

**IME PROFESSIONAL SERVICES RFP
 MED-10-001
 AMENDMENT 2**

WHEREAS the Department has determined it is necessary to amend RFP MED-10-001 to include the changes listed in the Revision History for Amendment 2

THEREFORE RFP MED-10-001 is amended as follows. In this amendment document and in the RFP's Revision History, new text added to existing requirements is in boldface font, and deleted text is marked through with a line (~~deleted text~~).

The IME Professional Services RFP is reposted with these changes listed in the revision history. They are incorporated in the cited sections with the boldface or strike-through markings. Rather, the text is fully and completely updated.

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| 1.1 | Removed SURS component, which will be included in a separate RFP for a Program Integrity component. That component also will include common analytical tools and associated analytical resources for use throughout the IME plus SURS and MARS services and system functions. |
| 3.3.77.b | Disease management (Medical Services) |
| 6.0 | <ul style="list-style-type: none"> • 6.1 General Requirements for All Components • 6.2 Medical Services • 6.3 Pharmacy Medical Services • 6.4 Provider Services • 6.5 Member Services • 6.6 Revenue Collections • 6.7 Surveillance and Utilization Review Services (SURS) • 6.78 Provider Cost Audits and Rate Setting (PCA) • 6.89 Estate Recovery Services |
| 6.1.1.1.c | Medical director (only for the Medical Services and Member Services contractors). |
| 6.1.1.1.1 | Figure 4, Key Person column: Medical director (Medical Services and Member Services units only) |
| 6.1.1.1.1 | Figure 4, Qualifications column: Medical Services contractor's medical director will be the Chief Medical Director for the IME. |
| 6.1.1.1.1 | Figure 4, Special Requirements column: Medical Services Medical Director must be on site and 100 percent dedicated to the Iowa Medicaid project. |
| 6.1.3.4.3.1.a | Services performed by the Medical Services contractor that are included in annually reported performance standards are care management, prior authorization (except pharmacy prior authorization), disease management, enhanced primary care case management, long term care assessments, lock in and member education, and reduction in the use of emergency room care, together with the identification and promotion of best practices for acute, long term and preventive health care under the direction of the medical director. |
| 6.1.3.4.3.1.a.1 | \$6 10 million in SFY 2011 |

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| 6.1.3.4.3.1.b | Should the activities cause the state to realize state savings in any year in excess of the above savings for the year, the excess (but not any deficit) shall be credited towards the state savings for the succeeding year. |
| 6.1.3.4.3.1.c | Became 6.1.3.4.3.1.b. |
| 6.1.3.4.3.2.c | Should the activities cause the state to realize state savings in any year in excess of the above savings for the year, the excess (but not any deficit) shall be credited towards the state savings for the succeeding year. |
| 6.1.3.4.3.2.d | Became 6.1.3.4.3.2.c. |
| 6.1.3.4.3.2.e | Became 6.1.3.4.3.2.d. |
| 6.1.3.4.3.4.d | Services performed by the Member Services contractor that are included in annually reported performance standards are lock-in and member health education program (MHEP), disease management, and enhanced primary care management. The Member Services contractor's performance will result in measurable state savings (including cost avoidance) as follows: 1. \$15 million in SFY 2011, \$16 million in SFY 2012 and \$17 million in SFY 2013 2. In every subsequent option year, an increase of 7 percent more than the SFY 2013 state savings or an increase of 7 percent more than the highest overall state savings in any year after SFY 2011, whichever is higher |
| 6.1.3.4.3.6 | 6.1.3.4.3.6 Surveillance and Utilization Review Services a. The SURS contractor will recover no less than 350 percent of the total state cost of SURS activities. b. Should the activities described in this subsection cause the state to realize state savings in any year in excess of the above specified state savings for the year, the excess (but not any deficit) shall be credited towards the state savings in the succeeding year. 6.1.3.4.3.67 Provider Cost Audit and Rate Setting |
| 6.1.3.4.3.6.c | Should the activities cause the state to realize state savings in any year in excess of the above savings for the year, the excess (but not any deficit) shall be credited towards the state savings for the succeeding year. |
| 6.1.3.4.3.7 | 6.1.3.4.3.87 Estate Recovery Services |
| 6.1.3.4.3.7.b | Should the activities cause the state to realize state savings in any year in excess of the above savings for the year, the excess (but not any deficit) shall be credited towards the state savings for the succeeding year. |
| 6.1.3.4.3.8 | 6.1.3.4.3.8 is no longer used. |
| 6.2 | Medical Services includes an array of professional and medical activities to support claims adjudication, program evaluation and quality assessment including the following functions: general medical and professional support; disease management; care management; prevention and promotion, which includes early and periodic screening, diagnosis and treatment (EPSDT) support; prior authorization for medical and professional services (excluding pharmacy prior authorizations), quality of care evaluation for managed care and long-term care (LTC) participants, and LTC reviews. The following topics describe the functions associated with the Medical Services component: <ul style="list-style-type: none"> • 6.2.1 Medical Support • 6.2.2 Disease Management • 6.2.3 Enhanced Primary Care Management • 6.2.4 6.2.2 Children's Health Care Prevention and Well-Child-Care Promotion • 6.2.5 6.2.3 Medical Prior Authorization |

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| | <ul style="list-style-type: none"> • 6.2.6 6.2.4 Long-Term Care (LTC) Reviews • 6.2.7 Lock-In • 6.2.8 6.2.5 Quality of Care • 6.2.6 Health Information Technology 6.2.9 Medicaid Value Management Program |
| 6.2.1.2.k | <p>Use the medical and professional staff and consultants to support the Department in responding to appeals on prior authorizations or other denials of coverage including claims inquiries, requests for exceptions to policy related to coverage of services, or other medical issues. The medical and professional staff or consultants, as appropriate, are required to attend appeal hearings and provide expert testimony in respect to their decisions on prior authorizations or other medical necessity cases. Medical and professional staff and consultants will also attend meetings with providers or other stakeholder groups in support of the Department programs and as requested by the Department. The Medical Services contractor's medical director will be the ultimate authority for medical decisions and will coordinate with the medical director of the Member Services contractor.</p> |
| 6.2.2 | <p>6.2.2 Disease Management</p> <p>Disease management is an innovative intervention for improving care, outcomes, and costs for individuals with certain disease conditions. The use of quality indicators that reflect accepted guidelines for members with specified disease processes and address many of the disease-related objectives of Healthy People 2010 that can improve the quality of care for members and use resources efficiently.</p> <p>Disease management is an organized, proactive approach to healthcare delivery that engages the member in self-management of their disease. Because many diseases are controlled primarily by the member living with the disease, an emphasis on self-management support is a means to change behaviors to improve disease control and health status. Key components of disease management are identification of the population with specified diseases, evaluation of candidates for disease management based on cost effectiveness guidelines, and use of recognized practice guidelines or performance standards for managing identified members. It is also imperative that the providers of service associated with members be involved with the education and intervention developed by the contractor.</p> <p>The Medical Services contractor will be required to develop a limited disease management protocol for non-HMO members, for presentation and approval by the Department. The contractor may propose a risk-based provision that would allow the contractor to assume limited risk for the outcomes of the disease management population, in exchange for receiving a bonus for positive outcomes. Performance standards will be identified and agreed upon in the final contract based upon the disease management approach that the successful bidder proposes.</p> <p>The data sources for the Disease Management function are:</p> <p>a. _____ Service utilization data from paid claims, encounters and Healthplan Employer Data and Information Set (HEDIS) findings</p> <p>b. _____ Medical profile indicators from disease management protocols</p> <p>6.2.2.1 State Responsibilities</p> <p>a. _____ Approve the clinical guidelines and requirements for enrollment in the disease management program.</p> <p>b. _____ Review and approve the contractor's proposal for and any expansion to the disease management program.</p> <p>c. _____ Monitor the activities of the contractor as they relate to the educational activities and clinical regimens developed and applied by the contractor.</p> <p>d. _____ Require changes in the plan for management of individually identified members or the</p> |

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| <p>program parameters as a whole, based on review of contractor's activity.</p> <p>e. Supply access to the MMIS data Point of Sale (POS) data or enterprise data warehouse tools and data stored therein.</p> <p>6.2.2.2 Contractor Responsibilities</p> <p>a. Meet the following objectives:</p> <ol style="list-style-type: none"> 1. Improvement of health status for selected members with chronic conditions. 2. Reductions in costs for high users of services who have specific medical maladies covered under the disease management program. 3. Design of protocols for better management of chronic diseases. <p>b. Maintain the following interfaces:</p> <ol style="list-style-type: none"> 1. MMIS and Data Warehouse/Decision Support (DW/DS) system for information on providers, members, services and costs 2. Communication with providers participating in the disease management protocols 3. Any contractor that may analyze data <p>e. Obtain all data files necessary to accomplish the goals of the program.</p> <p>d. Use recognized guidelines to review disease classes that may be amenable to intervention. This universe will include, at a minimum, diabetes, congestive heart failure, asthma and juvenile asthma. The contractor may suggest other disease processes that might show significant positive health outcomes and subsequent reductions in overall cost to the Department.</p> <p>e. Undertake studies as directed by the Department.</p> <p>f. Prepare an annual proposal identifying potential diseases and/or individual members for development of a program in disease management and present the proposal to the Department. Include any criteria that the Department requests.</p> <p>g. Submit clinical guidelines and enrollment requirements to the Department for approval prior to enrolling members in the disease management program.</p> <p>h. Enroll members in the disease management program.</p> <p>i. Develop reports and other monitoring devices as requested by the Department to demonstrate the results of the program.</p> <p>j. Report on clinical outcomes experienced by the enrolled members on a proposed schedule approved by the Department. These reports would include self-assessments of health status and physician assessments of member health status.</p> <p>k. Obtain Department approval before undertaking outreach to members or providers of service regarding disease management programs. Report outcomes of the Department-approved outreach to the Department.</p> <p>l. Develop and obtain Department approval of the methodology to be used in reviewing Medicaid utilization data to identify new diseases to be added as disease management candidates.</p> <p>m. Report to the Department, annually, on the cost effectiveness of the disease management program, including base line service utilization data and overall health status, intervention during the year, new baseline health status and cost, plus changes in utilization and cost. Outline the methodology for this analysis based on claims data to a level of detail that enables Department staff to substantiate the report's content.</p> <p>n. Any enrolled member who has designated a primary care or primary medical provider will have that provider involved with the management of the member. This means that the active medical management of the member may only be done with the consultation and approval of the primary medical provider.</p> <p>e. Coordinate with the Iowa Plan for persons enrolled in the Iowa Plan with physical diseases</p> |
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| | <p>that have a mental health or substance abuse issue or who are referred from the Iowa Plan due to physical issues’.</p> <p>p. Prepare a monthly report of member participation in disease management program, their service utilization and cost.</p> <p>q. Send enrolled members a satisfaction survey within 10 business days of the member’s sixth and twelfth month of enrollment.</p> <p>6.2.2.3 Performance Standards</p> <p>a. Complete initial health status assessments for each member within 30 days of enrollment.</p> <p>b. Complete health status assessments on all members who have been enrolled for at least one year within 30 days of the anniversary date of the member’s enrollment.</p> <p>e. Make recommendations for at least six studies that the Department agrees are valid.</p> |
| 6.2.3 | <p>6.2.3 Enhanced Primary Care Management</p> <p>In addition to the MediPASS primary care case management program, the Department operates an enhanced primary care management program for members with high costs or high utilization of services. A primary care provider is responsible for providing or authorizing certain Medicaid services for these members. Medicaid members in the enhanced primary care management program receive all Medicaid services to which they are entitled. Iowa Medicaid State Plan services are included, except emergency services, transportation, family planning, mental health and substance abuse services; annual eye examinations, and school-based or well-child clinics. All optional services and other services not specifically mentioned above are not managed.</p> <p>The data sources for the enhanced primary care management function are:</p> <p>a. Interviews with member, family, service providers, current service workers, or case managers or other applicable sources</p> <p>b. Copies of medical records or previously accessed/authorized services plans</p> <p>c. Program policies for LTC eligibility</p> <p>d. Claim information</p> <p>e. Care management member satisfaction survey</p> <p>6.2.3.1 State Responsibilities</p> <p>a. Provide guidelines for qualifications of contractor staff and primary care providers who will perform the enhanced primary care management functions.</p> <p>b. Provide written policy regarding care management.</p> <p>c. Provide written guidelines for an appeal process.</p> <p>d. Provide referrals for care management to the Medical Services contractor.</p> <p>e. Monitor the performance of the care management process.</p> <p>f. Approve care management edits and audits.</p> <p>6.2.3.2 Contractor Responsibilities</p> <p>a. Meet the objective to improve access to needed care and to reduce unnecessary and inappropriate utilization and costs.</p> <p>b. Maintain the following interfaces:</p> <p>1. Members referred for care management</p> <p>2. Case managers</p> <p>c. Accept referrals for care management upon request from the Department.</p> <p>d. Obtain additional information that is needed from the member’s medical providers to determine the individual’s need.</p> |

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| | <p>e. Perform a prescreening assessment on each member referred for care management.</p> <p>f. Provide professional medical staff to perform the care management functions.</p> <p>g. Prepare care plans for each member receiving care management and maintain documentation.</p> <p>h. Notify members and the Department of the results of the prescreening assessment in a format determined by the Department.</p> <p>i. Respond to phone calls regarding members enrolled in care management.</p> <p>j. Survey members regarding satisfaction of care management activities.</p> <p>k. Identify outliers in cost, utilization and treatment patterns that could benefit from enhanced primary care management and provide recommendations to the Department.</p> <p>l. Submit reports in a format and frequency approved by the Department.</p> <p>1. Summary of care management activities and services authorized for members</p> <p>2. Comparison of services and funding prior to and after receiving care management</p> <p>3. Summary of satisfaction survey of members</p> <p>4. Length of time that members receive care management</p> <p>m. Participate in meetings and develop a plan to review claims data for foster care children to determine compliance with current EPSDT standards. When outliers are noted, the care management team would get involved to intervene as necessary. For psychotropic medications, the IME will transfer data to Magellan and request that they perform a review to determine that the right medications are being prescribed at the right intervals.</p> <p>6.2.3.3 Performance Standards</p> <p>a. Upon referral, complete initial member contact for care management services for 95 percent of the members within five business days.</p> <p>b. Maintain a minimum enrollment of 50 members.</p> <p>c. Send enrolled members a satisfaction survey within 10 business days of the member's sixth month of initial enrollment and annually on the anniversary of their enrollment.</p> <p>d. Contact 95 percent of the care managed members within one business day following discharge from hospital.</p> <p>e. Demonstrate cost avoidance through a decrease in emergency room visits annually for members enrolled for at least 11 of 12 months.</p> <p>f. Demonstrate cost avoidance through a decrease in hospitalizations annually for members enrolled for at least 11 of 12 months.</p> |
| 6.2.4 | 6.2.46.2.2 Children's Health Care Prevention and Well-Child-Care Promotion |
| 6.2.4.1 | 6.2.46.2.2.1 State Responsibilities |
| 6.2.4.2 | 6.2.46.2.2.2 Contractor Responsibilities |
| 6.2.4.3 | 6.2.46.2.2.3 Performance Standards |
| 6.2.5 | 6.2.56.2.3 Medical Prior Authorization |
| 6.2.5.1 | 6.2.56.2.3.1 State Responsibilities |
| 6.2.5.2 | 6.2.56.2.3.2 Contractor Responsibilities |
| 6.2.5.2.c (now 6.2.3.2.c) | Provide professional medical staff to perform prior authorization on certain services, including a full-time, on-site medical director (an experienced managing physician who can be an MD or DO), nurses, and peer consultants (such as psychologists, dentists, therapists and other medical professionals) with recognized credentials in the service area being reviewed. These medical consultants must be |

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| | licensed or otherwise legally able to practice in the state of Iowa and possess the professional credentials to provide expert witness testimony in hearings or appeals. |
| 6.2.5.2.i (now 6.2.3.2.i) | Review all requests for prior authorizations that are required for services as well as prior authorization requests that providers submit when ambiguity exists as to whether a particular item or service is covered. PA requests, d Determine whether the service to be provided is medically necessary and appropriate and whether the service should be approved, denied or modified. |
| 6.2.5.3 | 6.2.56.2.3.3 Performance Standards |
| 6.2.6 | 6.2.66.2.4 Long-Term Care (LTC) Reviews |
| 6.2.6.1 | 6.2.66.2.4.1 State Responsibilities |
| 6.2.6.2 | 6.2.66.2.4.2 Contactor Responsibilities |
| 6.2.6.3 | 6.2.6 6.2.4.3 Performance Standards |
| 6.2.7 | <p>6.2.7 Lock-in</p> <p>The contractor will coordinate the member health education program (MHEP) and lock-in (LI) program. This includes the analysis of member surveillance and utilization reports, claim analysis, and referrals. The contractor will review medical utilization of members to identify overutilization, duplication of services, drug abuse, and possible drug interaction. The contractor will restrict members found to be misusing medical services to one physician, pharmacy, hospital, or combination of these providers.</p> <p>6.2.7.1 State Responsibilities</p> <p>a. _____ Determine compliance with overall federal regulations and state laws.</p> <p>b. _____ Establish policy regarding the administration of the member LI program.</p> <p>c. _____ Define all parameters regarding utilization to be used by the contractor in administering the LI program.</p> <p>d. _____ Approve the contractor's procedures for LI program administration.</p> <p>e. _____ Monitor the contractor's performance of LI program activities.</p> <p>f. _____ Conduct appeals and fair hearings related to LI decisions as needed.</p> <p>g. _____ Respond to member inquiries regarding LI status and LI processes.</p> <p>6.2.7.2 Contractor Responsibilities</p> <p>a. _____ Meet the following objectives:</p> <p>1. _____ Improve care and health of members</p> <p>2. _____ Reduce wasteful and duplicative services and therapies</p> <p>3. _____ Program savings</p> <p>b. _____ Review member utilization of medical services to identify misuse, drug abuse and duplicative services and secure medical providers to provide services to restricted members.</p> <p>c. _____ Provide supportive professional and administrative services for appeals, prepare case summaries, and provide testimony regarding the review process during the administrative hearing.</p> <p>d. _____ Using all available claims, enrollment and eligibility data in the MMIS and the DW/DS system, identify members for the LI program. The criteria for identifying candidates for the LI program will include, at a minimum:</p> <p>1. _____ Number of physicians</p> <p>2. _____ Number of pharmacies</p> <p>3. _____ Number of prescriptions</p> <p>4. _____ Controlled drugs</p> |

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| | <p>5. _____ Diagnoses</p> <p>6. _____ Total cost</p> <p>e. _____ For members identified for LI, set up a case in the workflow process and send a medical alert letter to the member notifying the member of the problem.</p> <p>f. _____ Evaluate the member's utilization after one quarter to determine if utilization has been reduced. If no reduction in utilization has occurred, notify the member by letter requesting that the member choose a primary care provider and report to the Department.</p> <p>g. _____ If the member chooses a primary care provider, prepare and send a letter to the chosen provider requesting the provider to become the primary care provider for the member. Contact the provider by telephone as a follow-up to the letter.</p> <p>h. _____ If the member does not choose a primary care provider, identify a provider who is willing to serve as the primary care provider.</p> <p>i. _____ Recruit providers who are willing to serve as primary care providers in all geographical areas of the state. If no providers in a specific area are willing to serve, notify the Department of the problem area.</p> <p>j. _____ On approval of the provider, prepare and send a letter to the member notifying the member of the primary care provider and report to the Department.</p> <p>k. _____ Set the LI indicator on the MMIS member database for each primary care provider for one year.</p> <p>l. _____ No less frequently than every quarter, review the member's utilization to determine if the problems have been corrected. If utilization is still high, recommend a course of action and extend the restriction for one additional year. If the problems have been corrected, release the member from restriction. Prepare and send notification letters to the primary care provider and the member as approved by the Department and report to the Department.</p> <p>m. _____ After a member has been released from the LI program restriction, review the member's utilization after two quarters to determine whether to reapply the LI, and notify the Department of the results of the review. Prepare and send letters to the primary care provider and the member as approved by the Department and report to the Department.</p> <p>n. _____ Reassign a member to a primary care provider if a selected primary care provider requests the reassignment or can no longer serve as the primary care provider.</p> <p>o. _____ Log all LI program activity in the workflow process, including the type of activity and the date the activity occurred.</p> <p>p. _____ Provide information to the Department on LI activities when requested for use in appeals and fair hearings, including preparing case summaries and providing testimony regarding the review process during the administrative hearing.</p> <p>r. _____ Meet monthly with Department staff to review restricted members, problems, and changes in review processes</p> <p>s. _____ Assist the Department with communications to provider and member who have health care quality issues.</p> <p>t. _____ Report the number of members on MHEP and on lock-in within 10 business days of the end of each quarter.</p> <p>6.2.7.3 Performance Standards</p> <p>a. _____ On a quarterly basis, report the MHEP and LI program savings and a quarterly measurable growth rate from pre-enrollment to post-enrollment for LI members. Outline the methodology for this analysis based on claims data to a level of detail that enables Department staff to substantiate the report's content.</p> |
| 6.2.8 | 6.2.86.2.5 Quality of Care |

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| 6.2.8.1 | 6.2.86.2.5.1 State Responsibilities |
| 6.2.8.2 | 6.2.86.2.5.2 Contractor Responsibilities |
| 6.2.8.3 | 6.2.86.2.5.3 Performance Standards |
| 6.2.9 | <p>Removed Medicaid Value Management Program, which will be included in a separate RFP for a Program Integrity component.</p> <p>6.2.9 Medicaid Value Management Program</p> <p>The Medicaid Value Management (MVM) program was developed under the direction of the Iowa Medicaid Director to establish a more comprehensive approach for improving the quality and value of medical services to Iowa Medicaid members. MVM is an assessment and analysis of an array of information and data categories. Expert analysis of integrated information will allow for formulation of strategies centered on the objective of increasing the overall value of the Medicaid programs. The program objectives are to:</p> <p>a. Compare nationally recognized benchmarks and data on utilization of services, gaps in care and to evaluate the Medicaid program and services in Iowa.</p> <p>b. Conduct a periodic evaluation utilizing the various sources to identify opportunities to improve the balance of healthcare quality, service and cost for the Iowa Medicaid Program.</p> <p>c. Develop through analysis of data, recommendations to add value to programs and services for the Medicaid member.</p> <p>d. Utilize a predictive modeling tool in analyzing Iowa Medicaid utilization and trends including but not limited to identifying populations, programs or services for intervention to target disease/care management programs and make other programmatic recommendations to reduce costs and increase quality.</p> <p>The bidder will propose the type and number of projects to complete in the first year. The IME and the bidder will agree on the standards for these projects during contract negotiation.</p> <p>6.2.9.1 State Responsibilities</p> <p>a. Convene a monthly meeting with the MVM team to review and discuss status of the projects.</p> <p>b. Select projects that meet the objectives of the MVM program.</p> <p>c. Establish performance measures</p> <p>d. Review and take action on recommendations.</p> <p>6.2.9.2 Contractor Responsibilities</p> <p>a. The IME Medical Director leads the MVM team in the evaluation and analysis of program data and developing project goals.</p> <p>b. Convene and manage an MVM program team that includes Medical Services, policy staff, and other groups as necessary to perform MVM.</p> <p>c. The team shall include a professional with health care data analysis experience such as informatics, health economics or other health care data analysis experience.</p> <p>d. Identify nationally recognized benchmark measures of health care quality and utilization and perform analysis of Medicaid data to compare to the national benchmarks to identify overutilization and deficiencies in provision of service and evaluate Iowa Medicaid performance and make recommendations to the Department.</p> <p>e. Develop tools and analyze Medicaid expenditures and trends over time to identify areas for possible savings or targeted interventions.</p> <p>f. Prepare monthly reports that address the following:</p> <p>1. Evaluate the effectiveness of the projects selected for the MVM program.</p> <p>2. Analyze the effectiveness in meeting the MVM program goals.</p> |

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| | <p>3. Conduct reviews that identify potential impact upon the MVM projects.</p> <p>4. Compare MVM results to industry standards and quality benchmark data.</p> <p>g. Identify projects to be included in MVM program that will benefit the IME with improving the quality of care, enhancing services, and cost savings for the Department. On a quarterly basis, recommend projects for Department review and approval.</p> <p>h. Conduct IME data systems searches that assist in the validation of project goals.</p> <p>i. Perform analysis of data and develop recommendations to add value to programs and services for the MVM program.</p> <p>j. Develop a comprehensive approach to improving quality and value for Iowa Medicaid members.</p> <p>k. Provide quarterly results to the Department from the review of the claims checklist, including Iowa Medicaid norms, industry standards, and quality indicators.</p> <p>l. Propose predictive modeling software for the Department's approval to be used in analyzing Iowa Medicaid utilization and trends to identify recommendations to reduce costs and increase quality for the Iowa Medicaid Program.</p> <p>m. Participate in monthly MVM meetings.</p> <p>n. Provide monthly reports prior to the monthly MVM meeting.</p> <p>e. Develop recommendations for project improvements.</p> <p>p. Identify trends that impact the operations or fiscal management.</p> <p>6.2.9.3 Performance Standards</p> <p>a. Achieve savings (through cost avoidance) of at least \$1 million annually from the projects.</p> <p>b. Target a number of projects to complete per year.</p> |
| new | <p>6.2.6 Health Information Technology</p> <p>The Department has begun development of a State Medicaid Health Information Technology (HIT) Plan. The document will describe the Department's strategic plan to align with the Iowa e-Health Project. The State Medicaid HIT plan will support the following objectives:</p> <p>Align with the Iowa HIE efforts</p> <p>Support provider adoption, including technical assistance and provider incentives</p> <p>Leverage the availability of clinical data for administrative efficiencies</p> <p>Provide quality reporting including population management for healthier Medicaid members and Iowans</p> <p>6.2.6.1 State Responsibilities</p> <p>a. Provide current policy, status and lines of communication regarding HIT plan.</p> <p>b. Set direction for contractor as plan matures.</p> <p>6.2.6.2 Contractor Responsibilities</p> <p>a. Participate in development of HIT plan as directed by the Department.</p> <p>b. Represent the Department in discussions with provider stakeholders.</p> <p>c. Protect the privacy of Medicaid members in all recommendations.</p> <p>d. Contribute to the definition of incentive payment strategies.</p> <p>e. Champion the plan within the Medical Services unit as the plan matures and features of the plan are enacted.</p> <p>f. Participate in planning and execution of statewide provider assessment as directed by the Department.</p> |
| 6.5, new | The Member Services component also includes the activities related to monitoring member |

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| second paragraph | care: locking in members to particular providers when necessary and managing treatment for particular conditions. In addition, the Member Services contractor will conduct activities related to improving the outcomes of delivery of services to members, including but not limited to analysis of and intervention with high-cost populations. |
| 6.5, after new second paragraph | The Member Services component includes the following responsibilities: 6.5.1 Managed Health Care Enrollment Broker 6.5.2 Member Inquiry and Member Relations 6.5.3 Member Outreach and Education 6.5.4 Member Quality Assurance 6.5.5 Medicare Part A and Part B Buy-In 6.5.6 Lock-In 6.5.7 Disease Management 6.5.8 Enhanced Primary Care Management |
| 6.5.3.1.e | Review initiatives that the contractor proposes for member education. |
| 6.5.3.2.a.5 | Educate members in the appropriate use of the health care system. |
| 6.5.3.2.a.6 | Increase effective and preventive use of program services and decrease inappropriate use of program services. |
| 6.5.3.2.q | Make recommendations to the Department for targeted education programs to member populations that are similar to standard screening, periodicity and treatment programs. |
| 6.5.3.2.r | Implement the targeted member education programs upon receipt of Department approval. |
| 6.5.3.3.d | Present at least six recommendations annually to the Department for targeted education programs for member populations. |
| 6.5.6 | Moved with no changes from 6.2.7 6.5.6 Lock-in The contractor will coordinate the member health education program (MHEP) and lock-in (LI) program. This includes the analysis of member surveillance and utilization reports, claim analysis, and referrals. The contractor will review medical utilization of members to identify overutilization, duplication of services, drug abuse, and possible drug interaction. The contractor will restrict members found to be misusing medical services to one physician, pharmacy, hospital, or combination of these providers. 6.5.6.1 State Responsibilities a. Determine compliance with overall federal regulations and state laws. b. Establish policy regarding the administration of the member LI program. c. Define all parameters regarding utilization to be used by the contractor in administering the LI program. d. Approve the contractor's procedures for LI program administration. e. Monitor the contractor's performance of LI program activities. f. Conduct appeals and fair hearings related to LI decisions as needed. g. Respond to member inquiries regarding LI status and LI processes. 6.5.6.2 Contractor Responsibilities |

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| | <p>a. Meet the following objectives:</p> <ol style="list-style-type: none"> 1. Improve care and health of members 2. Reduce wasteful and duplicative services and therapies 3. Program savings <p>b. Review member utilization of medical services to identify misuse, drug abuse and duplicative services and secure medical providers to provide services to restricted members.</p> <p>c. Provide supportive professional and administrative services for appeals, prepare case summaries, and provide testimony regarding the review process during the administrative hearing.</p> <p>d. Using all available claims, enrollment and eligibility data in the MMIS and the DW/DS system, identify members for the LI program. The criteria for identifying candidates for the LI program will include, at a minimum:</p> <ol style="list-style-type: none"> 1. Number of physicians 2. Number of pharmacies 3. Number of prescriptions 4. Controlled drugs 5. Diagnoses 6. Total cost <p>e. For members identified for LI, set up a case in the workflow process and send a medical alert letter to the member notifying the member of the problem.</p> <p>f. Evaluate the member's utilization after one quarter to determine if utilization has been reduced. If no reduction in utilization has occurred, notify the member by letter requesting that the member choose a primary care provider and report to the Department.</p> <p>g. If the member chooses a primary care provider, prepare and send a letter to the chosen provider requesting the provider to become the primary care provider for the member. Contact the provider by telephone as a follow-up to the letter.</p> <p>h. If the member does not choose a primary care provider, identify a provider who is willing to serve as the primary care provider.</p> <p>i. Recruit providers who are willing to serve as primary care providers in all geographical areas of the state. If no providers in a specific area are willing to serve, notify the Department of the problem area.</p> <p>j. On approval of the provider, prepare and send a letter to the member notifying the member of the primary care provider and report to the Department.</p> <p>k. Set the LI indicator on the MMIS member database for each primary care provider for one year.</p> <p>l. No less frequently than every quarter, review the member's utilization to determine if the problems have been corrected. If utilization is still high, recommend a course of action and extend the restriction for one additional year. If the problems have been corrected, release the member from restriction. Prepare and send notification letters to the primary care provider and the member as approved by the Department and report to the Department.</p> <p>m. After a member has been released from the LI program restriction, review the member's utilization after two quarters to determine whether to reapply the LI, and notify the Department of the results of the review. Prepare and send letters to the primary care provider and the member as approved by the Department and report to the Department.</p> <p>n. Reassign a member to a primary care provider if a selected primary care provider requests the reassignment or can no longer serve as the primary care provider.</p> |
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| | <p>o. Log all LI program activity in the workflow process, including the type of activity and the date the activity occurred.</p> <p>p. Provide information to the Department on LI activities when requested for use in appeals and fair hearings, including preparing case summaries and providing testimony regarding the review process during the administrative hearing.</p> <p>r. Meet monthly with Department staff to review restricted members, problems, and changes in review processes</p> <p>s. Assist the Department with communications to provider and member who have health care quality issues.</p> <p>t. Report the number of members on MHEP and on lock-in within 10 business days of the end of each quarter.</p> <p>u. Provide professional medical staff to perform Member Services services such as lock-in, disease management and enhanced primary care management as directed by the Department, including a medical director (an experienced managing physician who can be an MD or DO), nurses, and peer consultants (such as psychologists, dentists, therapists and other medical professionals) with recognized credentials in the service area being reviewed. These medical consultants must be licensed or otherwise legally able to practice in the state of Iowa and possess the professional credentials to provide expert witness testimony in hearings or appeals. The Member Services contractor's medical director will coordinate with the Chief Medical Director in Medical Services as needed.</p> <p>6.5.6.3 Performance Standards</p> <p>a. On a quarterly basis, report the MHEP and LI program savings and a quarterly measurable growth rate from preenrollment to postenrollment for LI members. Outline the methodology for this analysis based on claims data to a level of detail that enables Department staff to substantiate the report's content.</p> |
| 6.5.7 | <p>Moved with no changes from 6.2.2</p> <p>6.5.7 Disease Management</p> <p>Disease management is an innovative intervention for improving care, outcomes, and costs for individuals with certain disease conditions. The use of quality indicators that reflect accepted guidelines for members with specified disease processes and address many of the disease-related objectives of Healthy People 2010 can improve the quality of care for members and use resources efficiently.</p> <p>Disease management is an organized, proactive approach to healthcare delivery that engages the member in self-management of their disease. Because many diseases are controlled primarily by the member living with the disease, an emphasis on self-management support is a means to change behaviors to improve disease control and health status.</p> <p>Key components of disease management are identification of the population with specified diseases, evaluation of candidates for disease management based on cost effectiveness guidelines, and use of recognized practice guidelines or performance standards for managing identified members. It is also imperative that the providers of service associated with members be involved with the education and intervention developed by the contractor.</p> <p>The contractor will be required to develop a limited disease management protocol for non-HMO members, for presentation and approval by the Department. The contractor may propose a risk-based provision that would allow the contractor to assume limited risk for the outcomes of the disease management population, in exchange for receiving a bonus for positive outcomes. Performance standards will be identified and agreed upon in the final contract based upon the disease management approach that the successful bidder proposes.</p> <p>The data sources for the Disease Management function are:</p> <p>a. Service utilization data from paid claims, encounters and Healthplan Employer Data</p> |

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| | <p>and Information Set (HEDIS) findings</p> <p>b. Medical profile indicators from disease management protocols</p> <p>6.5.7.1 State Responsibilities</p> <p>a. Approve the clinical guidelines and requirements for enrollment in the disease management program.</p> <p>b. Review and approve the contractor's proposal for and any expansion to the disease management program.</p> <p>c. Monitor the activities of the contractor as they relate to the educational activities and clinical regimens developed and applied by the contractor.</p> <p>d. Require changes in the plan for management of individually identified members or the program parameters as a whole, based on review of contractor's activity.</p> <p>e. Supply access to the MMIS data Point of Sale (POS) data or enterprise data warehouse tools and data stored therein.</p> <p>6.5.7.2 Contractor Responsibilities</p> <p>a. Meet the following objectives:</p> <ol style="list-style-type: none"> 1. Improvement of health status for selected members with chronic conditions. 2. Reductions in costs for high users of services who have specific medical maladies covered under the disease management program. 3. Design of protocols for better management of chronic diseases. <p>b. Maintain the following interfaces:</p> <ol style="list-style-type: none"> 1. MMIS and Data Warehouse/Decision Support (DW/DS) system for information on providers, members, services and costs 2. Communication with providers participating in the disease management protocols 3. Any contractor that may analyze data <p>c. Obtain all data files necessary to accomplish the goals of the program.</p> <p>d. Use recognized guidelines to review disease classes that may be amenable to intervention. This universe will include, at a minimum, diabetes, congestive heart failure, asthma and juvenile asthma. The contractor may suggest other disease management initiatives and processes that might show significant positive health outcomes and subsequent reductions in overall cost to the Department, such as high-risk maternity, pharmacy case management, breast and cervical cancer, and other high-cost conditions.</p> <p>e. Undertake studies as directed by the Department.</p> <p>f. Prepare an annual proposal identifying potential diseases and/or individual members for development of a program in disease management and present the proposal to the Department. Include any criteria that the Department requests.</p> <p>g. Submit clinical guidelines and enrollment requirements to the Department for approval prior to enrolling members in the disease management program.</p> <p>h. Enroll members in the disease management program.</p> <p>i. Develop reports and other monitoring devices as requested by the Department to demonstrate the results of the program.</p> <p>j. Report on clinical outcomes experienced by the enrolled members on a proposed schedule approved by the Department. These reports would include self-assessments of health status and physician assessments of member health status.</p> <p>k. Obtain Department approval before undertaking outreach to members or providers of service regarding disease management programs. Report outcomes of the Department-approved outreach to the Department.</p> |
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| | <p>l. Develop and obtain Department approval of the methodology to be used in reviewing Medicaid utilization data to identify new diseases to be added as disease management candidates.</p> <p>m. Report to the Department, annually, on the cost effectiveness of the disease management program, including base line service utilization data and overall health status, intervention during the year, new baseline health status and cost, plus changes in utilization and cost. Outline the methodology for this analysis based on claims data to a level of detail that enables Department staff to substantiate the report's content.</p> <p>n. Any enrolled member who has designated a primary care or primary medical provider will have that provider involved with the management of the member. This means that the active medical management of the member may only be done with the consultation and approval of the primary medical provider.</p> <p>o. Coordinate with the Iowa Plan for persons enrolled in the Iowa Plan with physical diseases that have a mental health or substance abuse issue or who are referred from the Iowa Plan due to physical issues'.</p> <p>p. Prepare a monthly report of member participation in disease management program, their service utilization and cost.</p> <p>q. Send enrolled members a satisfaction survey within 10 business days of the member's sixth and twelfth month of enrollment.</p> <p>6.5.7.3 Performance Standards</p> <p>a. Complete initial health status assessments for each member within 30 days of enrollment.</p> <p>b. Complete health status assessments on all members who have been enrolled for at least one year within 30 days of the anniversary date of the member's enrollment.</p> <p>c. Make recommendations for at least six studies that the Department agrees are valid.</p> |
| 6.5.8 | <p>Moved with no changes from 6.2.3</p> <p>6.5.8 Enhanced Primary Care Management</p> <p>In addition to the MediPASS primary care case management program, the Department operates an enhanced primary care management program for members with high costs or high utilization of services. A primary care provider is responsible for providing or authorizing certain Medicaid services for these members. Medicaid members in the enhanced primary care management program receive all Medicaid services to which they are entitled. Iowa Medicaid State Plan services are included, except emergency services, transportation, family planning, mental health and substance abuse services; annual eye examinations, and school-based or well-child clinics. All optional services and other services not specifically mentioned above are not managed.</p> <p>The data sources for the enhanced primary care management function are:</p> <p>a. Interviews with member, family, service providers, current service workers, or case managers or other applicable sources</p> <p>b. Copies of medical records or previously accessed/authorized services plans</p> <p>c. Program policies for LTC eligibility</p> <p>d. Claim information</p> <p>e. Care management member satisfaction survey</p> <p>6.5.8.1 State Responsibilities</p> <p>a. Provide guidelines for qualifications of contractor staff and primary care providers who will perform the enhanced primary care management functions.</p> <p>b. Provide written policy regarding care management.</p> |

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| | <ul style="list-style-type: none"> c. Provide written guidelines for an appeal process. d. Provide referrals for care management to the contractor. e. Monitor the performance of the care management process. f. Approve care management edits and audits. <p>6.5.8.2 Contractor Responsibilities</p> <ul style="list-style-type: none"> a. Meet the objective to improve access to needed care and to reduce unnecessary and inappropriate utilization and costs. b. Maintain the following interfaces: <ul style="list-style-type: none"> 1. Members referred for care management 2. Case managers c. Accept referrals for care management upon request from the Department. d. Obtain additional information that is needed from the member's medical providers to determine the individual's need. e. Perform a prescreening assessment on each member referred for care management. f. Provide professional medical staff to perform the care management functions. g. Prepare care plans for each member receiving care management and maintain documentation. h. Notify members and the Department of the results of the prescreening assessment in a format determined by the Department. i. Respond to phone calls regarding members enrolled in care management. j. Survey members regarding satisfaction of care management activities. k. Identify outliers in cost, utilization and treatment patterns that could benefit from enhanced primary care management and provide recommendations to the Department. <ul style="list-style-type: none"> l. Submit reports in a format and frequency approved by the Department. <ul style="list-style-type: none"> 1. Summary of care management activities and services authorized for members 2. Comparison of services and funding prior to and after receiving care management 3. Summary of satisfaction survey of members 4. Length of time that members receive care management m. Participate in meetings and develop a plan to review claims data for foster care children to determine compliance with current EPSDT standards. When outliers are noted, the care management team would get involved to intervene as necessary. For psychotropic medications, the IME will transfer data to Magellan and request that they perform a review to determine that the right medications are being prescribed at the right intervals. <p>6.5.8.3 Performance Standards</p> <ul style="list-style-type: none"> a. Upon referral, complete initial member contact for care management services for 95 percent of the members within five business days. b. Maintain a minimum enrollment of 50 members. c. Send enrolled members a satisfaction survey within 10 business days of the member's sixth month of initial enrollment and annually on the anniversary of their enrollment. d. Contact 95 percent of the care-managed members within one business day following discharge from hospital. e. Demonstrate cost-avoidance through a decrease in emergency room visits annually for members enrolled for at least 11 of 12 months. f. Demonstrate cost-avoidance through a decrease in hospitalizations annually for |
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| | <p>members enrolled for at least 11 of 12 months.</p> |
| <p>6.7</p> | <p>Removed SURS component, which will be included in a separate RFP for a Program Integrity component. That component also will include common analytical tools and associated analytical resources for use throughout the IME plus SURS and MARS services and system functions.</p> <p>6.7 Surveillance and Utilization Review Services (SURS)</p> <p>The SURS contractor is generally responsible for all program integrity related activities, except provider enrollment and member lock-in, as they pertain to the Iowa Medicaid Program. Program integrity, for the SURS contractor, encompasses postpayment provider claims reviews and preliminary and full investigations of providers.</p> <p>The SURS contractor will develop and update parameters for use in the production of SUR subsystem reports in the Core MMIS, conduct desk reviews of providers to identify potentially abusive patterns, and conduct provider field reviews to verify the findings of desk reviews if needed. The SURS contractor will also conduct reviews on a sample of providers for whom the SUR subsystem reports do not indicate potentially abusive practices. When the reviews indicate aberrant billing practices, the SURS contractor will identify overpayments and send a request to the provider for refunds of the overpayments. When reviews indicate suspect practices, the SURS contractor will refer the case to the Medicaid Fraud Control Unit (MFCU).</p> <p>The SURS function includes use of claims data for overall program management and use of statistics to establish norms of care in order to detect inappropriate or overutilization of services. The SUR subsystem is designed to provide statistical information on members and providers enrolled in the Iowa Medicaid Program. The SUR subsystem in the Iowa Medicaid Management Information System (MMIS) contains a parameter-controlled claim detail reporting module. The subsystem produces exception profiles for participating providers based on the number of standard deviations or user provided fixed limits. The subsystem can also accept percentiles as the upper limit in exception processing. The SURS contractor will perform other data mining activity through the use of the paid claims files in the data warehouse/decision support (DW/DS) system.</p> <p>The SUR subsystem produces comprehensive profiles of the delivery of services and supplies by Medicaid providers and the use of these services by Medicaid members. The current subsystem features algorithms for isolating potential inappropriate utilization. It also produces an integrated set of reports to provide the Department and its contractors with utilization data for analyzing medical care and service delivery. The SURS contractor will develop other algorithms for use in identifying aberrant provider billing practices.</p> <p>The SUR subsystem also provides extensive capabilities for data management, exception processing, and report content and format. The Department and its contractors use the data to support several utilization management functions. The SURS function also includes a review of the delivery and utilization of medical care on a case basis to identify possible aberrant medical practice. The data sources for the SURS function are:</p> <p>a. _____ SUR subsystem reports produced by the Core MMIS contractor</p> <p>b. _____ MMIS paid claims data and any other provider or program statistics maintained by the Department</p> <p>c. _____ Medical record data collected during field reviews</p> <p>6.7.1 State Responsibilities</p> <p>a. _____ Approve all policy including the criteria used for utilization review and edit resolution.</p> <p>b. _____ Initiate and interpret all policy and make administrative decisions regarding utilization review.</p> <p>c. _____ Advise SURS contractor of providers to be placed on prepayment review or whose participation privileges are suspended or revoked.</p> <p>d. _____ Make provider referrals to peer review committees.</p> |

- e. Provide instructions to the contractor concerning suspended providers and providers to whom payment is suspended.
 - f. Make determinations on questionable practice of providers.
 - g. Determine services requiring preauthorization or postpayment review.
 - h. Determine which SUR subsystem reports are necessary.
 - i. Determine the frequency of reports.
 - j. Approve parameters of SUR subsystem reports.
- 6.7.2 Contractor Responsibilities
- a. Maintain the following interfaces:
 1. Providers for reviews
 2. MFCU for referrals of SURS cases
 - b. Update operational procedure manuals within 10 business days of the implementation of a change.
- 6.7.2.1 Profiling and Data Mining
- a. Provide a profile of health care providers and members through which the quality, quantity, and/or timeliness of services can be identified and assessed.
 - b. Provide continuous interrelated statistics in concert with the Management and Administrative Reporting (MAR) function to show how the total health care delivery system and its individual parts are meeting program objectives.
 - c. Aid management in the process of ensuring that only medically necessary covered services and items including prescribed drugs are provided in the appropriate setting at the lowest cost.
 - d. Create a comprehensive profile of health care delivery and utilization patterns established, in all categories of services including prescribed drugs, under the Iowa Medicaid Program.
 - e. Develop and coordinate the update of the parameters file on the MMIS to classify providers into peer groups using criteria such as category of service, provider type, specialty, type of practice or organization, enrollment status, facility type, geographic region, billing versus performing provider, and size for the purpose of developing statistical profiles by the end of each quarter, assuring that all provider types are reviewed in a one year period.
 - f. Develop and update parameters file to classify treatment into peer groups, by diagnosis or range of diagnosis codes, level of care, or other methodology for the purpose of developing statistical profiles.
 - g. Develop and update the SUR subsystem parameter file with data needed to apply weighting and ranking to exception report items to facilitate the identification of those with the highest exception ranking.
 - h. Compile provider profiles.
 - i. Maintain a process to evaluate the statistical profiles of all individual providers within each peer group against the matching exception criteria established for each peer group.
 - j. Identify providers who exhibit aberrant practice or utilization patterns, as determined by an exception process, comparing the individuals' profiles to the limits established for their respective peer groups, reviewing each provider type scheduled in that quarter.
 - k. Review SUR subsystem reports generated by the Core MMIS contractor to identify providers who exceed calculated norms based on the SUR subsystem parameters identified and input to the SUR subsystem parameter file.
 - l. Perform analysis of service and billing practices to detect utilization and billing problems, including but not limited to incidental or mutually exclusive procedures, unbundling of procedure codes and bill splitting.

- m. Receive referrals on potential provider fraud and abuse from all the other Iowa Medicaid Enterprise (IME) units for a preliminary investigation and coordinate IME-related referrals to the MFCU of suspected cases of provider fraud.
- n. Analyze and propose cost avoidance initiatives and regular self review requests to providers, including credit balance reviews for hospitals and other institutional providers.
- 6.7.2.2 Reviewing
- a. Provide a basis for conducting medical reviews to verify that covered health care services have been documented and that payments have been made in accordance with state and federal policies, regulations, and statutes.
- b. Protect Medicaid participants against the occurrence of overutilization and underutilization of health care services by providing support for the following processes:
1. Referring providers, whose practices are suspect, to the appropriate medical component for review
 2. Initiating administrative actions to curtail aberrant behavior
 3. Referring suspect cases to an investigative agency
- c. Conduct review of providers (including nursing facility (NF) and intermediate care facility for the mentally retarded (ICF/MR) facilities) based on SURS exception criteria.
- d. Perform the provider reviews pursuant to the Department's requirements.
- e. Perform all provider review activities and recovery activities for erroneous provider payments
- f. Conduct field reviews on request, including managed care activities and reviews of health maintenance organization (HMO) and Medicaid-managed behavioral care encounters.
- g. Perform the analysis of provider practice patterns and review of medical records on site in provider offices.
- h. Perform preliminary and full investigations on all cases opened from referrals.
- i. Monitor compliance with any new federal or state laws that are related to mandatory provider documentation as a part of a preliminary investigation.
- j. Annually review claims for all provider types. Reviews selected will be based on outlier status, any additional information that indicates potential billing abnormalities, or both. The reviews will involve performing both in-house and field audits (annual and cumulative).
- 6.7.2.3 Case Follow-Up and Reporting
- a. Provide management with information to assist in overall program direction and supervision.
- b. Have written procedures for all SURS activities, including review criteria for all provider groups.
- c. Report findings from medical record reviews to the Department on a quarterly basis.
- d. Meet periodically with the Department SURS staff to discuss individual cases reviewed and determine action to be taken.
- e. Refer providers requiring sanctions to be imposed against them to the Department in accordance with current Iowa Administrative Code rules on sanctions.
- f. Initiate appropriate action to recover erroneous provider payments.
1. Notify the Core MMIS and Provider Services contractors of requested actions on providers, including requests to recover payment through the use of the credit and adjustment procedure in the case of erroneous payments, such as wrong provider, incorrect amount, wrong procedure, etc.
 2. Under the direction of the Department, direct the Core MMIS contractor to process refunds to providers who have been identified as having been underpaid.
- g. Meet all the federal certification standards for operation of surveillance and utilization review functions.

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| <p>h. Follow up by sending findings letters and collecting overpayments or processing refunds for underpayments resulting from Payment Error Rate Measurement (PERM) errors in those years that Iowa participates in the PERM project.</p> <p>i. Receive and review Explanations of Medical Benefits (EOMBs) and follow up as needed.</p> <p>j. Adjust claims to recover inappropriate provider payments that result from optical character recognition (OCR) scanning errors.</p> <p>k. Coordinate referrals of cases with and between the MFCU according to the following criteria:</p> <ol style="list-style-type: none"> 1. Refer all cases of suspected provider fraud to the MFCU 2. Promptly comply with a request from the MFCU for the following: <ol style="list-style-type: none"> i. Access to, and free copies of, any records or information kept by the Department or its contractors ii. Computerized data stored by the Department or its contractors. These data must be supplied without charge and in the form requested by the MFCU iii. Access to any information kept by providers to which the Department is authorized access by section 1902(a)(27) of the Social Security Act and section 42 CFR 431.107 of the federal regulations and protection of the privacy rights of Medicaid members. 3. On referral from the MFCU, initiate any available administrative or judicial action to recover improper payments to a provider. <p>l. Follow up on overpayments identified by the CMS Medicaid Integrity contractors (MICs).</p> <p>m. Record payments received in the IME accounts receivable system for GAAP reporting and bank account reconciliation purposes.</p> <p>n. Upon request, assist the Department with policy related items, such as updates to the state plan, Iowa Administrative Rules, Iowa Code, and provider manuals.</p> <p>o. Maintain and update operational procedures as necessary and in a format designated by the Department.</p> <p>p. Log and prepare all payments to be deposited in the state owned Title XIX recovery bank account according to RFP Section 6.1.8 Banking Policies.</p> <p>q. Meet the following reporting requirements.</p> <ol style="list-style-type: none"> 1. Produce and submit monthly to the Department a report summarizing provider review activity, including the following information in the report at a minimum: <ol style="list-style-type: none"> i. Names of providers reviewed ii. Dates of each review iii. Review findings iv. Actions taken v. Outcome of referral authorization review vi. Educational letters sent 2. Produce a quarterly identification of the medical services for which overutilization is most prevalent. <p>6.7.2.4 Appeals</p> <p>a. Prepare documents and assist in appeal hearings for all SURS cases that result in an appeal by the provider.</p> <p>6.7.3 Performance Standards</p> <p>a. In each contract year, recover no less than 350% of the total state cost of SURS and provider review activities including the following:</p> <ol style="list-style-type: none"> 1. Measurable and quantifiable recoveries, which are actual recoupments made and money |
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| | <p>received</p> <p>2. _____ Avoided costs, which are those expenses eliminated or reduced as reducing future costs of the Medicaid program (such as identifying a new MMIS edit that will reduce costs of Medicaid claims)</p> <p>3. _____ Enhanced revenues that are additional recoveries that the SURS staff identified, including those funds that are included in pending appeal hearings at any point in time</p> <p>b. _____ Annually review a random minimum sample of .5 percent of paid claims.</p> <p>1. _____ The reviews will involve performing both in-house and field reviews.</p> <p>2. _____ Review cases must include providers who exceed calculated norms and a random sample of providers who do not exceed norms.</p> <p>c. _____ Open a minimum of 60 cases for provider reviews during each quarter according to the following criteria:</p> <p>1. _____ All cases referred from the Department must be opened in the quarter referred.</p> <p>2. _____ Review cases must include both providers who exceed calculated norms, and a random sample of providers who do not exceed norms.</p> <p>3. _____ The contractor must describe in its proposal the percentage of cases to be opened for providers who exceed the norm and the percentage of cases for the random sample.</p> <p>d. _____ On average for all cases, complete reviews within 90 days when all documentation required necessary to perform the review has been obtained.</p> <p>e. _____ Proposals for cost avoidance measures submitted by SURS staff members or other entities will be analyzed and addressed with a response for proposed action (including the option of closure) within 30 days of the date the proposal was submitted.</p> <p>f. _____ Proposals for cost avoidance measures that have been approved for follow up action to be implemented by the SURS unit will be addressed with the identified follow up action within 45 days of the date that the proposal was approved by the SURS contract director.</p> |
| 6.8 | 6.8 6.7 Provider Cost Audits and Rate Setting |
| 6.8 | <p>6.8.1 6.7.1 Rate Setting, Cost Settlements, and Cost Audits</p> <p>6.8.2 6.7.2 State Maximum Allowable Cost Program Rate Setting</p> <p>6.8.3 6.7.3 Rebasing and Diagnosis Related Group and Ambulatory Payment Classification Recalibration</p> <p>6.8.4 6.7.4 Reimbursement Technical Assistance and Support</p> <p>6.8.5 6.7.5 IowaCare</p> |
| 6.8.1 | 6.8 6.7.1 Rate Setting, Cost Settlements, and Cost Audits |
| 6.8.1.1 | 6.8 6.7.1.1 State Responsibilities |
| 6.8.1.2 | 6.8 6.7.1.2 Contractor Responsibilities |
| 6.8.1.2.1 | <p>Perform the provider audit or desk review, the cost settlement, and the rate determination function, when applicable, for the provider types listed in RFP Section 6.8.1.2 6.7.1.2 Contractor Responsibilities. Cost settlements entail a mix of retrospective and prospective methodologies. The contractor shall notify each provider in writing of any corrections made as a result of a desk review. Ensure the thoroughness and mathematical accuracy of submitted reports and ensure conformance to the requirements for allowance of costs as stated in the Code of Federal Regulations (CFR) and Iowa Administrative Code (IAC).</p> |
| 6.8.1.2.n | <p>Perform on-site audits for providers identified by the Department on request. Audits shall be sufficiently detailed to enable contractor to express an opinion on total costs and statistical data provided by the cost report. The protocol for and selection of providers subject to on-site audits (for</p> |

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| | provider types listed under RFP Section 6.8.1.2 6.7.1.2 Contractor Responsibilities) will be based on criteria developed by the contractor and will be subject to approval by the Department. |
| 6.8.1.3 | 6.8.1.3 6.7.1.3 Performance Standards |
| 6.8.1.3.b | In SFY 2011, Iowa shall realize state savings through collection of overpayments or avoidance of overpayments by the Provider Cost Audits and Rate Setting contractor of no less than \$850,000. These savings are expected to result from the more intense scrutiny provided by the cost and payment audit activity described in the RFP. In SFY 2012 and thereafter, the amount of the state savings shall be increased by 10 percent a year over the previous year's state savings. Should the activities described in this subsection cause the state to realize state savings in any year in excess of the savings specified above, the excess (but not any deficit) shall be credited toward the state savings for the succeeding year. |
| 6.8.2 | 6.8 6.7.2 State Maximum Allowable Cost Program Rate Setting |
| 6.8.2.1 | 6.8 6.7.2.1 State Responsibilities |
| 6.8.2.2 | 6.8.2.2 6.7.2.2 Contractor Responsibilities The following subsections list the contractor responsibilities for the SMAC program: 6.8.2.2.1 6.7.2.2.1 General Responsibilities 6.8.2.2.2 6.7.2.2.2 State Maximum Allowable Cost Program and Rate Schedule Maintenance 6.8.2.2.3 6.7.2.2.3 Program Monitoring, Product and Rate Review and Adjustments 6.8.2.2.4 6.7.2.2.4 State Maximum Allowable Cost Program Administrative Support and Assistance to the Department 6.8.2.2.5 6.7.2.2.5 Support for Prescribing Providers and Pharmacies 6.8.2.2.6 6.7.2.2.6 Technical Support, Pharmacological Expertise, and Evaluation Services |
| 6.8.2.2.1 | 6.8.2.2.1 6.7.2.2.1 General Responsibilities |
| 6.8.2.2.2 | 6.8.2.2.2 6.7.2.2.2 State Maximum Allowable Cost Program and Rate Schedule Maintenance |
| 6.8.2.2.3 | 6.8.2.2.3 6.7.2.2.3 Program Monitoring, Product and Rate Review and Adjustments |
| 6.8.2.2.4 | 6.8.2.2.4 6.7.2.2.4 State Maximum Allowable Cost Program Administrative Support and Assistance to the Department |
| 6.8.2.2.5 | 6.8.2.2.5 6.7.2.2.5 Support for Prescribing Providers and Pharmacies |
| 6.8.2.2.6 | 6.8.2.2.6 6.7.2.2.6 Technical Support, Pharmacological Expertise and Evaluation Services |
| 6.8.2.3 | 6.8.2.3 6.7.2.3 Performance Standards |
| 6.8.3 | 6.8.3 6.7.3 Rebasing and Diagnosis Related Group and Ambulatory Payment Classification Recalibration |
| 6.8.3.1 | 6.8.3.1 6.7.3.1 State Responsibilities |
| 6.8.3.2 | 6.8.3.2 6.7.3.2 Contractor Responsibilities |
| 6.8.3.3 | 6.8.3.3 6.7.3.3 Performance Standards |
| 6.8.4 | 6.8.4 6.7.4 Reimbursement Technical Assistance and Support |
| 6.8.4.1 | 6.8.4.1 6.7.4.1 State Responsibilities |
| 6.8.4.2 | 6.8.4.2 6.7.4.2 Contractor Responsibilities The following topics list the contractor responsibilities for this function: |

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| | 6.8.4.2.1 6.7.4.2.1 General Responsibilities 6.8.4.2.2 6.7.4.2.2 Upper Payment Limit Tests 6.8.4.2.3 6.7.4.2.3 Other Technical Assistance and Monitoring 6.8.4.2.4 6.7.4.2.4 Reporting |
| 6.8.4.2.1 | 6.8.4.2.1 6.7.4.2.1 General Responsibilities |
| 6.8.4.2.2 | 6.8.4.2.2 6.7.4.2.2 Upper Payment Limit Tests |
| 6.8.4.2.3 | 6.8.4.2.3 6.7.4.2.3 Other Technical Assistance and Monitoring |
| 6.8.4.2.4 | 6.8.4.2.4 6.7.4.2.4 Reporting |
| 6.8.4.3 | 6.8.4.3 6.7.4.3 Performance Standards |
| 6.8.5 | 6.8.5 6.7.5 IowaCare |
| 6.8.5.1 | 6.8.5.1 6.7.5.1 State Responsibilities |
| 6.8.5.2 | 6.8.5.2 6.7.5.2 Contractor Responsibilities |
| 6.8.5.3 | 6.8.5.3 6.7.5.3 Performance Standards |
| 6.9 | 6.9 6.8 Estate Recovery Services |
| 6.9 | <p>The Estate Recovery Services component includes the requirements listed in the following sections:</p> 6.9.1 6.8.1 Recoverable Assets 6.9.2 6.8.2 Criteria for Exemptions and Delays 6.9.3 6.8.3 Estate Recovery 6.9.4 6.8.4 Medical Assistance Income Trusts and Special Needs Trust Recovery |
| 6.9.1 | 6.9.1 6.8.1 Recoverable Assets |
| 6.9.2 | 6.9.2 6.8.2 Criteria for Exemptions and Delays |
| 6.9.3 | 6.9.3 6.8.3 Estate Recovery |
| 6.9.3.1 | 6.9.3.1 6.8.3.1 State Responsibilities |
| 6.9.3.2 | 6.9.3.2 6.8.3.2 Contractor Responsibilities |
| 6.9.3.3 | 6.9.3.3 6.8.3.3 Performance Standards |
| 6.9.4 | 6.9.4 6.8.4 Medical Assistance Income Trust and Special Needs Trust Recovery |
| 6.9.4.1 | 6.9.4.1 6.8.4.1 State Responsibilities |
| 6.9.4.2 | 6.9.4.2 6.8.4.2 Contractor Responsibilities |
| 6.9.4.3 | 6.9.4.3 6.8.4.3 Performance Standards |
| 7.1.d.4 | <p>Removed SURS component, which will be included in a separate RFP for a Program Integrity component. That component also will include common analytical tools and associated analytical resources for use throughout the IME plus SURS and MARS services and system functions.</p> <p>RFP component for which the bid proposal is being submitted for consideration:</p> <ul style="list-style-type: none"> i. Medical Services ii. Pharmacy Medical Services iii. Provider Services |



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| | <ul style="list-style-type: none">iv. Member Servicesv. Revenue Collectionsvi. Surveillance and Utilization Review Services (SURS)vii.vi. Provider Cost Audits and Rate Settingviii.vii. Estate Recovery Services |
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