the claims engine, will be provided in an electronic file, via secure data exchange, to the county offices. Subsequently, if paper invoices are required, the APHP document management component will support the creation and distribution of the paper invoice.

FMR-35 Att L - 25

APHP provides functionality to support county billing based on the Agency's need to collect the non-federal share of specific services. APHP accumulates paid claims and stores information on each claim line, including member's county of legal settlement, to support county billing.

FMR-36, FMR-37 Att L - 25

Through the claims engine APHP provides invoices generated from the financial management component to the carriers, county offices and other entities as defined by the Agency in an electronic file, via secure data exchange. If paper invoices are required, the document management component will support the creation and distribution of the paper invoice.

FMR-38 Att L - 25

APHP provides accounts receivable functionality that generates a financial transaction for every receipt. Receipt source data is kept in the financial transaction record such that the AR can be easily traced back to the provider, member or other entity that submitted it to the program. AR and Accounts Payable (AP) management leverage standard services which can be applied across all areas of financial management. APHP will utilize the claims COTS product to process financial transactions for providers, members and other entities. All data supporting outstanding AR balances will be applied during the payment cycle to offset provider payments accordingly.

The APHP Framework delivers a core financial management component (accounting system) supporting the capture and application of multiple types of accounts receivables (AR) including, but not limited to, premium collections, cost settlements and recoveries generated from estate probate, client annuities, and property liens. All financial data surrounding provider credit and AR transactions, including claim history applicable to the AR or credit balance, will reside in the APHP operational data store (ODS). The APHP Enterprise reporting component will access this data for standard and ad hoc reporting as required.

We provide reports that help manage proper budgetary control of the Agency and related Medicaid stakeholders. The APHP portal transmits financial data, manages the billing process, and accumulates claims information. The documentation system will produce paper reports for mailing. APHP is preset with the core ability to track amounts of financial transactions. The interface allows comprehensive adjustments of related business services to fulfill these requirements via configuration.



4C.16 PROGRAM INTEGRITY

2.7.16 Program Integrity Management

The Contractor shall perform operational requirements for Program Integrity. The Program Integrity function within the MMIS accommodates and provides for the necessary data interfaces from the MMIS to the Service Utilization and Review module managed by the Program Integrity contractor, including paid claims and provider profile information.

Program Integrity operational responsibilities are included in Attachment L – Operational Requirements Matrix.

We understand our role in providing the data (in the form of actionable information) for the Agency and other contractors to manage the Medicaid Program. The IME will be able to use paid claim and provider data from APHP to examine and monitor the performance of Medicaid providers, collect and analyze traditional fee-for-service claims data with encounter data and validate that program policy is being administered correctly. The analysis of claims and encounter data enables IME’s Program Integrity contractor to identify fraud, waste, and abuse trends as well as help identify potential gaps in services or provided services that are inconsistent with diagnoses. Of utmost importance are the integrity, confidentiality and availability of this data to the operational areas that we support.



Secure Information Exchange for the IME

- Secure delivery of files and reports through APHP EDI capabilities, APHP web portal, and other secure transmission methods
- Multiple secure and efficient delivery channels promote, protect and safeguard data integrity and confidentiality
- Integrated workflow tool allows ability to efficiently configure new or modify existing custom interfaces
- Controlled and proven processes foster efficient and accurate data management and reporting workflows

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Using APHP, data exchange in multiple formats through several mediums will be available to the IME. It provides secure delivery of files and reports through APHP Electronic Data Interchange (EDI) capabilities, secure web services via the APHP portal and flat files sent through secure transmission methods. We understand the criticality of efficient, accurate data interfaces and data exchanges that will support the Program Integrity contractor in their work with the IME.

Our Processes and Controls

Collaboratively, we will work with the IME and other trading partners to address secure and reliable exchange of data. Our adherence to structured Health Insurance Portability and Accountability Act (HIPAA) compliant data exchange protocols for both standard and customized interfaces is a priority and APHP web services’ capabilities uses Secure File Transfer Protocol (SFTP) interface access, or secure email in data formats such as Portable Document Format (PDF) or an Excel spreadsheet. APHP includes robust reporting functionality for rapid development of standard reports and a user friendly interface for ad hoc reporting. Please reference Section 4C.14 Program Management and Federal Reporting for a more detailed explanation of our reporting capabilities. We are committed to protecting your client data and our experience with Texas Medicaid Healthcare Partnership, with over 900 interface files and 40 external partners, shows our capability in managing the data exchange and related security requirements that help maintain data integrity.

We accept the responsibility to provide the IME Program Integrity (PI) contractor and other PI stakeholders, including the Agency, timely and accurate claims, encounter, provider, and long term care (LTC) payment information. During the Implementation Phase, we meet with the Agency to document and validate the required interfaces. During operations, we apply quality assurance checks based on those requirements to meet four specific operational process criteria as discussed in Table 4C.16-1.

Control and monitoring of the file and report submissions is critical to supporting the Agency's program integrity module. We will validate the deliverables necessary to support the Program Integrity contractor and other stakeholders (Member services contractor, MFCU, Agency of Inspections and Appeals).



Table 4C.16-1. Quality assurance processes help mitigate risks, promoting Program Integrity through collaboration and open communication.

Criterion	Description
Completeness	Each file or report record must contain values in the required fields. Any missing fields or values will trigger an alert that initiates a research action to determine if there is a system issue or problem. Optional fields are also evaluated and reported in an overall data profile report for each submitted file.
Accuracy	Each file is balanced to validate that the total number of records written for the output files match the selection count for all the records that meet the extract criteria. Reports are balanced as part of the process and errors are rejected and escalated for review.
Consistency	We perform the current week's record/report counts to the previous week's record/report counts or average counts to determine if the variance is outside a specified range. This additional quality check identifies deliverables that do not contain all the expected records or contain other volume anomalies, which when identified are routed via workflow to the appropriate user.
Timeliness	Operational processes include monitoring for file/report creation from the production schedule. We generate an alert if the expected deliverable is late and escalate it appropriately.

Response to Attachment L Requirements

For each Attachment L requirement narrative response we provide a cross reference of the **requirement number and the page** of the matrix provided in Tab 4G: Worksheets for Submission.

Att. L Req.	Tab 4G Page
PIMR-1, PIMR-2, PIMR-3, PIMR-4	Att L - 25

APHP provides secure delivery channels for sharing and exchanging data with IME partners in accordance with HIPAA. We will work with the Agency and other IME Team contractors to establish standard interoperability protocols. Sharing partners, including the Program Integrity contractor, the

Member Services contractor, the Medicaid Fraud Control Unit and the Agency of Inspection and Appeals will receive file exchanges and reports securely and in a timely manner as stipulated by the Agency and shown in Table 4C.16-2.

Table 4C.16-2. All requirements defining schedule and format are met.

Requirement	Acknowledgement
PIMR-1 Provide weekly or as required by the Agency, a file of all paid claims to Program Integrity Contractor, Member Services Contractor and a Medicaid Fraud Control Unit (MFCU).	✓
PIMR-2 Provide weekly or as required by the Agency, a copy of the provider claims history profile report to the Agency of Inspection and Appeals.	✓
PIMR-3 Produce for the Agency of Inspection and Appeals an electronic summary of LTC.	✓
PIMR-4 Provide to the Agency Medicaid Fraud Control Unit, weekly or as directed by the Agency, an electronic copy of all checks paid and Electronic Fund Transfers (EFTs) made.	✓

Our team will provide files and reports through web services, SFTP transmission, and email distribution of electronic file formats such as an Excel spreadsheet and viewable format from a document management system repository.

PIMR-5	Att L - 25
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In addition to managing the data interfaces between the SUR module, managed by the Program Integrity contractor and the MMIS, APHP portal services will be available to IME authorized entities such as the Program Integrity (PI) contractor. The Agency can share data and services with other agencies or departments, other states or the federal government.



4C.17 MANAGED CARE

2.7.17 Managed Care

The Contractor shall perform operational requirements for the Managed Care function. The Managed Care function within the MMIS accommodates and provides for the processing of member eligibility updates. Based upon member eligibility for one of the managed care options offered through the IME, this MMIS function supports the enrollment and disenrollment of members in managed care plans, the PACE program, or the transportation brokerage benefit.

Managed Care operational responsibilities are included in Attachment L – Operational Requirements Matrix.

Iowa has demonstrated its commitment to providing Medical Services to Medicaid members through managed healthcare wherever feasible. Our understanding is that there are currently five different managed care initiatives, none of which are capitated, in Iowa:

- A Primary Care Case Management (PCCM) program called the Medicaid Patient Access to Service System (MediPASS).
- A managed behavioral health plan called the Iowa Plan for Behavioral Health (Iowa Plan)
- The Medical Home program provides initial care and the majority of ongoing healthcare needs
- The Program of All-inclusive Care for the Elderly (PACE)
- The non-emergency medical transportation brokerage system

The Agency will receive a solution which provides the capability for expansion to support these plans and future managed care plans associated with Iowa Medicaid.

We support managed care plan administration natively in APHP. From benefit plan configurations that contain the managed care plan service coverage rules, member eligibility and enrollment records that connect the member to the specific plan services, through detailed encounter transaction processing and comparison against FFS payment methodologies for shadow pricing and other analytical review, APHP meets all Managed Care requirements of the IME today and will best position the Agency to operate like an MCO/HMO operational model in the future.

Our Processes and Controls

Using APHP's flexible framework of commercially based products, we configure rules for Iowa's defined managed care programs including capitation for primary care, behavioral health services, non-emergency transportation, home evaluation and medical home services – all specific to each individual plan based on program policy. All of these plans can be configured to be reimbursed alone or along with fee-for-service processing. These functions are configured based on the requirements agreed upon with the Agency including State requirements for annual category updates, creation of capitation rates, and monthly payment generation. In addition, we build rules in the medical claim system to identify the division of financial responsibility (DOFR) so that claims can be forwarded or not paid for services that are capitated or carved out. We support Iowa's commitment to providing medical services to Medicaid members through managed healthcare using a combination of a benefit plan and a provider reimbursement feature.

The Agency's goals are aligned with those of a managed care program that emphasizes communication, responsiveness and a strong customer service orientation. Accenture supports the Agency and managed care contractors through numerous defined activities and responsibilities. Our team collaborates with the Agency and the managed care contractors in the enhancement of managed care programs, with an emphasis on member eligibility and assignment, provider enrollment, program enhancement and the collection and analysis of encounter data.

The IME Benefits from Robust Functionality Designed to Effectively Manage Member Plan Participation

- Up-to-date member plan status and utilization information available by plan
- Detailed plan information such as covered services and limitations available online
- Workflows to assist with automation of enrollment and disenrollment activities
- Real-time communication channels via APHP portal available to assist managed care contractors

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Want to see more? MANAGED CARE AND PCCM Screenshots

available in the Technical Specifications Supporting Information folder of the electronic submittal.



We work closely with the Agency to meet your managed care goals of promoting and improving access to quality care in a cost-effective manner. As your partner, we will develop contractual standards for quality of care and other measures, collect data to measure compliance with these standards and position the Agency to either reward or sanction health plans based on their performance. Solution features and benefits for the IME are shown and described in Table 4C.17-1.

Table 4C.17-1. The IME benefits from a solution that brings numerous forward-thinking features to address current IA managed care requirements and accommodate future needs.

Features	Benefits to Iowa
Flexible tool capable of managing a multi-program and multi-plan environment	The ability to define and manage current and future programs using existing tool functionality without the need for costly and time-consuming code changes
HIPAA compliant security and data protection	Protected Health Information (PHI) and Personally Identifiable Information (PII) are secured through appropriate firewall and encryption protocols
Integrated and automated reporting solution that ties together data across the program lifecycle	Transparent and accessible data throughout the program lifecycle from enrollment through encounter and claims processing
Modular, MITA-aligned architecture	Meets the CMS Seven Conditions for Enhanced Funding and provides flexibility to share data with other systems through standard web services and interfaces and interchangeable tools to support changes in the future as new products and technologies become available
Document Management System	Improved quality, control, and efficiency with an estimated 24 hour turn-around of received documents. Configurable workflow to support various document types through an Integrated OCR/data entry functionality. Supports documents received and correspondence distributed in a single Enterprise Document Management store that is integrated with the MMIS, CRM and Portal solutions.

A benefit plan and provider reimbursement methodology is configured within APHP for specific options and related attributes for each plan. Each benefit plan has a unique identification number which enables customization for specific attributes, such as the capitation rates and service categories covered under that capitation. The unique identifier for each plan plays a significant role in the control management processes including audit trail and tracking of activity across each plan. The benefit plans include product and/or services that are covered for a member assigned to a capitated program. APHP allows updates without complicated, time-consuming and costly programming needed with legacy MMIS systems. It does this by allowing authorized individuals direct access to each of the core component's native business rules engine for program configuration. The advanced design of APHP allows reusability of benefit plan configurations for multiple groups and members who require specific Medicaid services.

Response to Attachment L Requirements

For each Attachment L requirement narrative response we provide a cross reference of the **requirement number and the page** of the matrix provided in Tab 4G: Worksheets for Submission.

Att. L Req. Tab 4G Page <u>MCR-1</u> Att L - 26	Our team will implement an automated interface to process enrollment, re-enrollment, or disenrollment of Medicaid eligible members into Iowa's managed care contractors and transportation broker. The Service-Oriented Architecture (SOA) model of APHP includes an Enterprise Service Bus (ESB) architecture that creates the opportunity for secure and accurate data exchange, data storage and reporting between the Provider Services contractor, the various managed care contractors and transportation broker processes and the Agency.
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As updates are received and processed into our system, we identify individuals/members who have terminated enrollment, dis-enrolled, or are deceased and should be excluded from capitation payments and adjust the calculations accordingly. Control reports are generated and available for reconciliation activities.

<u>MCR-2</u> Att L - 26	We accept and process managed care and transportation broker provider data from the Provider Services contractor. Managed care and transportation provider data is
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imported through structured update transactions from the Provider Services contractor to APHP through automated system operational protocols. Feedback is provided to the originating source, which includes a reconciliation of records processed in APHP against the incoming source file. This helps to verify proper totaling and supports error correction and synchronization early in the process to reduce the total processing time.

MCR-3 Att L - 26 APHP tracks and makes accurate payments to managed care contractors and transportation brokers. APHP pulls data directly from our claims processing component and captures department-defined rate factors including age, sex, category of eligibility, health status, and geographic location and automatically calculates per member per month (PMPM) capitation payments based on this data. Our solution enables the Agency to track the exact amount of eligibility per member, per month and calculates capitation payments in accordance with the actual days of eligibility per month. APHP also calculates and issues administrative, incentive and capitation payments as well as capitation adjustments.

MCR-4 Att L - 26 APHP enables IME to automatically implement State and program rules to correctly identify capitated services and suppress fee-for-service (FFS) payments as well as a FFS duplicate services. Using APHP's rules-based solution, we configure the system to identify services covered under capitation payments and automatically deny duplicate FFS payments. For detailed operational capabilities on how we adjudicate FFS claims, please refer to Section 4C.9 Claims Adjudication.

MCR-5 Att L - 26 We will work with the Agency during ACD to fully understand the inventory of reports required by the Agency. APHP will enable the Agency to automatically track and report on FFS claims for services performed outside of capitation agreements (e.g., for services “carved-out” of the managed care program). APHP reports offer an extensive array of out-of-the-box reports. Reports can be tailored by user, scheduled to run at a certain day/time and can be available through an ad hoc schedule.

Because APHP integrates Case, Member, and Care Management functions, related information to support managed care initiatives is consolidated and made available through the portal. This level of integration:

- Increases effectiveness of Case Manager
- Improves customer service
- Achieves optimal outcomes

Real time data processing enables the availability for almost immediate reporting on capitation payments by managed care contractor or transportation broker containing a variety of categories including eligibility group and rate cell. APHP's reporting module allows the Agency and other stakeholders' actionable insight into the cost effectiveness of managed care.

MCR-6 Att L - 26 APHP provides the functionality to automate the operations and manage payments to managed care contractors and transportation brokers. APHP pulls data directly from the claims processing component. APHP captures Agency-defined rate factors including age, sex, category of eligibility, health status, and geographic location and automatically calculates per member per month (PMPM) capitation payments based on this data.

We will use APHP to print and mail provider checks and remittance advice notices and also send electronic payment transactions (ASC X12N 835 and 820) matching the standards required by 45 CFR Part 162. APHP also has the capability to generate either an electronic or paper remittance advice with electronic funds transfer transactions.

APHP supports electronic payment transactions and has the capability to handle HIPAA EDI transactions outbound via the portal. We send electronic payment transactions and prints and mails checks and letters to Residential Care Facilities (RCF) as is currently done and until an alternate solution is mutually agreed upon through the change management process.

APHP accepts special Agency payment requests, such as provider or capitation payments during the payment cycle. APHP also accepts directions to generate certain administrative payments as directed by the Agency. APHP validates data upload requests, applies instructions, and tracks activity. The Payment Information Repository provides access to payment records to other business area applications and users, such as the managed care program, member, contractor, and provider information processes, via record transfers, response to queries, and “publish and subscribe” services.



MCR-7 Att L - 26

APHP automatically enables IME to easily implement State and program rules to edit and deny payments to FFS providers, when the billed services are included in a member's benefit package. APHP identifies FFS services included in the benefit package and applies pre-packaged edits to block those payments for FFS providers in accordance with State rules.

APHP adjusts capitation payment based on reconciliation of errors or corrections (e.g., retroactive adjustments to a particular capitation payment based on more accurate data that the MMIS obtains retroactively on Beneficiary enrollments, dis-enrollments, and terminations). Data flows into the system via our automated interfaces and capitation rates and payments are adjusted as soon as the data updates are received.

If errors to FFS and/or capitation payments do occur, IME can rest assured that APHP will help IME Team contractors and the Agency to correct the errors in an accurate and timely fashion. APHP is designed to quickly configure and perform mass adjustments in accordance with State policies (e.g., annual adjustment, negotiated rate change, court settlement, etc.). Specific consolidated payment histories include:

- Encounters
- Claims
- Provider payments
- Capitation payments
- Beneficiary direct payments
- Services covered by capitation payments to insurance carriers
- Medicare buy-in payments

APHP reconciles and reports on beneficiary records against managed care and PCP enrollment records and automatically reverses incorrect payments on regularly scheduled intervals as determined by the Agency.

MCR-8 Att L - 26

APHP automatically generates HIPAA-compliant 834 electronic enrollment maintenance rosters to managed care contractors and transportation brokers using federal standards for member-level data exchange, but customized by the Agency's policies and procedures. The 834 frequency is twice per month, several days before the first and 15th of each month or on a schedule as determined by the State. While the generation of electronic enrollment rosters is preferred, paper based enrollment rosters can also be generated.

MCR-9 Att L - 26

We will automatically post remittance advice to the web-based Provider Portal for viewing by managed care contractors and transportation broker immediately following the completion of the financial cycle. All providers, including the managed care contractors and transportation broker, can review payment status information, including check amounts, as well as view and download remittances advice posted to the APHP Provider Portal following the financial cycle.

MCR-10 Att L - 26

Accenture is very aware of the Agency's emphasis on quality through programs that provide statistical processing controls, key measurements and improvement processes. APHP collects and prepares critical managed care and transportation broker data for the actuarial contractor. Data is shared with the actuarial contractor through APHP secure data exchange and will be transmitted on an Agency approved schedule.



4C.18 ELIGIBILITY VERIFICATION SYSTEM (ELVS)

2.7.18 Eligibility Verification Information System (ELVS)

The Contractor shall perform operational requirements for the ELVS function. This area of responsibility provides support for recipient eligibility request and response by providing eligibility data for use through an IVR system, web portal access, or standard HIPAA inquiry/response (270/271) transaction. ELVS operational responsibilities are included in Attachment L – Operational Requirements Matrix.

Iowa Medicaid will receive an eligibility verification (EV) solution that is a native part of APHP and supports multiple mediums. Defined as the EV component within APHP, eligibility verification services integrate with the existing IVR system via web services for EV transactions, while also providing user friendly APHP portal access, shown in Figure 4C.18-1 which puts the EV information at the user's finger tips. Additionally, we process standard HIPAA inquiry and response (270/271) transactions through the EDI gateway. As with other APHP modules, the ability exists to configure Iowa specific rules for EV.

Automated Eligibility Verification Maximizes the Administrative Effectiveness Across the IME

- Eligibility verification using multiple mediums
- Integration of IVR functionality and web services for eligibility verification transactions
- User friendly web portal access for verification
- Reduces eligibility searches in multiple systems

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Regardless of the medium, requests are funneled to a single data source, APHP member eligibility components. This allows the Agency to have a single, secure source for eligibility information that is also linked to provider and claim information and includes integration with the existing IVR. With APHP, Agency users no longer have to access multiple systems depending on the type of data, whether it is member eligibility, claim information or provider information.

Our Processes and Controls

The Accenture Delivery Methods for the APHP Member Eligibility functionality focus the integration with existing IME functions, such as the IVR. This methodology supports the following and is used as a basis for ongoing enhancements:

- Requirements and use case analysis
- Functional and technical design
- Technical architecture development
- Deployment of the solutions
- Post deployment changes related to ongoing maintenance

Eligibility Verification - Charlie Alford Add To Recipient Group Add Download PDF

Inquiry Information			
NPI / API 1225031271	Eligibility From 08/30/2013	Eligibility To 09/30/2013	Verification Date
Last Name Alford	First Name Charlie	Member ID 590001BIN	
Social Security Number	Date of Birth 02/05/1979		

Member Information			
Name Charlie Alford	Date of Birth 02/05/1979	Gender M	Member ID 590001BIN
Address 2751 Leo Ct, Des Moines IA, 50301	Social Security Number	Medicare Number	
Country			

Medicaid Segments		
Benefit Code ARMMIS-Arkansae	Benefit Desc Medicaid FFS	MedicalCoverage M1 Medical / Dental
Program FFS-FreeForService	ProgramType Title XIX	SpendDownIndicator
Effective Date 10/01/2012	Terminate Date	Created date 08/05/2011

IA MMIS-2 13 408

Figure 4C.18-1. Authorized users can verify eligibility through single sign-on within the APHP Portal. <Data in screenshot is fictitious>





Response to Attachment L Requirements

For each Attachment L requirement narrative response we provide a cross reference of the requirement number and the page of the matrix provided in Tab 4G: Worksheets for Submission.

Att. L Req. Tab 4G Page
EVSR-1 Att L - 26
We deliver member eligibility updates to the IVRS through web services as a native capability of APHP. These web services are provided to the IA IVR, allowing the Agency to provide real-time access to the most current information that is stored on the MMIS. APHP provides eligibility information in standard HIPAA X-12 270/271 to various interface partners including the IVR. Also, APHP can be configured to support custom interfaces with the IVR, if required. APHP receives and refreshes eligibility information from ELIAS and stores the information securely in APHP. APHP makes the data available for multiple uses by authorized users. We will collaborate with the Agency as to the frequency of updating member eligibility based on business needs.

EVSR-2 Att L - 26
The necessary data elements are sent to IVRS via web services from APHP through automated operational protocols. This functionality is native in APHP and uses existing out-of-the-box web services. The IVR verifies information it receives from touch-tones entered by the provider and sends those inputs to the APHP MMIS database for verification. Once verified, the APHP responds with information to the IVRS through secure web services with the appropriate data elements.

EVSR-3 Att L - 26
Requested member eligibility and provider information will be provided back to the requestor through the IVRS. Voice response is available to all providers with a touch-tone telephone as a typical standard in an IVRS. We will meet this requirement by continuing to use the existing IVR system and integrating it via web-services with APHP as the source data.

EVSR-4, EVSR-5 Att L - 26
Our solution conforms to state and federal confidentiality laws and meets Agency data security standards. Confidentiality of eligibility information will be protected. Only authorized administrative users have access to the source data/system. Administrators accessing the system will need to log in through a Graphical User Interface (GUI) and Command Line Interface (CLI). User passwords are inaccessible and are encrypted on the system using the 128-bit Secure Hash Algorithm (SHA). This provides the needed security to keep unauthorized personnel from obtaining confidential information within the APHP database. Additional information on our security processes and approach can be found in section 4B.3.1.f.

HTTP over Secure Sockets Layer (SSL) access to the GUI is added for secure connectivity to the system. Additional security features include configurable system behavior when end users erroneously log in to telephone user interface (TUI) handling. This approach gives the Agency the flexibility to apply its specific security policies.

To support member identification when users try to access the IVR, the users are prompted for their predefined access key information. The IVR system authenticates the information provided by the user and gives the user access to only those items to which they should have access based on their security profile. Our team works with the State to leverage existing predefined access keys to limit the impact to end users.

EVSR-6 Att L - 26
APHP will automatically log all transactions for member eligibility. We log key information as it is available, including date and time of request, medium, requestor (if available from the IVR), and member information. APHP enables the Agency, upon request, to view requests for eligibility information from phone inquiries as well as the APHP UI as we share/leverage a common logging component, which eases the burden on the Agency.

EVSR-7 Att L - 26
If requested by the Agency, APHP will interface with the IVR to report on caller statistics via an ad-hoc or standard report out of APHP. We will support similar reporting out of the IVR chosen by the State for implementation in early 2014.

EVSR-8 Att L - 27
We will coordinate with the Agency to provide sufficient communication capabilities to all providers utilizing the system. An Acceptance Review (AR) will be conducted (hardware, software and data capacity) to document final acceptance by the Agency that the defined eligibility verification support requirements have been met. In addition to those requirements, the frequency of the data updates will be included.



The process for conducting these ARs is documented in the Acceptance Review Delivery Plan (ARDP). This plan encompasses the appropriate groups and responsibilities of each group, and delineates the overall approach which the data elements as well as major systems and components must meet to be compliant with the Agency's requirements. An ADRP containing documents verifying quality, reliability, and functional acceptance of the MMIS integration to Iowa's IVR is delivered to the Agency.

EVSR-9 Att L - 27 We will leverage the support agreement between the State and vendors and partners, such as Cisco, the Iowa Communications Network (ICN) or DHS Division of Data Management (DDM) to address performance and operational issues with the MMIS. For issues that are assigned to our team and are believed to be defects in the delivered applications or infrastructure, we will initiate contact with the vendor's support Infrastructure to resolve the issue. Additionally, we will maintain contact with the vendors throughout the investigation and resolution of the issue to help confirm that the issue is actively tracked and ultimately resolved. In rare cases where critical issues require escalation, members of the State's leadership team are used to escalate issues to the vendor client support representative.

EVSR-10 Att L - 27 We will take over the existing IVR system with its current functionality that includes this ability and we will maintain it via our service management methods and protocols such that erroneous computer generated pronunciations are addressed accurately.

EVSR-11 Att L - 27 The operational issue management process provides a systematic approach for identifying and managing technical or operational issues. The process consists of steps for identifying, analyzing, prioritizing, resolving, reporting, and escalating issues on an ongoing basis, and it includes notification to identified Agency designees within one hour of issue identification.

EVSR-12 Att L - 27 We will provide knowledge transfer to the Provider Services contractor in the use of IVRS options and will work collaboratively with the IME Provider Services contractor to plan and deliver training on the use of IVRS and respond to questions from the Provider Services contractor. We will work collaboratively with the current Provider Services contractor to:

- Provide input to help identify personnel that would benefit from each targeted training session. It is expected that the identified attendees have a role in using or supporting the IVR System.
- Develop a Knowledge Transfer Approach to address knowledge, skill, and ability gaps through collaboratively working and communicating the Provider Services team.
- Plan and schedule "lunch and learn" sessions as a forum for ongoing knowledge sharing based on a jointly established set of topics and times to minimize disruption to normal business activities.

Self-service knowledge transfer is also available to the IME Provider Services contractor through a provider education icon on the homepage of the APHP provider portal login screen.

EVSR-13 Att L - 27 Defined as the EV component within APHP, eligibility verification services integrate with the existing IVR system via web services for EV transactions, while also providing user friendly portal access which puts the EV information at the user's finger tips. Additionally, we process standard HIPAA inquiry and response (270/271) transactions through the EDI gateway. As with other APHP modules, the ability exists to configure Iowa specific rules for EV.

EVSR-14 Att L - 27 APHP supports the integration of electronic eligibility verification received from encoded member cards as part of the base out-of-the-box functionality. APHP receives and processes requests received from eligibility data in APHP and produces a response to the inquiry using standard HIP4A GDI X12/5010 transactions.



4C.19 WEB SERVICES

2.7.19 Web Services

The Contractor shall perform operational requirements for the Web Services function.

The Web Services function enables providers, members, and other Agency-designated entities to electronically send and receive secure HIPAA and non-standard transactions, access information and managed information maintained through the web portal.

Web Services operational responsibilities are included in Attachment L – Operational Responsibilities.

The IME will benefit greatly through improved access to information and increased functionality for providers, members and other Agency designated entities. The APHP Portal provides the Agency, a single access point to all Medicaid business functions of the COTS component applications, through a consistent, easy-to-use web interface for providers, members and IME staff.

The Agency will benefit from web services that are designed to be flexible, scalable and configurable to meet the demands and expectations of an expansive Medicaid program. The APHP provider, member and worker portals provide the Agency with the ability to tailor the user interfaces specifically for Iowa Medicaid, while remaining adaptable for the future to accommodate Iowa programs needs and changing Federal regulations.



Communication, Collaboration, and Participation are Enhanced Across the IME with a Robust, Secure Web Portal Product

- MITA aligned, standards based, configurable
- Single sign-on to all components
- 24x7 Self-service web based portals for providers, members, and workers
- Intuitive, consistent web interface
- Configurable to meet IME specific needs
- Configurable content management

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Our Processes and Controls

APHP web services communicate using X12/5010 standards, the APHP MITA business services and with non-standard transaction formats. Modifications and enhancements of the APHP portal are controlled through the same change management and configuration management procedures as we use during the Implementation Phase of the MIDAS MMIS Project. Our change management procedures are aligned with the Project Management Institute's (PMI) Project Management Body of Knowledge (PMBOK) and Information Technology Infrastructure Library (ITIL) operational procedures. We are CMMI Level 4 assessed in the public sector and apply those principles to the APHP portal operational procedures. We adhere to these procedures from the time an APHP portal change is initially identified to the time it is implemented. Following a consistent, repeatable process, each portal change request is properly documented, evaluated and managed by the Project Management in conjunction with the Agency.

Web Services Operational Functionality

The APHP portal is not just a browser enabled version of a window or screen nor is it the user interface from a supporting COTS product in the Application Layer. The APHP portal is an advanced medium through which a well-constructed interface provides better, faster ways of doing work especially for the Medicaid community. It is built to accommodate the Agency's desire for ease of use and provides multiple avenues to access and manage information that is ultimately coordinated and saved in a single location.

Web service plays a critical role in providing the Agency with a flexible tool to provide secure data exchange and communication between the Agency staff, IME members, provider community, member community and business partners. Given today's Medicaid environment, web access and ease of navigating through the APHP portal is crucial to meeting the provider's high expectations of customer service. Providers submit claims, members get issues resolved, and all stakeholders communicate through an interactive portal that provides critical and timely information to all Medicaid stakeholders. The APHP portal interface gives access to providers, members and workers/IME partners in a consistent and integrated way. All users get the same look and feel and can access everything needed to complete an inquiry or transaction in a single session. APHP was designed specifically for the Medicaid community. Accordingly, it provides a structure to easily accommodate the unique program changes faced by the Agency, as well as new capabilities, such as member eligibility and enrollment and health information exchange.

Our dual layer approach consists of a public layer and a secure layer. The public layer is a flexible content manager solution with user friendly navigation features built in Microsoft .NET technologies. Based on the



Agency's needs and as defined during conference room pilot sessions, APHP can deploy web forms, browser-based applications or a Windows forms application with comprehensive portal capabilities. The APHP enterprise service bus (ESB) directs the interaction and communication between the APHP COTS software applications and the portal. The interoperability functionality provides the Agency with the power and flexibility of a dynamic portal that is responsive to the needs of providers, members and stakeholders

The APHP portal is configured for three entry points. Additional portals can be added as necessary to expand and extend the MMIS into other areas.

- Provider
- Member
- Worker/IME Partner

Provider Portal

The Provider Portal, sample shown in Figure 4C.19-1, has an intuitive interface designed to make provider interactions with the MMIS as easy as possible. Key functions available via the Provider Portal include but are not limited to:

- On-line provider enrollment and updating
- Member eligibility verification and COB/TPL information
- Claims submission and claim status inquiry
- Prior authorization requests and status
- Remittance and payment inquiry

Web access and ease of navigating through the APHP portal is crucial to meeting the provider's high expectations of customer service for items such as claims submittal, provider communications, and other relevant information. The Provider Portal has key usability functions to ease provider use, such as claim templates that enable a provider to create a common claim once with key information and save it for multiple submissions in the future. This feature saves providers time as they do not have to rekey the entire claim each time they need to submit a similar claim.

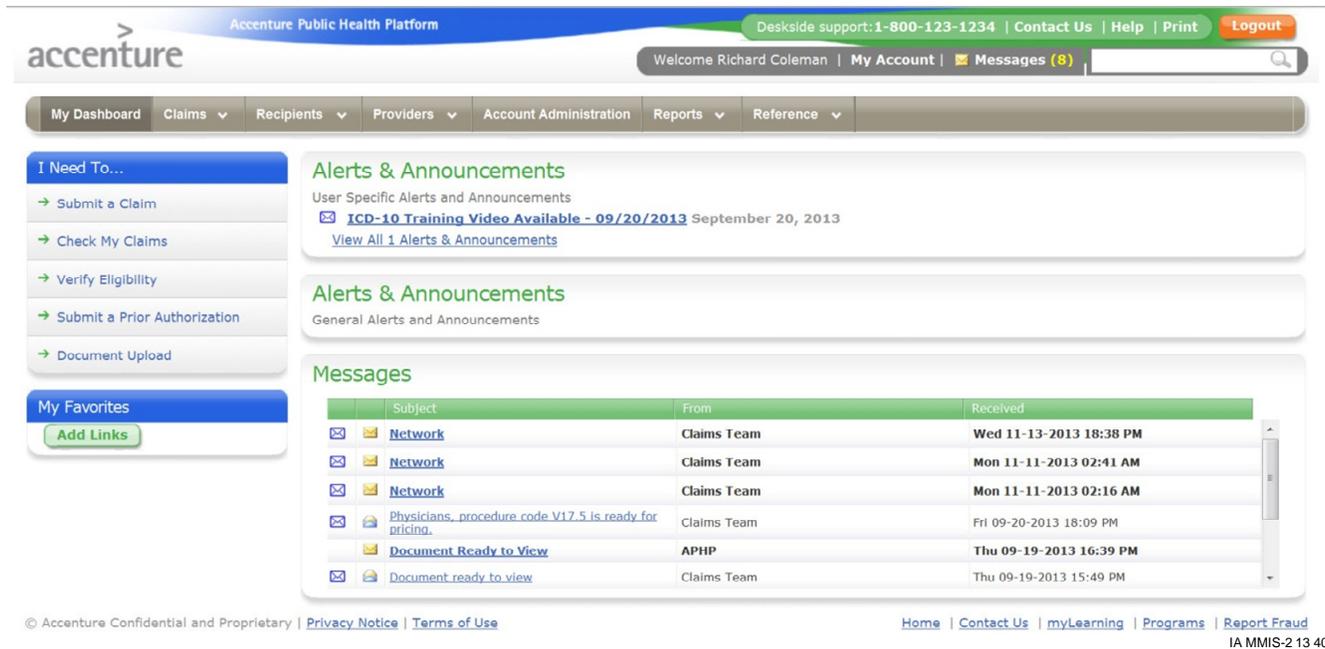


Figure 4C.19-1. Provider portal offers self-services, targeted communication, and a secure mailbox.



The screenshot shows the Member Portal interface. At the top, there is a navigation bar with the Accenture logo and the text 'Accenture Public Health Platform'. To the right of the logo are links for 'English', 'Español', 'Contact Us', 'Help', 'Print', and 'Logout'. Below this is a user greeting: 'Welcome Jenny Hebert | My Account | Messages (4)'. A secondary navigation bar contains tabs for 'MyDashboard', 'Check My Claims', 'Find a Provider', 'Check My Eligibility', and 'Reference'. The main content area is divided into three sections: 'Alerts & Announcements' (User Specific Alerts and Announcements), another 'Alerts & Announcements' section (General Alerts and Announcements), and a 'Messages' section. The Messages section contains a table with columns for Subject, From, and Received.

	Subject	From	Received
	Document Ready to View	APHP	Mon 09-23-2013 10:35 AM
	PCP Change	Claims Team	Fri 09-20-2013 18:40 PM
	Document Ready to View	APHP	Thu 09-19-2013 16:39 PM
	Document ready to view - 1	Claims Team	Thu 09-19-2013 16:09 PM
	Document ready to view	Claims Team	Thu 09-19-2013 15:59 PM
	Document Ready to View	APHP	Tue 09-17-2013 09:48 AM
	Document Ready to View	APHP	Tue 09-17-2013 08:18 AM

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Figure 4C.19-2. Member portal offers self-service, easy to use web site, tailored to the needs of a member community.

Member Portal

The Member Portal, illustrated in Figure 4C.19-2, gives members access to their benefit plan, profile and transactions, allowing them to become stewards of their information and engaging members in the management of their own health. Many functions are available to members, such as:

- Benefit plan summary
- Report suspect fraud or abuse
- Eligibility status
- Program news

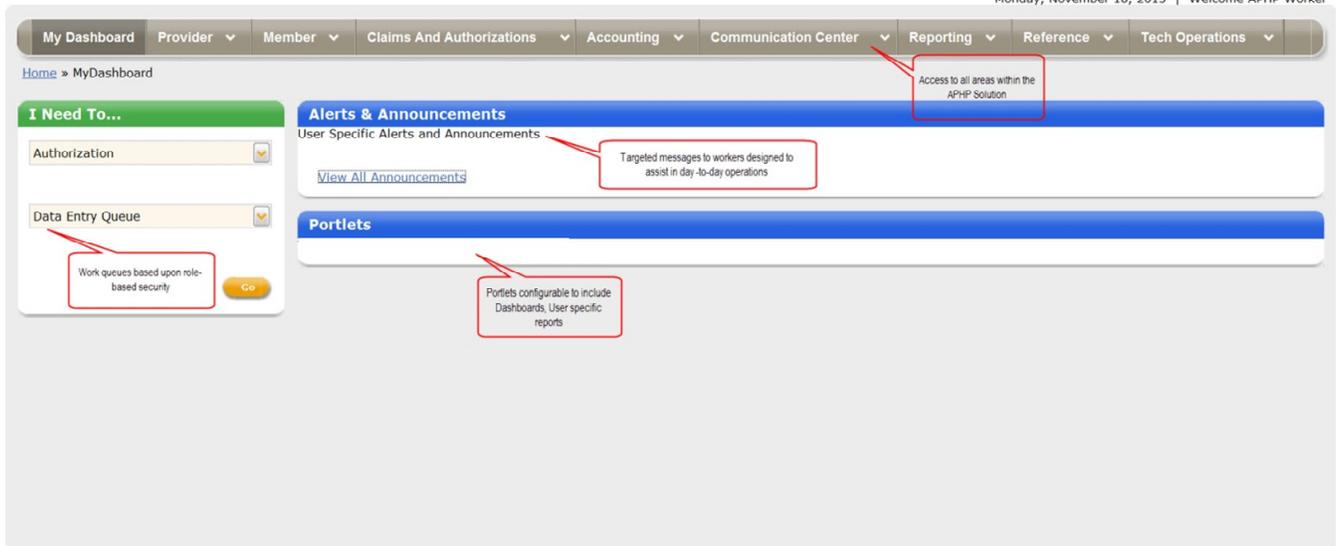
The Member Portal is a key feature for the Agency’s expansion and response to change. Today, members have limited engagement with the MMIS and it is usually transactional, such as notification after a prior authorization decision is made. The APHP portal can "host" other Member Portal functions or "serve" MMIS functions to other portals to achieve and promote multiple access channels to services. It is truly expandable to integrate services from other systems and platforms for members and to interoperate with the agency's programs and other IME Team contractors.

Worker Portal

The Worker Portal, shown in Figure 4C.19-3 gives easy and secure access to the Agency, IME partners, professional services contractors and other authorized users who rely on the MMIS, or information from it, to perform their job responsibilities. A wide range of functions is available via the Worker portal, including but not limited to:

- Suspended claim adjudication
- Business rule access and management
- Provider enrollment
- Workflow management
- APHP configuration changes
- Operations monitoring via the APHP dashboard
- Prior authorization processing and inquiry

The Worker portal has the same look and feel as the Provider and Member Portals. Likeness in work tools helps people connect and work together effectively. This is especially relevant to work that is handed off to other team members across the IME. The Worker portal is designed to increase efficiency and enable IME staff with everything needed to complete end-to-end processes, from document images to code explanations to letter generation, all in one continuous process. Data fields are pre-populated or menu-driven via business rules, thereby improving quality and decreasing time spent on duplicate activities.



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Figure 4C.19-3. Worker portal is designed from an operations perspective to allow for easy research, and navigation.

External Web Services

APHP web services are provided externally for use by authorized entities. This gives the Agency the ability to share services with other agencies or departments, other states, other IME Team contractors or the federal government.

The Agency may also wish to use the APHP portal to make information more widely available to the Medicaid community, such as vision statements, strategic plans and Medicaid brochures.

Response to Attachment L Requirements

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Table with 2 columns: Att. L Req. (WSR-1) and Tab 4G Page (Att L - 27)

Microsoft SharePoint is integrated within the APHP framework to foster content management changes without requiring any coding changes and allowing efficient content update of the APHP portal.

Table with 2 columns: Att. L Req. (WSR-2) and Tab 4G Page (Att L - 27)

We will comply with the defined Agency usability and content standards (i.e. style guide) and provide user-configurable resolution, fonts and color choices which are compliant with the current state and federal requirements.



WSR-3 **Att L - 27**

Updates to interactive content such as alerts, and reference content such as fee schedules, or other configurations within the agreed upon and approved timelines are supported by APHP. Example interactive content that is easily updateable includes enrollment forms, Medicaid claims information, special billing forms, training announcements, field representatives' names and contact information, links, fee schedules, and provider inboxes. For example, the APHP Portal functionality provides for posting of announcements specific to the user type at sign-on. This allows for immediate, focused notification based on the defined users the Agency is looking to target. APHP's alert functionality allows the Agency to make their communications as direct and targeted as possible. Users have easy access to institutional fee schedules, professional fee schedules, and global payment value assignments. As required by the Agency, our authorized staff members are able to update fee schedules within timeframes mandated by the Agency. The control procedures are combined with quality assurance to verify and validate that fee schedule updates are accurate and consistent.

WSR-4 **Att L - 27**

We monitor and manage the web services applications and infrastructure 24x7 fostering the shortest downtime, and provide timely notification of performance degradation or service unavailability. APHP's flexible and defined alerting conditions, triggered actions, and escalation scripts provide the Agency confidence that the web services applications and infrastructure are performing optimally. APHP automatically discovers and monitors network resources, regardless of type or location. APHP provides a single pane view of performance and availability of web services. All APHP portal transactions are monitored and system performance can be viewed in real-time. APHP monitors for downtime, as well as user-access events such as timeouts or login errors. We know that providers and members count on consistently being able to access needed information whenever and at the moment they need it.

WSR-5 **Att L - 27**

We notify the Agency immediately of any unscheduled downtime and will set alerts within APHP for individual resources, groups of resources, and at the application level that identify unscheduled downtime. Based on the type and severity of the condition that triggers an alert, APHP will follow a documented protocol to initiate an automatic alert, for instance, an email notification or text messaging to the approved distribution. The Agency and other IME contractors benefit from the ability to create and maintain approved notification procedures, alert protocols and pre-determined distribution lists to foster rapid, open and critical communications.

APHP provides a view of performance and availability results from the user perspective. The Agency can quickly and easily view and analyze these performance metrics in performance reports. The APHP provides monitoring capabilities that give a view into web service operations and overall transaction processing metrics. As we work through resolving any unscheduled downtimes, we will keep the Agency and impacted partners informed of the downtime status. As requested by the Agency, we will provide written action plans for State review and approval to resume activities, including the timeline for system availability. As part of our Governance process within the PMO, we will produce a detailed weekly report in a pre-approved format describing the downtime parameters, root cause, and corrective action. As with all performance standards, performance measures will be available anytime on our Service Level Dashboard.

WSR-6 **Att L - 27**

We will work with the Agency to obtain approval of the documents as well as the portal functionality to meet the Agency's requirements. Prior to posting any information on the web, our team works with the Agency designated contacts to review and seek approval of content. We understand the critical nature of the information posted to providers, members, or trading partners. As with all of our initiatives, we drive the documentation and functionality approval process using a defined, repeatable process with standard checks and balances in place. For example, our web-master will be required to prove adequate sign-off has been provided prior to receiving access to modify the content on the web. Once approved, the APHP Portal allows easy access to documents for user guidance and training.



4C.20 WORKFLOW MANAGEMENT

2.7.20 Workflow Management

The Contractor shall perform operational requirements for the Workflow Management function. Workflow Management services supports the use of the Agency's Workflow Process Management system to maximize efficiencies in business processes, work assignments, call log tracking, and escalation.

Workflow Management operational responsibilities are included in Attachment L – Operational Responsibilities.

The Agency needs the flexibility to change with the health care industry and needs to connect and interact with contractors and contributors within the health care ecosystem. The APHP solution is designed to maximize efficiencies in business processes management. We understand that OnBase has been the key driver behind the Agency's workflow management since 2005. We also recognize that the Agency has invested heavily in customizing and developing OnBase to reflect changing workflow requirements, as well as changing business requirements. The existing enterprise workflow will continue to use OnBase, while new workflows that are created using the APHP solution will be configured using K2 blackpearl.



IME Gains a Complimentary Approach to Maximizing Overall Workflow Capabilities

- APHP workflow management is highly configurable using smart object drag-and-drop graphical interfaces
- Interoperable approach preserves the Agency's investment in OnBase through the adoption of current workflows
- Triggers within the APHP workflows create the opportunity to lessen manual processes and review burdens

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The K2 workflow capability provides a robust capability that is well aligned to Medicaid for business process rule management. Changes to the workflows and business rules through APHP require minimal technical skill as configurations are performed by a business analyst. This allows the Iowa Medicaid Enterprise (IME) to adapt to policy, regulatory, and technology changes quickly. Through the workflow design, Business Analyst, SMEs, stakeholders, and technicians can easily contribute to the creation of viable and efficient processes and workflows. In addition to ease of maintenance and update, the Agency benefits from the integration of automated and manual processes that provide consistency in business services across the entire IME.

We understand implementing a new MMIS will introduce significant change for the Agency's staff and other contractors. A targeted, methodical approach to adjusting the business process is appropriate to minimize disruption and mitigates the potential concerns among staff, stakeholders and the Agency. By integrating the structure of the workflows between K2 and the existing OnBase suite of configured workflows, the change to the end users' ability to receive and process work is minimized and familiar ways of performing activities is preserved.

The Prior Authorization workflow provides a good example of this evolution of current to future state workflows. While current Prior Authorization workflow is structured in OnBase, our future state proposes to integrate the data of the Prior Authorization workflow self-contained in APHP from a transaction processing perspective; however the image will remain in OnBase. The key is that the worker can process and view documents through the worker portal and not have to 'toggle' between separate programs. This same concept applies to provider enrollments, claims documents, and other types of typical standard forms.

Response to Attachment L Requirements

For each Attachment L requirement narrative response we provide a cross reference of the **requirement number and the page** of the matrix provided in Tab 4G: Worksheets for Submission.

Att. L Req. Tab 4G Page
WMR-1 Att L - 27

The Agency has invested considerable effort in creating critical workflows within the OnBase solution to enable the key IME business processes. As the needs of the IME continue to evolve, our team continues to maintain OnBase

workflows, as well as leverage the APHP enterprise workflow solution (K2 blackpearl) to configure new workflows, as appropriate.

WMR-2 Att L - 27

We will import and reconstruct the current IME workflow processes as necessary. Our solution minimizes the need for such mass export/import and reconstruction of existing workflow processes as we continue to operate the existing OnBase workflows. This approach helps to lower both the effort and overall risk as we maintain the years of experience that is contained within these processes.





Additionally, our team reviews all of the workflows and where appropriate, connects or moves them into the APHP enterprise workflow. After we analyze the current OnBase workflow, we work with the Agency to determine if the OnBase workflow efficiently addresses the requirements. We then make recommendations for the optimal workflow tool to support the process.

Our methodology takes the guess work out of the workflow management and reduces the time required to configure and document the workflow modifications. By having defined actions and steps, each person knows the next steps that are needed based on the previously determined decision. Our workflow management brings additional functionality which allows authorized users to make real-time workflow changes in response to fluctuating business needs.

WMR-3 Att L - 27 We follow our Change Management Process as detailed in Tab 4C.3 to manage and document workflow revisions and updates. Our workflow solution allows for rapid design which can be critical to foster optimum quality and productivity. If there are new programs or policy changes that require a workflow revision, updates to process steps, or a new work queue the APHP solution will provide the necessary tools to manage the change. Our business analyst team will be trained and skilled in configuration of both the APHP and OnBase workflow solutions to accommodate reconfiguration as required in order to support revised business processes

WMR-4 Att L - 27 We create the process for assigning and transferring claims within the workflow. Our APHP solution includes preconfigured claims workflow that automatically assigns claims to specialized user groups for efficient processing, volume/load management and exception processing as required by our claims team. Our objective is to process claims in an efficient, timely and accurate manner.

APHP Enterprise workflow processes are integrated into the logic of edits and audits and other business rules so that claims systematically route to the appropriate queue. This functionality is fully configurable and performed through our integrated workflow management tool. APHP loads business rule logic into the rules engine and each claim/document is governed by those business rules. The APHP integrated workflow management automatically transfers the claim to the appropriate users as configured through the rules engine to maximize operations and program efficiency.

The power of the APHP configurable workflow management solution is its dynamic routing capability. This means that our claims operations has the ability to quickly make claims queue changes to route claims to different queues as needed to maintain optimal throughput and quality from the claims staff. This dynamic routing may include claims escalation, prioritization changes, or other types of processing adaptations that routinely occur in the claims environment.

The claims staff can resolve basic data validation edits. Other claims resolution such as manual or special pricing, medical review by the IME Medical Services Contractor or other more complex edits, can instantly be routed to appropriate specialized staff. Some cases may require routing to State or external contractors for review based on business requirements. We can change claims queues quickly and seamlessly through our flexible and adaptable APHP workflow management solution.

WMR-5 Att L - 27 We monitor activities and distribute workloads. We understand that the real value of workflow management is in its capability to monitor real-time and report on what is occurring in operations, and make workflow changes, if necessary, to improve efficiency or redistribute workloads. APHP provides the Agency with a real-time view of operational activities and workload distribution dashboard so that at any given point, operational workload such as claims inventory may be reviewed, understood, and dynamically rerouted as necessary. Our operations management staff, as well as the Agency staff, can view and monitor operations activities and redistribute workloads as required quickly and expeditiously.

WMR-6 Att L - 27 We are pleased to have the opportunity to demonstrate our workflow management solution to the Agency. We document all workflows configured during the ACD Phase along with their corresponding business processes. All of the workflow diagrams are stored in the SharePoint repository to provide current, accurate documentation of the IME business processes.



We will, at the Agency's request demonstrate production workflows to validate both the business process and the workflow processes. We work collaboratively with the Agency and, if required, the IME Service contractors to determine if any modifications should be recommended to optimize the business process and corresponding workflows. Teaming with these stakeholders fosters both the relationships and open communication that the Agency expects.

WMR-7 Att L - 27 We recognize that safeguarding source documents is a fundamental and important responsibility we would have as the Agency's MMIS contractor. Protecting source documents during destruction is essential to maintaining the trust of the Agency, and that trust is at the focal point of every one of our Health and Public Services client relationships.

We will adhere to the Agency's requirements and mandated procedures for destroying source documents. We rely on the Agency to provide any specific procedures that the Agency would like us to follow and would welcome discussions on the most secure easy and expeditious processes.



4C.21 BUSINESS RULES MANGEMENT

2.7.21 Business Rules Management

The Contractor shall perform operational requirements for the Business Rules Management function. The Business Rules Management function supports the use and maintenance of the rules engine and documentation of Iowa Medicaid rules through the rules engine. Business Rules Management operational responsibilities are included in Attachment L – Operational Responsibilities.

The IME will benefit greatly through the use of a distributed rules engine approach to business rule management. APHP gives the Agency the ability to apply new or edit current business rules that support claims adjudication or that drive extensive business processes in a manner that promotes rapid change and the least amount of ongoing maintenance.

In our role as the MIDAS MMIS contractor, we provide the ability to add, edit or delete business rules and implement rules revisions within our MMIS solution, APHP, using online Configuration Consoles for:

- Member services
- Provider services
- Benefit plan services,
- Claim receipt and adjudication services
- Reference services
- Managed care services
- Financial services
- Federal reporting services
- System parameter services

All of the specific business rules supporting the above areas of the IME will be documented thoroughly and viewable, including a complete change history, in the TFS tool, which is a web-based tool accessible via a link from the APHP Portal. Additionally, credentialed users will be able to access the business rule and process configurations directly within the APHP product.

Benefit to IME

By selecting APHP, the IME receives a solution for claims processing and benefits administration that is supported by a robust, but accessible business rules configuration. It provides the Agency the power and assurance of secure import, revision and operational maintenance of the agreed upon business rules.

Our solution optimizes the use of business rules, data, workflows and COTS application functionality to sustain a dynamic, distributed business rules environment. With our solution, no hard coding or programming is required to add or maintain business rules. Also using the native configuration components from each COTS product in our solution facilitates accurate interpretation of the business rules configuration and eliminates the need for rules replication or compilation.

Process Analysis

One of the key benefits to the IME is that through our approach to business rules management, “what if” scenarios can be applied using a model environment that mirrors current operations and current program data. Scenarios of how the new or revised rule perform can be played out in a secure test environment and the IME can have a much clearer view into the impact and any potential ramifications that the rule change may invoke. This benefit will help the IME make downstream operational decisions so as to best prepare for the implementation of a new or revised business rule. APHP delivers clear and critical insight so the Agency and other IME contractors are prepared operationally to support the business rules.



A Distributed Rules Engine Approach for Comprehensive IME Business Rules Management

- APHP Leverages the native business rules engine from each of the integrated functional COTS components
- Business rules for claims receipt, editing, adjudication and payment, plus benefit plans, workflow, reporting reference, provider and member management are all viewable within APHP
- Configuration Consoles for the Portal, Claims Engine, Workflow and Reporting tools are used to add, edit or delete business rules with less effort through criteria driven, drop down selection eliminating custom coding or the need to maintain business rules in multiple places
- Agency and other approved users will be able to view the rules documentation, including a complete change history, in the TFS tool, which is a web-based tool accessible via a link from the MIDAS Portal
- Business rule configurations are kept in tack throughout all Product upgrades for APHP functional releases thus removing any negative impacts to daily operations

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Want to see more? BUSINESS RULES Screenshots

available in the Technical Specifications Supporting Information folder of the electronic submittal.



Development and Management

Our baseline configuration included as a pre-packaged element with the APHP software will be fully configured during ACD phase to maximize the policy, rules and administration of Iowa's Medicaid Program. The MIDAS team will then manage the business rules during the Operations Phase. As configuration changes are needed to update a new policy or process rule, we will work through configuration strategies that both meet the requirement of the new or revised rule and that once applied, create the most efficient environment to maintain the business rule(s) moving forward.

Throughout the change management process each business rule change request is properly controlled and managed by the IME Systems Services project management office and governed by our ADM change control management. From initial request and analysis of a new or revised business rule requirement all the way through to the final production deployment and documentation of the business rule, the Agency will be able to check on current status and have a clear view of all the steps that have been completed and those that are still to be completed.

Response to Attachment L Requirements

For each Attachment L requirement narrative response we provide a cross reference of the requirement number and the page of the matrix provided in Tab 4G: Worksheets for Submission.

Att. L Req.	Tab 4G Page
BRMR-1	Att L - 28

Our team will be responsible for maintaining the IME business rules which are housed within the APHP solution. Agency users, contractors and other authorized staff will be trained on specifically how to access the business rules within APHP that are required their roles. We also provide easy to access reference materials and job aides. These materials are user friendly, promote rapid learning and foster the immediate use of the training content and designed to promote "just-in-time" knowledge transfer.

During the business rules training, we provide participants with opportunities for hands-on interaction with APHP. These activities provide participants an opportunity to practice and help to reinforce the information presented during the training session. Our approach to knowledge transfer improves the participant's ability to quickly and effectively use APHP after implementation.

BRMR-2	Att L - 28
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Ongoing maintenance and modification of IME business rules will be completed by our support team. Configuration of the business rules is accomplished through the use of configuration consoles specific to the various COTS products that reside on the APHP framework. This approach to rules management provides transparency, control and insight into the impact that can be anticipated by each rule change – before the rule is promoted to the production environment. Modifications of business rules follow our controlled Change Management Process as detailed in Tab 4C.3. The APHP solution is based upon the MITA 3.0 processes and maintains alignment with evolving maturity levels. These processes are executed through business services-initiating workflows and COTS products.

BRMR-3	Att L - 28
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Management summary reports on the overall status the business rules and on all rules engine modifications during the period as directed by the Agency are available to authorized users. This information is available online via the Microsoft Team Foundation Server (TFS) toolset that maintains documentation that supports the reason for each business rule change. TFS will be available from a link off of the MIDAS portal.

The Agency will receive timely reporting and immediate access to status and performance metrics and by using the Client Services Report Manager that allows authorized users to run custom reports. The report details include information on adjudication details, sequences and dependencies associated with specific business rules' modifications. We can tailor the reports or dashboard for specific rule changes.

BRMR-4	Att L - 28
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The rules and business logic contained within our APHP solution may be viewed and/or directly queried online in a variety of ways. The business rules viewer in our APHP portal provides easy access to benefit structures, and business rules providing a holistic presentation of the relevant system logic. As an example, users have the ability to launch directly from the claims detail into a view of the benefit plan, fee schedule and other key rules that drive the outcome of the claim. Authorized users may also query rules' configurations across the distributed rules engines within each of the functional COTS products. Each of these methods provides quick access to the needed information enabling the Agency or



administrators to use the most appropriate method for any given situation. Transparency and ease of use is built into our rules engine to allow authorized Agency personnel easily and quickly access the information they need.

BRMR-5 Att L - 28

We will maintain the business rules documentation in a manner so as to include all of the details necessary to support the reason for each change to a rule and will include a time/date stamp process that captures who specifically from the Agency directed the rule change. Changes to the business rules follow the approved change management process.

Each requested business rule change is logged as a change management request. It is managed and tracked just like all other change management request. Each business rule change has a defined audit trail that shows who made the change, what change was made and when the change occurred.



4C.22 TECHNICAL OPERATIONS

2.7.22 Technical Operations Support

The Contractor shall act as the manager for all Medicaid Management Information Systems applications, including system integration, capacity planning, inventory tracking, performance monitoring, disaster planning, and maintenance of systems documentation library. The Contractor’s MMIS solution may be hosted at the Contractor’s data centers, the State of Iowa’s data centers or an alternate solution offered by the Contractor. If the solution is hosted at State of Iowa facilities, the Contractor and the State of Iowa hosting department must establish a service level agreement for operating system support and network connectivity management.

Successful transition to and management of the MMIS during operations is critical to the IME to provide improved and timely service to members, providers, and other stakeholders. In order to be successful, the key users areas referenced in Attachment E will require Technical Support operations.

Through our 10 years of experience with performing the Medicaid Technical Operations for the Texas Medicaid program(s) we understand the issues that operations and State agencies encounter on a day to day basis. This includes having timely access to technical support staff to assist with troubleshooting functionality, system applications, capacity and disaster planning, performance monitoring, and knowledge transfer.

We have delivered numerous post implementation support solutions for a variety of IT system implementations across the globe. The Agency benefits from Accenture’s experience on these projects and the use of our established Delivery Suite toolsets and Accenture Delivery Methodology, which provide field-tested processes and practices to distribute work and operate with consistent outstanding results. The common methodologies, tools, architectures and metrics of the Accenture Delivery Suite unify the MIDAS MMIS team.



The Agency Benefits from Comprehensive Operational Management across the IME

- Collaboration through organized and reliable communication channels with all IME contractors and the Agency
- Transparency into performance available via web portal tools
- SLA tracking across IME using near real time metrics that alert Agency and contractor leadership of operational inefficiencies
- Dependable network management to prevent unnecessary downtime and/or access issues for stakeholders

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2.7.22.1 Systems and Data Management

The Contractor shall provide the maintenance, integration, and enhancements of the software solutions provided to meet the technical and interface requirements. The Contractor shall ensure the system performs consistently and accurately, and ensure the system is available to all internal and external stakeholders during normal business hours.

The Contractor shall assure the quality, and management of all data utilized and stored within the MMIS software solution set. Data must be kept secure from unauthorized access. Data must be backed up and protected from damage due to hardware, software, or human error. The data must be auditable and complete enough to support business rule decisions. The data must be retained and available as per the Agency, State, and Federal requirements.

The Contractor shall maintain current procedural, technical and user documentation and training materials.

The Contractor shall monitor system performance and capacity to ensure the Iowa Medicaid Enterprise business processes is protected from impacts due to hardware or data storage as all increases are included in the bid price. The Contractor will maintain a current disaster recovery plan and will participate in all internal and external data systems audits.

The Contractor shall create, manage, and monitor all system interfaces with internal and external partners.

System components and data stores have been identified in the following table. Many of these components have operational or technical requirements specific to the component, and the Operational Requirements Matrix in Attachment L outlines general and specific operational requirements. Additional background information on these components can be found in Attachment E.

Module or Component	Description	Key Users
Member Management	Member data and the business processes that support benefit plan enrollment and member communications	Member Services
Provider Management	Maintain provider data and the business processes that support enrollment, re-enrollment, payment and tax reporting	Provider Services
Managed Care	Enrollment of members into service plans, including but not limited to HMO, Behavioral Health, PACE, care coordination, qualified health plans, employer health insurance plans, and lock-in.	Member Services
Claims Receipt	Accept electronic, paper, and manually keyed claims. Store all	Provider Services





<i>Claims Adjudication and Payment</i>	<i>documentation regarding the claim. Apply business rules to determine payment, suspension, or denial of a claim. Execute a payment cycle and make electronic payments to providers. Check payments may be made where appropriate.</i>	<i>Provider Cost Audit Medical Services Program Integrity Provider Services Revenue and Collections TPL</i>
<i>Reference Data</i>	<i>Manage all code sets related to claims adjudication and other business process support.</i>	<i>Policy Provider Cost Audit</i>
<i>Encounter Data</i>	<i>Accept encounter data electronically from health plans. Edit and validate the data before storing in the IME data repository.</i>	<i>Health Plans IME Policy CMS</i>
<i>Federal Reporting</i>	<i>Maintain and extract data to effectively report to the Centers for Medicaid and Medicare or other federal agencies or business partners as needed.</i>	<i>CMS</i>
<i>Financial Reporting</i>	<i>Provide financial reports to support federal participation payment, state budget and fiscal reporting, and public and policy reporting.</i>	<i>Fiscal Services</i>
<i>Program Management</i>	<i>Provide data reports for public and policy reporting, and overall program monitoring.</i>	<i>Iowa Medicaid Policy</i>
<i>Workflow Management</i>	<i>Provide triggers and notifications to prompt efficient and accurate workflow within the Iowa Medicaid Enterprise</i>	<i>All IME staff</i>
<i>Electronic Data Interfaces</i>	<i>Manage the software to accept electronic data transactions using standard industry formats and operating rules. Provide help desk assistance to providers and their technical representatives.</i>	<i>Provider Services Providers</i>
<i>Eligibility Verification Services</i>	<i>Maintain and operate multiple methods for providers to verify member eligibility for services. Access methods include but are not limited to electronic data interfaces, web portal application, and integrated voice response system.</i>	<i>Provider Services Providers</i>
<i>Rules Engine</i>	<i>Maintain business rules in engine specific and plain English formats.</i>	<i>CMS All Units</i>
<i>Interfaces</i>	<i>Monitor and execute all interfaces internal and external to the MMIS systems and data. Participate in partner meetings to ensure interfaces are accurate and timely.</i>	<i>IME Policy IME Units</i>
<i>External Web Portals</i>	<i>Monitor and maintain an external portal for Members and Providers.</i>	<i>Members Providers Member Services Provider Services</i>
<i>Hardware and OS</i>	<i>Manage and maintain the hardware and operating systems for the MMIS systems.</i>	

Our proposed approach includes APHP system support. We have provided the hardware and software system configuration that will be implemented during the ACD phase. As prescribed in the RFP, we will work with the Department of Administrative Services Information Technology Enterprise (ITE) to develop service levels for the ITE to provide the following in support of the configuration that we will deliver:

- Server Management
- Storage Management
- Backup Management
- Support for DR Annual Test from Server and Storage Teams
- Server Monitoring
- Storage Monitoring
- Qualys Server Scanning for compliance
- DLP Support

System Performance, Maintenance, and Availability - The APHP solution and team provide the maintenance, integration, and enhancements of the software solutions to meet the technical and interface requirements. As discussed in AR.SS.10 product updates/upgrades are provided to the State as part of the support provided through active, in-place software maintenance/support agreements.

The IME needs the ability to view performance and transaction data for key business processes and standard Federal requirements. The SOA (used here for backend monitoring) performs business activity monitoring for key business processes, identifying any process bottlenecks to be fixed. As discussed in response in 4A.2.8 APHP will be available 24 hours a day, 7 days a week, with 99.5% availability.

Quality & Management of Data - Quality and management of all data used and stored within the MMIS solution is kept secure, backed up and protected. Our solution supports the ability to audit the data and is retained and available per the Agency, State, and Federal requirements. The process for these activities are



described in 4B.3.1.f. APHP’s security and privacy solution provides leading-practice capabilities that meet the explicit RFP requirements and support compliance with applicable State, Federal, and Medicaid-specific regulatory security requirements.

Documentation - We maintain current procedure, technical and user documents and training materials. Updates to these documents occur per the change management process and are stored within the MMIS Repository, which is a combination of SharePoint and Microsoft TFS. Documentation processes are described in section 4A (responses to requirements 2.2.4.g, 2.6.3.C, and 2.9).

System Performance & Capacity - The APHP technical operations team monitors system performance and capacity through the use of multiple environments to support the production and change management activities. Further detail of the use of these environments is located in 4B.3.1.i. We will follow and support the Business Continuity Plan (BCP) with specific focus towards backups and recovery. A description of the BCP is available in section 4A.2.11.d.

System Interfaces - Through the APHP solution we have the ability to create, manage, and monitor all system interfaces for internal and external partners. APHP will interact with the Data Warehouse/Decision Support (DW/DS), call center systems, and other systems to effectively support the IME.

APHP uses a variety of interface formats including real-time web services, batch transmission, Secure File Transfer Protocol (SFTP), and other mechanisms. Additionally, our Interface Team includes staff with significant experience designing and configuring interfaces and data exchange solutions for a variety of state government health care systems. Additional information concerning the interface process is available in section 4A.2.

Open & Transparent - Through our prior work with the Agency, and in reviewing the RFP and associated documentation, we understand the professional services and vendors that make up the IME. We communicate openly with the Agency, other State agencies, and vendors to support timely maintenance that is transparent to the IME data systems. Through our experience working with the IME, we understand the unique scenarios for each Agency trading partner. We will continue to follow the IME governance policies put in place during the MIDAS project as the need for a governance process does not stop upon implementation. Per RFP requirements, we have included responses to Attachment L requirements as part of this section.

Response to Attachment L Requirements

For each Attachment L requirement narrative response we provide a cross reference of the **requirement number and the page** of the matrix provided in Tab 4G: Worksheets for Submission.

Att. L Req.	Tab 4G Page
TOR-1	Att L - 28

Our team will install and manage all Medicaid Management Information Systems components. The complexity of installing and managing the Iowa Medicaid Enterprise program requires an approach that addresses all phases of the contract, not only as an information technology (IT) implementation, but also as a cohesive program, working in harmony across multiple IME Team contract holders for services and additional products, that deliver from contract award through the Turnover Phase and throughout ongoing operations. Our approach to all phases of the project demonstrates that we understand the Agency's requirements and have the requisite competencies, skills and experience to consistently deliver. Combined with our APHP solution as the new MIDAS MMIS, we offer the best combination of systems integration and product excellence to meet the needs of the Agency, now and in the future. APHP is a technical architecture that provides an integrated services structure for COTS business software packages. The platform is highly configurable and flexible. COTS products can be added, upgraded, replaced or retired via configuration, rather than by long, expensive system development projects.

TOR-2	Att L - 28
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We provide application technical support to assist in the identification and resolution of technical issues. This involves performing database administration and maintenance at peak levels. This support includes:

- Database administration ('Logical') - Maintain database schema; Maintain application objects (tables, indexes, views, etc.); Assist with tuning and troubleshooting database issues
- Managing technology problems
- Managing the standard non-production operating environment, including the technical architecture
- Trouble shooting infrastructure issues that impact the in-scope software
- Development environment technical support
- Performing technical administrative functions
- Periodic environment/database refreshes



- Code promotion to base environments (i.e. Migrations)
Data maintenance activities are categorized as routine requests. The application support team will create workflows for data requests that are limited to 24-hour turn around and have an acceptable risk profile. Data requests that have greater risk exposure and require additional time are analyzed for effort and routed through the change management process for evaluation.

TOR-3 Att L - 28

Our team incorporates stringent security and privacy controls within APHP to meet federal and state requirements for security and confidentiality in the implementation and operation of the system. APHP is a MITA-aligned component-based solution that includes a common security framework that integrates and enforces authentication, access and privacy controls across all of the constituent COTS products. Application security is provided within this framework. For instance, APHP portal access is strictly controlled through single sign-on and role-based security profiles. Each user is assigned a role and each role is assigned levels of access. The identity management module provides the ability to synchronize identities and credentials with other State Data Center resources. Active Directory records all access attempts, successes and data inquiries providing monitoring and notification of potentially unauthorized access. Security features include:

- The single sign-on module provides end user convenience while maintaining the levels of security and privacy necessary to safeguard protected and sensitive information.
- Access is defined at the functional and data levels to prevent unauthorized transactions and exposure of sensitive or protected information to unauthorized users.
- APHP has a common security service structure to provide robust protection and control of data based on IMA's policies and regulations.
- APHP Security is administered by Microsoft Active Directory Federation Services (Active Directory)
- The identity management module is provided by Microsoft Forefront Identity Manager.
- The identity management module validates that only authorized users have access to APHP

TOR-4 Att L - 28

We will provide help desk support for the MMIS components. This technical support help desk provides a Single Point of Contact for all incidents as it relates to MMIS. It includes providing technical assistance for MIDAS MMIS application related issues, such as system availability, system access, and user notifications as system changes are implemented. We also support the non-production environments to maintain the integrity of the environments and support the needs of problem resolution. Logical Database Administration is also a service included in technical support. We have an escalation process for help desk issues to help verify that all calls are resolved appropriately and in a timely manner.

We provide level 1 help desk support to the team and Agency staff as follows:

- Support system access issues such as password resets
- Provide support for testing activities.

We provide Level 2 support as follows:

- Support to resolve service requests that cannot be resolved by Level 1
- Accept and triage inbound incidents, problem calls, emails and log cases through integration with the Agency's Help Desk
- Acknowledge receipt of the incident
- Provide issue resolution for incidents that do not require code changes
- Implement workarounds as needed until permanent fix can be implemented by Level 3
- Provide configuration, account management, application profile setting, database/application monitoring, and availability management.

We provide level 3 support as follows:

- Provide deep and specialized skills to resolve application, interface, report or data-related issues that require a change to the associated base-code/configuration
- Perform Bug-fixes that are passed to Level 3 for support.



TOR-5 Att L - 28

We will provide capacity management which will include performing capacity and performance monitoring, storage management, and preventive maintenance strategies to provide infrastructure reliability, improve run time performance, and prevent problems from occurring. Our team uses the Agency's existing data center operations management software for monitoring physical servers and physical infrastructure devices hosted in the State's data center. We collaborate with the Agency to implement quality improvement procedures based on proactive improvements (perfective maintenance) as well as retroactive responses.

We participate in quality improvement initiatives that may occur in response to careful system forecasting and capacity planning. As appropriate, we assist in the planning and implementation of quality improvement procedures and system changes driven by perfective maintenance. Our goal is to proactively identify potential operational risks or inefficiencies and implement solutions. To accomplish this goal, our team builds upon a variety of time-tested methods to achieve optimal results:

- Improving the performance, maintainability, or other attributes of an application system
- Conducting preventive maintenance
- Restructuring data tables and re-indexing
- Purging data to reduce/improve data storage
- Improving run time performance/operations
- Replacing utilities to reduce run time
- Correcting potential problems
- Expanding data sets to avoid space problems

Our team develops a Configuration Management Plan (CMP) that covers all aspects of the MMIS system lifecycle. The CMP addresses our team organization, configuration identification, change management, internal audit procedures and other configuration aspects of the project. The CMP also includes:

- Compliance with IME standards and guidelines
- Change management approach
- Configuration management roles and responsibilities across the Accenture and IME teams
- Configuration management tools and processes

TOR-6 Att L - 28

APHP web services can be exposed externally for use by authorized entities. This gives the Agency the ability to share services with other agencies or departments, other states or the federal government. The Agency can allow new external entities to integrate with the MMIS without having to build custom interfaces. For example, if the Agency wanted to use software as a service solution to provide new functionality to a class of provider, the standards-based integration could occur without system modification.

The MMIS is made available via the web to entities and individuals that are not authorized users under security protocols. Some examples of the types of entities and individuals that may access the MMIS through an external web service are providers seeking information about participating in the program and members looking for information about eligibility. In addition, the Agency may wish to make information widely available, such as vision statements, strategic plans and Medicaid brochures. All content that is published on the external web site is coordinated with and approved by the Agency. Content is easily published on APHP external web site for the Iowa MMIS so that it can be consumed by external sources.

During the Analysis and Design activities, we create a comprehensive interface plan that identifies all external interfaces and methods on working with the interface partners to validate functionality. This plan is updated throughout the Implementation and Transition to Operations Phases of the project. With the support of the Agency, external partners are identified in the Integration Test Plan that we exchange test data with to verify results satisfy requirements. For inbound interface testing, we typically use converted files from the Production environment. For example, accepting client eligibility information may not require participation by the eligibility vendor as Production eligibility files are available for use. However, outbound interfaces such as data exchanges with Print vendors for outbound letters do require participation by the vendors to verify not only that our outbound interface produces the expected output, but that the vendor or vendors who receive that output are able to successfully accept and process it. Trading Partner testing scenarios, participants and schedules are detailed in the Integration Test Plan and our team coordinates with participating vendors to facilitate the exchange of test information and verify results meet the requirements.



TOR-7 Att L - 28

We will maintain server hardware and software inventory of Agency controlled IME assets. An inventory of all IME assets, not including financial assets, is maintained and kept up to date. Some of the benefits to the Agency of our approach are as follows:

- Secure storage and easy retrieval of artifacts generated on project.
- Strong foundation for artifact storage and retrieval that support integrity of materials and services.
- Configuration management and versioning supports the integrity of current information.

Configuration Management is a sub process within our Change Management methodology designed to confirm that we use only authorized items in the APHP environment. We monitor and track the hardware and software items throughout their component life cycle. Configuration Management covers the identification, control, maintenance, and verification of configuration items, including their versions, constituent components, and relationships. We store all software and hardware elements as configuration items within the configuration management database.

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We will provide Backup and Recovery processes and documentation. Accenture's Business Continuity and Disaster Recovery (BCDR) functions deliver planning and process outputs that reduce the risk of data loss and that support the restoration of data and of system function. Our Disaster Recovery (DR) Planning culminates in an Iowa-specific DR plan. The DR plan is an effective roadmap and guide to recovery from catastrophic system failure. It provides detailed business process instructions and technical instructions to guide the resumption of business functions. DR allows the resumption of applications, data, hardware, communications (such as networking) and other IT infrastructure. This DR plan will be tested on an annual basis.

In addition to disaster recovery, we will implement an EMC Avamar backup appliance to enable backup of the production environment. Utilizing an integrated toolset to monitor and manage backups, we will confirm that the production database is successfully backed up on a daily basis, to support data integrity in case of a disaster. We will work collaboratively with the Agency to develop comprehensive, cost-effective business continuity and disaster recovery strategies to reduce the impact of unexpected service outages. These strategies include contingency plans, clear definition of what events must occur to trigger a contingency response and the redeployment of personnel and activation of resources needed to restore levels of program functionality. We perform backup, disaster recovery (DR), and contingency activities at sites specified in our plan, subject to Agency approval.

We work with Agency staff to complete a backup security plan according to State guidelines, including timing for backup cycles. The IT information contained on the backup media will be secured in a manner that is integrated with the established Agency storage backup cycle and retention procedures. As shown in Figure 4C.22-1, there are three event levels that require attention: before an event occurs, during an event, and after an event. Users occasionally make requests of operations to restore a file or data structure and the latest or user identified version for the recovery is used. When the next backup is executed, the most recent restored version becomes the most current backup.

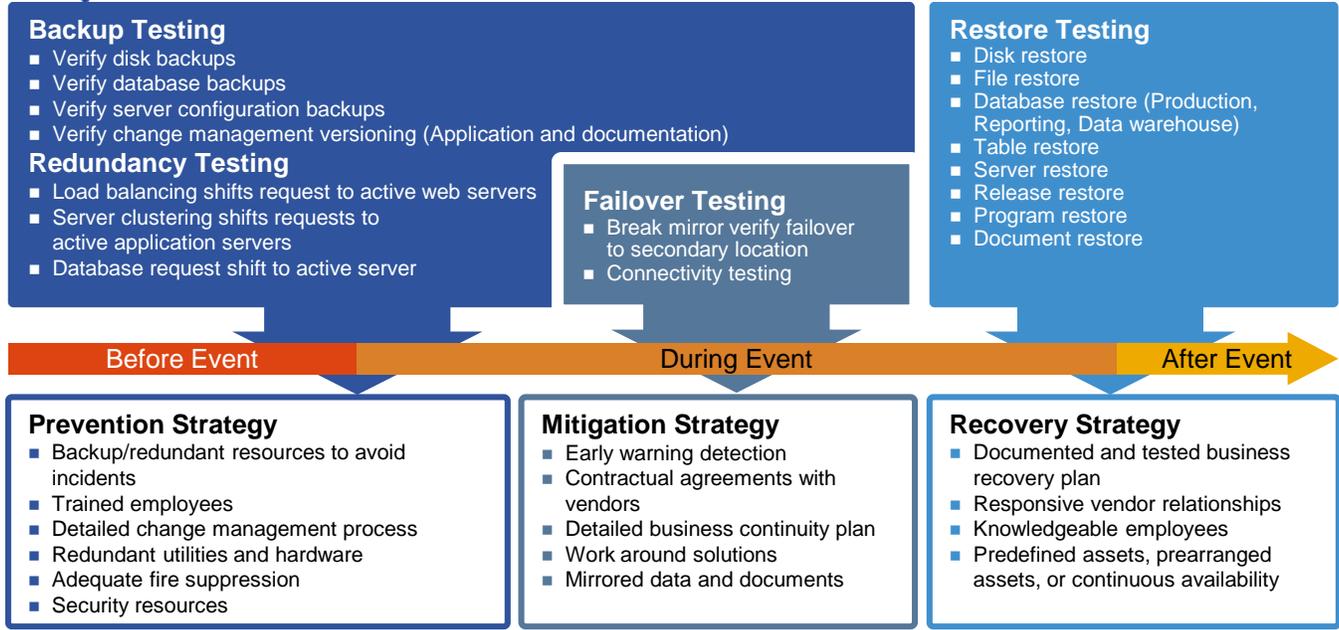
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Enhancements to system functionality are initiated from a number of directions, but are performed for the purpose of improving processing, adding new or additional functionality to an existing COTS product, or adding a new COTS product to the APHP. Our team collaborates with the Agency and other IME stakeholders as needed to perform MMIS component upgrades and maintain required documentation and audit trails. Ways in which enhancements may be initiated include:

- COTS product version releases or patches
- Hardware and software upgrades, release, or patch
- System or operational improvements
- Add or remove data elements
- Legislative and/or regulatory policy changes

We use the same ADM methodology and Microsoft Team Foundation Server (TFS) tool suite to manage changes through the development lifecycle as is used in the management of incidents and release upgrades. The difference is that we layer a change control governance process in the beginning stages to confirm that the user community supports the change and that the change is fully vetted and prioritized within the work schedule.

Change of any nature begins with the identification of a desired enhancement and documented in the TFS tool suite. The change then begins a life cycle and approval process beginning with inception of the change and



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Figure 4C.22-1: Prevention, mitigation and recovery strategies are validated with rigorous testing through actual restores; statistical sampling to verify backup integrity.

ending with implementation and closure. During the change management process, we work collaboratively with the Agency to identify the activities and project controls required to manage the change to a successful conclusion. We understand various activities directly related to the daily operational aspects of the Agency’s primary data center and other systems that impact the MIDAS MMIS operational status. Thus, our team knows it is critical that adequate planning across multiple disciplines is performed for each and every enhancement to the MIDAS MMIS.

Depending on the urgency of the enhancement, the turnaround time for the enhancement or modification may be accelerated taking priority over other work activities. We communicate such accelerated work effort requests appropriately.

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To be able to coordinate and oversee the different COTS components and the vendors who provide them, we build transparency and collaboration into our governance approach and our project management processes. We encourage open and honest interactions with the Agency, the IME Team contractors and other professional services contractors to promote a single, integrated MMIS Team working collaboratively with each other. COTS products’ vendors have responsibility for keeping up with industry standards to meet new business, functional, and data exchange requirements and this is an ongoing process throughout the life of the contract. It includes software inventory, capacity management, and maintaining backup and recovery processes.

We provide the Agency the management, coordination and standard proven processes to perform vendor relations and product delivery and maintenance effectively and efficiently. This includes coordinating and collaborating among all vendors and Agency staff to accurately maintain critical items such as the software inventory, capacity management, and maintenance of backup and recovery processes previously discussed within this section.

Our Team applies standard, tested methods, tools, and metrics to promote predictable and repeatable project delivery for the MIDAS project. We provide the Agency and IME business partners an environment centered on a shared purpose with the proposed program governance model. This shared purpose and vision fosters collaboration between our Team, the Agency and other MIDAS MMIS contractors. APHP uses detailed product roadmaps, a mature release methodology, including product upgrades and patches, allowing the Agency to meet its own and CMS deadlines for standards’ implementation.



We work with the Agency to document a Governance Model for the project. The Governance Model identifies the roles and participants in each level of project and program management activities and processes. It helps identify the resources required to participate in the different MIDAS MMIS project management meetings. We know how valuable each participant’s time is and work to only invite specific, impacted attendees to maximize the meetings effectiveness along with minimal disruption to attendees’ daily activities.

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Accenture’s documented Business Continuity and Disaster Recovery (BCDR) is a Continuity of Operations Plan (COP). The functions of the plan deliver planning and process outputs that reduce the risk of data loss and that support the restoration of data and of system function. These are reflected in the continuity of operations plan for Iowa. BCDR is comprised of four areas of focus shown in Table 4C.22-1 below.

Table 4C.22-1. The proven BCDR approach and functions provide both the steps, actions and artifacts to maintain a comprehensive and executable continuity of operations plan.

Focus Area	Description
Back-Up	Backup processes provide software and hardware which compresses data and copies it to disk based devices. The data is then encrypted and sent across an encrypted network connection to a second datacenter, where it is stored on a copy of the device. In the event a restore is needed locally, backups of files from the past 30 days are retrievable. In the event of a disaster, the entire system is recoverable from the replicated device onto virtual or physical servers.
Business Impact Analysis (BIA)	BIA is driven by a detailed assessment of the as-built and to-be systems and networks to identify and prioritize technical and process functions that are critical to operation of the business. Accenture’s BIA methodology is used to structure the approach. The critical areas for redundancy and support are identified and the cost of loss and/or system downtime is projected.
Disaster Recovery (DR) Planning	The DR plan is an effective roadmap and guide to recovery from catastrophic system failure. It provides detailed business process instructions and technical instructions to guide the resumption of business functions. DR allows the resumption of applications, data, hardware, communications (such as networking) and other IT infrastructure.
Business Continuity (BC) Planning	The Business Continuity (BC) plan is designed to identify the organization’s exposure to internal and external threats. It specifies the necessary policies, processes, plans and procedures for providing effective prevention and recovery for the organization in the event of an unforeseen event.

We have performed Business Continuity (BC) planning for multiple clients across the globe. The BC plan is designed to identify the organization’s exposure to internal and external threats. It specifies the necessary policies, processes, plans and procedures for providing effective prevention and recovery for the organization in the event of an unforeseen event. We develop a BC plan that addresses how each core business processes is handled during an emergency or situation that disrupts normal operations, leaving office facilities damaged or inaccessible. Our methodology is based on many years of practical and pragmatic experience. We bring that depth of knowledge to planning for the MIDAS MMIS business continuity processes, procedures and creation of related documentation and training.



4C.23 PERFORMANCE MEASURES

Accenture's service management methodology supports our philosophy of rigorous project management based on quantitative measures. Through transparent operations and open, honest communication, we establish, and track the agreed on performance measures to help enable the MIDAS Project to operate effectively.

Establishing and managing appropriate performance measures is critical for addressing the Agency's objectives and determining if the MIDAS Project is delivering against defined requirements. We work closely and collaboratively with the State to adopt the appropriate performance measures and then monitor our performance against these agreed upon standards.

Accenture's Performance Management Framework uses metrics both to demonstrate performance and to provide data for analysis, enabling the Agency to make timely and informed decisions at each level of governance. We focus on a set of metrics which are aligned to the Agency's goals and strategy. Our comprehensive set of metrics includes productivity leading indicators and tells a compelling story of performance over time. In addition, these metrics demonstrate productivity and efficiency improvements regardless of whether we are measuring productivity using an Output or Component Based approach

Our performance measurement approach for the MIDAS Project uses our experience with the Texas Medicaid and Healthcare Partnership (TMHP) and other similar outsourcing client engagements. We provide a reporting suite that presents a clear view into MIDAS Project operations. This includes the AHP Service Level Dashboard (SLD) and our project management tools, such as the Microsoft Team Foundation Server (TFS). The Agency can access these tools at any point throughout the project to gain insight on an ongoing basis into Accenture's ability to meet the requisite performance measures.

Measurement Processes

In the section that follows, we describe the processes we use to collect and evaluate the information needed to report on MIDAS Project performance measures. We have identified five processes for measuring project performance based on the measures requested by the Agency. These processes allow us to report performance for the following five types of performance metrics:

- System reporting
- Random sample audits
- Event based reporting
- Batch cycle reporting
- Surveys

System Reporting

Performance measures identified as verified through System Reporting are measured based on data captured automatically by our solution components, such as the scanning system, claims engine or monitoring tools. These data points are available in our MIDAS solution for reporting and audit activities.

Random Sample Audits

Random sample audits are used to determine adherence to performance standards by extrapolating the outcome measures of statistically valid, sample populations. The Quality Assurance Team applies audit procedures at predetermined intervals. Audits can be used to sample performance for measures such as claims processing and payment accuracy.

Event Based Reporting

With event based performance measures, we track actions taken in relation to a defined event. For example, when a problem is identified, we create a ticket, or service request, in our Service Management tool to initiate and track problem resolution. This tool records a date/time stamp when the ticket is opened and when ticket status changes, including the date and time when the ticket is closed. This tool allows us to identify the number of days it takes us to successfully resolve event-based issues. We use this same process to track other types of service requests, such as operational procedure updates and mass adjustment requests.

Batch Cycle Reporting

Batch cycle completion (Batch Monitoring) is used with performance measures that call for our team to complete a systematic process on a recurring basis. We work with the Agency during the ACD phase to define the batch calendar and schedule.

Surveys

We use survey mechanisms to assess certain performance standards, such as those measuring Agency or user satisfaction. We have developed standard surveys as part of our industrialized service management programs. The results of the surveys will be made available to the State.



Attachment L Performance Measures

In Table 4C.23-1 we have mapped every one of the performance measures in Attachment L to one or more of the five processes for measuring project performance described above. The results highlight that we are compliant to all Performance Measures.

Table 4C.23-1. The process we use to verify compliance for each of the Performance Measures in Attachment L fall into one or more of five categories.

Performance Measure #	System Reporting	Random Sample Audits	Event Based Reporting	Batch Cycle Reporting	Surveys
Internal Quality Assurance					
IQAP-1		✓			
IQAP-2		✓			
IQAP-3		✓			
IQAP-4			✓		
IQAP-5			✓		
IQAP-6		✓			
Change Management Process					
CMP-1			✓		
CMP-2			✓		
CMP-3			✓		
CMP-4					✓
Mail room and Courier Service					
MRP-1			✓		
MRP-2			✓		
MRP-3			✓		
MRP-4	✓				
Member Management					
MMP-1				✓	
MMP-2			✓		
MMP-3			✓		
MMP-4			✓		
MMP-5		✓			
MMP-6			✓		
MMP-7	✓				
MMP-8				✓	
MMP-9	✓				
MMP-10			✓		
MMP-11				✓	
MMP-10			✓		
Medically Necessary					
MNP-1	✓				
MNP-2	✓				
MNP-3	✓				
MNP-4	✓				
MNP-5			✓		
MNP-6				✓	



Performance Measure #	System Reporting	Random Sample Audits	Event Based Reporting	Batch Cycle Reporting	Surveys
Provider Management					
PMP-1	✓				
PMP-2	✓				
PMP-3			✓		
PMP-4			✓		
PMP-5			✓		
PMP-6			✓		
PMP-7			✓		
PMP-8				✓	
PMP-9			✓		
Claims Entry and Receipt					
CEP-1	✓				
CEP-2	✓				
CEP-3	✓				
CEP-4		✓			
CEP-5	✓				
CEP-6				✓	
CEP-7	✓				
CEP-8			✓		
CEP-9	✓				
CEP-10	✓				
CEP-11			✓		
CEP-12				✓	
CEP-13	✓				
CEP-14			✓		
CEP-15	✓				
Claims Adjudication					
CAP-1	✓				
CAP-2	✓				
CAP-3	✓				
CAP-4	✓				
CAP-5			✓		
CAP-6			✓		
CAP-7				✓	
CAP-8			✓		
Encounter					
EP-1	✓				
EP-2	✓				
EP-3				✓	
EP-4			✓		
EP-5				✓	
Reference					
RFP-1				✓	
RFP-2	✓				
RFP-3			✓		
RFP-4			✓		



Performance Measure #	System Reporting	Random Sample Audits	Event Based Reporting	Batch Cycle Reporting	Surveys
RFP-5				✓	
RFP-6			✓		
RFP-7			✓		
RFP-8		✓			
RFP-9			✓		
RFP-10			✓		
RFP-11				✓	
Prior Authorization Management					
PAP-1	✓				
PAP-2	✓				
PAP-3	✓				
PAP-4			✓		
PAP-5				✓	
Third Party Liability Management					
TPLP-1			✓		
TPLP-2	✓				
TPLP-3	✓				
TPLP-4	✓				
TPLP-5	✓				
TPLP-6				✓	
TPLP-7		✓			
Program Management Reporting					
PMRP-1				✓	
PMRP-2			✓		
PMRP-3			✓		
PMRP-4			✓		
PMRP-5			✓		
PMRP-6			✓		
PMRP-7				✓	
PMRP-8		✓			
Federal Reporting Management					
FRP-1			✓		
FRP-2				✓	
FRP-3			✓		
FRP-4			✓		
FRP-5			✓		
FRP-6				✓	
FRP-7		✓			
Financial Management and Reporting					
FMP-1			✓		
FMP-2				✓	
FMP-3	✓				
FMP-4	✓				
FMP-5			✓		
FMP-6	✓				
FMP-7	✓				



Performance Measure #	System Reporting	Random Sample Audits	Event Based Reporting	Batch Cycle Reporting	Surveys
FMP-8	✓				
FMP-9		✓			
Program Integrity Management					
PIMP-1			✓	✓	
Managed Care					
MCP-1	✓				
MCP-2	✓				
MCP-3	✓				
MCP-4			✓		
MCP-5				✓	
Eligibility Verification System					
EVSP-1			✓		
EVSP-2			✓		
EVSP-3	✓				
EVSP-4	✓				
EVSP-5			✓		
EVSP-6			✓		
EVSP-7			✓		
EVSP-8			✓		
EVSP-9				✓	
EVSP-10		✓			
Web Services					
WSP-1			✓		
WSP-2				✓	
WSP-3		✓			
Workflow Management					
WMP-1			✓		
WMP-2				✓	
WMP-3		✓			
Business Rules Management					
BRMP-1			✓		
Technical Operations Management and Support					
TOP-1			✓		
TOP-2			✓		
TOP-3			✓		