

**IME PROFESSIONAL SERVICES RFP
 MED-10-001
 AMENDMENT 5**

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 5

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 not incorporated in the cited sections with the boldface or strike-through markings. Rather, the text is fully and completely updated in the RFP sections.

Amendment 05	
Section	Revision
3.2.2	Removed item i and renumbered items j, k and l: i. Medicare Provider Number File – On request, the Medicare intermediary furnishes to the Core MMIS contractor a file containing Medicare provider numbers. This file is used by the Core MMIS contractor to verify Medicare provider numbers during the Medicaid enrollment process. The file is also used to investigate crossover claim cross-referencing problems. i.j. Monthly paid claims file – The Core MMIS contractor provides a monthly paid claims file to other contractors including but not limited to the current Revenue Collections contractor. jk. Iowa Department of Public Health – EPSDT eligibility data, except pharmacy, kl. Automated license verification files from Iowa Board of Nursing, the Iowa Board of Medicine and the Iowa Dental Board.
6.7.1.2	Add to item b: 18. Community mental health centers
6.7.1.2	Add to item c: 16. Community mental health centers
6.7.1.2	Modified item pp: pp. Provide to the Department the acuity analysis report for pay-for-performance measures semiannually by March 1 and August 1 of each contract year and the pay-for-performance measures report annually by June September 15 of each contract year.
6.7.1.3	Amended as follows: The contractor will be required to meet the following standards. a. Perform annual desk reviews of all providers including cost settlements and calculation of interim rates; settle cost reports for all institutional providers; and notify the provider and the Department of the new payment rate (if applicable) by sending a rate sheet within 90 days of receipt of the financial and statistical report.

	<ul style="list-style-type: none"> a. Settle cost reports for all institutional providers within three months after receipt of the final Title XVIII Medicare cost report or if no Title XVIII Medicare cost report is submitted, within twelve months after receipt of the submitted Medicaid report. b. For NF, ICF/MR, RCF and HCBS providers, notify the provider and the Department of the new payment rate by sending a "rate sheet" within two months of the end of the month after receipt of the financial and statistical report. c. For NFs a "rate sheet" shall be sent to each NF on a quarterly basis based on the case mix index by the fifteenth day of the first month of the quarter. db. 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. e. Settle cost reports for remedial service providers, habilitation waiver service providers, and community mental health centers within six months after receipt of the submitted Medicaid report. f. Perform annual desk reviews of all providers under the purview of the Iowa Departments of Education (LEAs and AEAs) and Public Health (Infant and Toddler), including cost settlements and calculation of interim rates, within 90 days after receipt of the annual financial and statistical report.
6.7.2.2.1.c	<p>Modify item 1:</p> <p>1. Providers to conduct audits and respond to questions or concerns</p>
6.7.4.2.1	<p>d. Upon request, analyze new CPT, ICD and HCPCS codes in the fourth quarter of each calendar year and recommend to the Department by January 1 of the next year the coverage status and evaluating and providing the pricing amount or logic if incorporated into an existing reimbursement system.</p>
8.3.2	<p>Modify first sentence of first paragraph:</p> <p>Each evaluation committee will review the proposal's executive summary, the overall quality of the proposal (including appendices), and the general qualifications of the bidder.</p>