# Iowa Medicaid Enterprise Program Integrity Request for Proposal

## RFP MED-10-013

Incorporating Amendment 01

Release Date: November 2, 2009
Proposal Due Date: January 4, 2010

Note: This document is formatted for two-sided printing.

Fields of Opportunities

STATE OF IOWA

**CHESTER J. CULVER, GOVERNOR**
**PATTY JUDGE, LT. GOVERNOR**

DEPARTMENT OF HUMAN SERVICES
CHARLES J. KROGMEIER, DIRECTOR

November 2, 2009

Dear bidders:

Thank you for your interest in the Iowa Medicaid Enterprise Program Integrity Procurement. You are invited to submit bid proposals in accordance with the attached Request for Proposals (RFP) # MED-10-013. The Department of Human Services (the Department) will select a contractor to provide the services described in this RFP.

The Department will hold a bidders' conference on the date listed in RFP Section 2.1 Procurement Timetable at 10:00 a.m., Central Time, via teleconference. Callers should dial in to conference telephone number 866-685-1580 and enter conference code 0009991774 as directed. Although participation in the bidders' conference is not a mandatory requirement for submission of a proposal, the Department strongly encourages bidders to participate. For the purpose of clarifying the RFP's contents, bidders may submit written questions by Monday, November 30, 2009, via e-mail to: *medicaidrfp@dhs.state.ia.us*. **All bid proposals must be submitted by January 4, 2009, at or before 3:00 p.m. to**:

Mary Tavegia
Issuing Officer
Iowa Department of Human Services
Iowa Medicaid Enterprise
200 Army Post Road, Suite 2
Des Moines, Iowa 50315

Regardless of the reason, late responses will not be considered and will be disqualified.

Responses must be signed by an official authorized to bind the bidder to the scope of work for the RFP component bid under consideration. Also, please include your federal identification number on the cover sheet of your response. Evaluation of bid proposals and selection of bidders will be completed as quickly as possible after receipt of responses.

The Department looks forward to receiving your bid proposals.

Regards,

Mary Tavegia
Issuing Officer, RFP MED-10-013
Iowa Department of Human Services

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# REVISION HISTORY

This table lists the revisions in any amendments. New text (if any) is in boldface font. Deleted text (if any) has a strike-through line in it.

Within the remainder of the RFP (outside of this revision history), these changes are incorporated fully. Any boldface font that appears within the other RFP sections is present for emphasis. Strike-through lines will not appear, as deleted text is removed.

Some sections have been added, moved, or changed. Please note the changes in section numbering that have occurred as a result. The changes in section numbers are included in the table below.

## Revision History Table

| Section | Revision Description |
|---|---|
| **Amendment 01** | |
| 5.12 | Add to end of item d:<br>**Scheduled for Implementation by July 1, 2010.**<br>Delete after item d:<br>~~This application will be in place by December 2009.~~ |
| 5.15 | Update first sentence of third paragraph:<br>The Pharmacy POS system provides for on-line, real time adjudication of pharmacy claims with edits **(including application of prior authorization requirements)** and audits that support the Department's policies and objectives. |
| 5.15 | Update items 13 and 17:<br>13. Preferred drug list and recommend drug list ~~support~~ **enforcement through claims processing**<br>17. Administration of **all aspects of** federal and supplemental rebates **excluding supplemental rebate negotiation and contracting** |
| 6.1.1.1 | Change to Figure 4, Operations Manager:<br>~~May not serve in any other capacity.~~ **May also serve as transition manager.** |
| 7.1 | Change item j:<br>Bidders will submit one original, eight copies, and one sanitized copy of the Technical and Cost Proposals and ~~one original of the~~ Company Financial Information – each in a separate binder (or set of binders) – for each bid proposal submitted. As explained above, bidders submitting bid proposals for more than one of the separate contract awards would therefore submit one original, eight copies, and one sanitized copy of the Technical Proposal and Cost Proposal and ~~one original of the~~ Company Financial Information for each separate RFP Component contract under consideration. |
| 7.1 | Make the following changes to item n:<br>As much as possible, Technical Proposal sections should be limited to discussion of elements relevant to the proposed solution for Iowa. The ~~"Services Overview"~~ **"Executive Summary"** and ~~"Corporate Organization, Experience, and Qualifications"~~ **"Corporate Qualifications"** sections of the Technical Proposal allow bidders to expound in greater detail about past or current projects. |

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| 7.2.2 | Change number 1 in item c:<br>1. All subcontractors should be identified, and a statement included that indicates the exact amount of work to be done by the prime contractor ~~(not less than 60 percent)~~ and each subcontractor, as measured by percentage of total contract price. |
| 7.2.2 | Add items p and q:<br>p. A statement that the submitted Bid Proposal Security shall guarantee the availability of the services as described throughout the bid proposal.<br>q. A statement that the bidder acknowledges the acceptance of all term and conditions stated in the RFP. |
| 7.2.8.3 | Change first sentence:<br>The bidder must provide resumes and references for all identified key personnel, including the bidder's ~~project~~ **account** manager who will be involved in providing the services contemplated by this RFP. |
| 7.2.8.4 | Remove first sentence from last paragraph:<br>~~The prime contractor for this contract must perform at least 60 percent of the work awarded as a result of this RFP.~~ |
| 7.2.9.5 | Change sentence:<br>The bidder must include ~~a statement that indicates the bidder's agreement to the certifications and guarantees that appear in RFP Section 9 Attachments~~ **signed copies of Attachments B through J. Signature must be from an individual authorized to bind the company.** |
| 7.3.3 | **Bidders are to include Pricing Schedule N-1** in RFP Attachment N. **Fields on the pricing schedule are designated for pricing for transition, implementation (for any additional hardware and software that the bidder proposes for Department approval), and operations.** |
| 8.1 | Change last sentence:<br>Finally, an evaluation committee that ~~may~~ **will** consist of members from the Department's Division of Fiscal Management will evaluate the financial stability and viability of the bidder. |
| 8.3 | Renumber items as follows:<br>8.3.1 Executive Summary to 8.3.2 Executive Summary<br>8.3.2 General Requirements to 8.3.3 General Requirements<br>8.3.3 Professional Services Requirements to 8.3.4 Professional Services Requirements<br>8.3.4 Project Management to 8.3.5 Project Management<br>8.3.5 Corporate Qualifications to 8.3.6 Corporate Qualifications |
| 8.3 | Change second paragraph:<br>The evaluation committees will meet ~~at the completion of~~ **during** their evaluation process to address any technical questions raised by their respective reviews and discuss the relative merits of each bidder's bid proposal. ~~At the conclusion of this discussion, the evaluation committee members may independently reevaluate and rescore any section of any proposal.~~ |
| 8.3.1 | Last two sentences of first paragraph:<br>The Technical Proposal will be evaluated ~~first~~ and a minimum score of 4,500 points out of the maximum of 7,500 points must be accumulated for the Technical Proposal to be considered competitive ~~and determines whether the Cost Proposal will be evaluated~~. ~~If the Technical Proposal receives less than 4,500 points, the Cost Proposal will not be considered.~~ |
| 8.3.1 | Last paragraph:<br>~~After the first round of scoring, the~~ **The** Department will hold oral presentations **for all bidders**. Following oral presentations, **the evaluation committees will convene to discuss the results of** |

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| | **the oral presentations. After the meeting, each member of** the evaluation committee~~s~~ ~~may~~ **will** independently ~~re~~evaluate and ~~re~~score ~~any section of any~~ **the** proposal**s**. After ~~the final rescore~~**scoring the proposal**, each evaluation committee will convene and average the bidder's scores (from each of its members) for each section of the bidder's technical proposal to facilitate a composite and final technical proposal score for each bidder. |
| 8.5 | First sentence:<br>~~A separate~~ **The evaluation** committee will review and score the cost proposals**, but a separate committee will review and score the cost proposals** from all bidders meeting the mandatory requirements. |
| 8.8 | First sentence:<br>The Department ~~is likely to~~ **will** request oral presentations **from each bidder** and **request** a subsequent "best and final offer" (BAFO) from those bidders that have demonstrated to the evaluation committee their ability to satisfy the requirements of the RFP. |
| 8.8 | Last sentence:<br>Upon completion of oral presentations, individual evaluation committee members may ~~re-~~score bidder's Technical Proposal ~~score~~ based on any clarifications received during that bidder's oral presentation. |
| 9, Figure 10 | Updated title on item O in table. Attachment itself was correct. |
| 9, Attachment I | Replace Business Associate Agreement |
| 9, Attachment L, Bid Proposal Mandatory Requirements Checklist, item 5.c | Add Professional Services to RFP title:<br>c. RFP title (Iowa Medicaid Enterprise Program Integrity Procurement) and RFP reference number (~~MED-10-001~~ **MED-10-013**) |
| 9, Attachment L, Bid Proposal Mandatory Requirements Checklist, item 11 | Update requirement:<br>Is one sanitized copy of the proposal volumes **and Company Financial Information** included if any bid proposal information is designated as confidential? |
| 9, Attachment L, Bid Proposal Mandatory Requirements Checklist, item 13 | Remove note:<br>~~(Note: This status will be determined when Cost Proposals are opened after Technical Proposals have been evaluated.)~~ |
| 9, Attachment L, Bid Proposal Mandatory Requirements Checklist, item 15 | Insert hyphen:<br>15. Are all bid proposals also submitted on CD**-**ROM copies per bid proposal? |
| 9, Attachment L, Bid Proposal Mandatory Requirements | Specify Technical Proposal and Cost Proposal:<br>Does one submitted CD-ROM contain one full version of ~~each bid proposal part~~ **the Technical Proposal and Cost Proposal** and the other submitted CD**-ROM** contain one sanitized version of ~~each bid proposal part~~ **the Technical Proposal and Cost Proposal**? |

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| Checklist, item 16 | |
| 9, Attachment L, Bid Proposal Mandatory Requirements Checklist, item 17 | Specify PDF files:<br>Are all electronic files in **read-only** PDF format ~~or in Microsoft Word 2000 format (or a later version)~~? |
| 9, Attachment L, Bid Proposal Mandatory Requirements Checklist, item 18.c | Specify status:<br>~~Version~~ **Status (original, copy or sanitized)** |
| 9, Attachment L, Bid Proposal Mandatory Requirements Checklist, item 21 | Changed item d:<br>d. Identification of all subcontractors and a statement included that indicates the exact amount of work to be done by the prime contractor ~~(not less than 60 percent)~~ and each subcontractor, as measured by a percentage of the total work? |
| 9, Attachment L, Bid Proposal Mandatory Requirements Checklist, item 21 | Added item q:<br>q. A statement that the submitted Bid Proposal Security shall guarantee the availability of the services as described throughout the bid proposal. |
| 9, Attachment L, Bid Proposal Mandatory Requirements Checklist, item 21 | Added item r:<br>r. A statement that the bidder acknowledges the acceptance of all term and conditions stated in the RFP. |
| 9, Attachment L, Bid Proposal Mandatory Requirements Checklist, item 25 | Change item c:<br>c. ~~Professional Services~~ **Program Integrity** Requirements Cross-Reference |
| 9, Attachment L, Bid Proposal Mandatory Requirements Checklist, item 29 | Replace item d:<br>~~d. Signed Felony Disclosures (Section 7.2.9.4)~~<br>**d. A signed copy of each of Attachments B through J inclusive with signature from an individual authorized to bind the company.** |
| 9, Attachment L, Bid Proposal Mandatory Requirements Checklist, item 29 | Remove items e through k:<br>~~e. A signed copy of Attachment E (Authorization to Release Information) which authorizes the release of information to the Department~~<br>~~f. A signed copy of Attachment D (Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion – Lower Tier Covered Transactions) which certifies that the bidder is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded~~ |

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| | ~~from covered transactions by any federal, department or agency~~<br>~~g. A signed copy of Attachment C (Certification of Independence and No Conflict of Interest) which certifies that the bid proposal was developed independently, and also certifiers that no relationship exists or will exist during the contract period between the bidder and the Department that interferes with fair competition or is a conflict of interest.~~<br>~~h. A signed copy of Attachment B (Proposal Certifications and Declarations) which certifies that the contents of the bid proposal are true and accurate.~~<br>~~i. A signed copy of Attachment J (Proposal Certification of Available Resources) which certifies that the bidder has sufficient available resources to provide the services proposed in the bid proposal.~~<br>~~j. A statement that stipulates that, with the submitted bid proposal, the bidder acknowledges the acceptance of all terms and conditions stated in the RFP. (Note: If the bidder objects to any term or condition, a specific reference to the RFP page, section, paragraph, and line numbers must be made. Objections or responses that materially alter the RFP shall be deemed nonresponsive and disqualify the bidder.)~~<br>~~k. A written guarantee regarding the availability of the services offered and that all bid proposal terms, including price, will remain firm for at least 120 days after the date set for completion of contract negotiations and execution of the contract.~~ |

# 1 PROCUREMENT OVERVIEW

In alignment with the Centers for Medicare and Medicaid Services (CMS) Medicaid Information Technology Architecture (MITA), the State of Iowa currently operates a modular Medicaid business model using multiple contractors and operating a certified Medicaid Management Information System (MMIS). This unique business model is a complex, modular MMIS structure that requires an interdependence of the various modules as well as their supporting contracts.

In anticipation of an orderly transition of the current professional services contracts that are expiring, the state must competitively reprocure these services. The following sections highlight the content of this procurement:

- 1.1 Procurement Background
- 1.2 Request for Proposal (RFP) Purpose
- 1.3 Authority
- 1.4 RFP Summary
- 1.5 RFP Organization

# 1.1 Procurement Background

The Iowa Department of Human Services (the Department) is the single state agency responsible for administering the Medicaid program in Iowa. The Iowa Medicaid Program reimburses providers for delivery of services to eligible Medicaid recipients under Title XIX of the Social Security Act through enrolled providers and health plans.

The Department will maintain the Iowa Medicaid Enterprise (IME), which comprises state management of the Iowa Medicaid Program and the third-party professional services and systems services contractors that jointly administer the Iowa Medicaid Program. The Department has determined that the continuation of the current business model will provide the best operational support to the Iowa Medicaid Program.

The Department has experienced effective results with the IME in contracting for best-practice approaches from a variety of vendors for the professional services and systems services that support the Iowa Medicaid Program operation. Reprocurement of the professional services is required, as contracts for professional services will expire on June 30, 2010, as noted in RFP Section 2.1 Procurement Timetable. The Department is procuring services in this RFP for Program Integrity.

The Iowa MMIS that remains in use has been in continuous operation since October 1979. It has evolved continually as a result of phased-in developments and enhancements. The Iowa MMIS is certified and eligible for 75 percent federal financial participation (FFP) under 42 CFR, Part 433, Subpart 3 and Section 1903(a)(4) of the Social Security Act.

# 1.2 RFP Purpose

The Department's purpose for this procurement is to promote fair, impartial, and open competition among all prospective bidders for program integrity business processes for the Iowa Medicaid Program. As an outcome of the required procurement, the Department intends to meet the following objectives:

- To secure a contractor to support the unique and highly complex nature of Iowa's modular Medicaid program administration structure
- To continue the use and enhancement of the Iowa MMIS to meet all federal and state requirements as stated in the Code of Federal Regulations and the needs of Iowa as listed in the RFP
- To obtain competitive pricing for the IME professional services contract through open competition
- To coordinate any currently intended modifications to the system to support all components of the IME

The resultant winner of the contract award is expected to perform all contractor responsibilities of the Program Integrity component, as defined by this RFP and its supporting documentation, throughout the duration of the contract as specified in the sample contract in RFP Attachment O Sample Contract.

# 1.3 Authority

This RFP is issued under the authority of Title XIX of the Social Security Act (as amended), the regulations issued under the authority thereof, and the provisions of the Code of Iowa and rules of the Iowa Department of Administrative Services (DAS). All bidders are charged with presumptive knowledge of all requirements of the cited authorities, as well as any program integrity performance review standards. The submission of a valid bid proposal by any bidder will constitute admission of such knowledge on the part of the bidder.

# 1.4 RFP Summary

The Department's objective for this procurement is to maintain the current business model of the cohesive IME with "best-of-breed" contractors located with state staff at a common facility. The IME is not unlike the conceptual view of the operation of a managed care organization (MCO) or health maintenance organization (HMO). This strategy allows the state to retain greater responsibility for the operation and direction of healthcare delivery to Medicaid members in Iowa.

RFP Section 5 Operating Environment describes the tools that will remain in place for the IME program integrity component contractor. As part of their operation, all contractors operating within the IME will use the following existing, common managerial tools where necessary to perform their functions:

- The Iowa MMIS that the Core MMIS contractor operates and maintains

- The OnBase workflow process management system that the Core MMIS contractor operates and maintains
- The Data Warehouse/Decision Support (DW/DS) system that the state operates and maintains
- The Cisco Unified Contact Center Express contact management (call center) system that the Department anticipates will be operational by December 4, 2009

Of particular importance is the Department's intent to award the program integrity component in this RFP to obtain the most effective services available today. The Department intends to purchase the managerial skills and knowledge specific to the program integrity component from a vendor with specializations and staff expertise in the designated medical and administrative management areas.

The program integrity component is expected to continue to support the federally-certified MMIS and comply with relevant mandates under Health Insurance Portability and Accountability Act (HIPAA) legislation. The Department expects that colocation with state staff and staff from other component contractors will continue to yield significant efficiencies for the IME, allowing the state to continue to provide a highly effective level of service for both members and providers alike.

Bidders are expected to describe a complete solution for the program integrity component, including a work plan to prepare for operations. Work plans should contain tasks and subtasks, duration, resources, milestones and deliverables, and target dates for the milestones and deliverables. All dates are subject to change, as they will be reviewed and integrated into the overall IME transition work plan.

Since this procurement is for an individual component contract with a vendor that will operate in conjunction with other contractors for other professional services in the IME, the identification and explanation of all interfaces and inputs that the bidder's solution requires from other IME components is an important evaluation criterion. As such, the work plan for the program integrity component must also identify the required interfaces to other key data sources. As a reference for possible interfaces and interactions, RFP MED-10-001 describes the requirements that those other component contractors must meet. During the transition, it is essential that the contractor specify any contractor interface-related decision support requirements or capabilities that the data warehouse / decision support team can develop to streamline business processes for the IME.

The successful contractor for the program integrity component will be required to work with the Core MMIS contractor and state technical staff to support integration of the respective work plans into the overall project plan for the IME. RFP Section 2.1 Procurement Timetable identifies the timeframe that the program integrity contractor, as well as all other IME contractors, will have after contract award in which to complete all transition-related tasks.

# 1.5 RFP Organization

This RFP contains the following primary sections:

- Section 1: Procurement Overview
- Section 2: Procurement Process

- Section 3: Program Description
- Section 4: Project Management
- Section 5: Operating Environment
- Section 6: Program Integrity
- Section 7: Proposal Format and Content
- Section 8: Evaluation Process
- Section 9: Attachments

# 2 PROCUREMENT PROCESS

This section includes the following topics:


- 2.1 Procurement Timetable
- 2.2 Issuing Officer
- 2.3 Communication Restrictions
- 2.4 RFP Amendments
- 2.5 RFP Intent
- 2.6 Resource Library
- 2.7 Bidders' Conference
- 2.8 Letter of Intent to Bid
- 2.9 Questions and Clarification Requests
- 2.10 Proposal Amendments and Withdrawals
- 2.11 Proposal Submission
- 2.12 Proposal Opening
- 2.13 Proposal Preparation Costs
- 2.14 Proposal Rejection
- 2.15 Disqualification
- 2.16 Material and Nonmaterial Variances
- 2.17 Reference Checks
- 2.18 Information from Other Sources
- 2.19 Proposal Content Verification
- 2.20 Proposal Clarification
- 2.21 Proposal Disposition
- 2.22 Public Records and Requests for Confidential Treatment
- 2.23 Copyrights
- 2.24 Release of Claims
- 2.25 Oral Presentations
- 2.26 Proposal Evaluation
- 2.27 Financial Viability Review
- 2.28 Notice of Intent to Award
- 2.29 Acceptance Period

- 2.30 Review of Award Decision
- 2.31 Definition of Contract
- 2.32 Choice of Law and Forum
- 2.33 Restrictions on Gifts and Activities
- 2.34 No Minimum Guaranteed

# 2.1 Procurement Timetable

The following dates are informational. The Department reserves the right to change the dates.

**Figure 1: IME Program Integrity Procurement Timetable**

| Key Procurement Task | Date |
|---|---|
| Notice of intent to issue RFP | September 28, 2009 |
| RFP issue | November 2, 2009 |
| Bidders' conference | November 17, 2009 |
| Bidders' questions due | November 30, 2009 |
| Letters of intent to bid requested | November 30, 2009 |
| Written responses to bidders' questions | December 14, 2009 |
| Closing date for receipt of bid proposals and amendments | January 4, 2010 |
| Oral presentations | January 19 through 27, 2010 |
| Request for best and final offers (if any) | January 19 through 27, 2010 |
| Best and final offers due (as requested) | January 26 through February 3, 2010 |
| Notice of intent to award to successful bidders | February 16, 2010 |
| Completion of contract negotiations and execution of the contract | February 24, 2010 |
| CMS contract approval | April 24, 2010 |
| Execution of contracts | April 24 through 30, 2010 |
| Transition phase of contracts | May 3, 2010 |
| Operations phase of contracts | July 1, 2010 |
| Data analytics operational | November 1, 2010 |

# 2.2 Issuing Officer

The issuing officer is the sole point of contact regarding the Request for Proposal (RFP) from the date of issue until the Department selects the successful bidders.

Mary Tavegia, Issuing Officer
RFP MED-10-013
Iowa Department of Human Services
Iowa Medicaid Enterprise
200 Army Post Road, Suite 2
Des Moines, Iowa 50315

# 2.3 Communication Restrictions

From the issue date of this RFP until announcement of the successful bidder, bidders may contact only the issuing officer or designee. The Department may disqualify bidders if they contact any state employee other than the issuing officer or designee regarding this RFP.

The issuing officer will respond only to questions regarding the procurement process. The Department requests that bidders submit their point of contact for any required bidder follow-up by the Department's issuing officer. Bidders must submit questions related to the procurement process in writing by mail to the issuing officer or by electronic mail to *medicaidrfp@dhs.state.ia.us* by 3:00 p.m., Central Time on the due date for questions listed in RFP Section 2.1 Procurement Timetable or in writing at the bidders' conference on the date listed in the timetable. Questions related to the interpretation of the RFP follow the protocol set forth by RFP Section 2.9 Questions and Clarification Requests. The Department will not accept verbal questions related to the procurement process. Bidders can e-mail procurement process questions to *medicaidrfp@dhs.state.ia.us*

# 2.4 RFP Amendments

The Department will post all amendments at *www.ime.state.ia.us* in the resource library. The Department advises bidders to check the Department's homepage periodically for any amendments to this RFP, particularly if the bidder originally downloaded the RFP from the Internet. The Department will require bidders to acknowledge receipt of subsequent amendments within their proposals. If the bidder requested this RFP in writing from the Department, the bidder will automatically receive all amendments.

# 2.5 RFP Intent

The Department intends that this RFP provide bidders with the information necessary to prepare a competitive bid proposal. This RFP process is for the Department's benefit, and the Department intends that it provide the Department with competitive information to assist in the selection of bidders to provide the desired services. Each bidder is responsible for determining all factors necessary for submission of a comprehensive bid proposal.

# 2.6 Resource Library

A resource library will be available electronically for potential bidders to review material relevant to the RFP. Information on how to obtain access to the electronic resource library will be available at the bidders' conference. RFP Attachment K Resource Library Content lists materials that will be available in the resource library.

# 2.7 Bidders' Conference

A bidders' conference will be held on the date listed in RFP Section 2.1 Procurement Timetable at 10:00 a.m., Central Time, via teleconference. Callers should dial in to conference telephone number 866-685-1580 and enter conference code 0009991774 as directed. Although participation in the bidders' conference is not a mandatory requirement for submission of a proposal, the Department strongly encourages bidders to participate.

The purpose of the bidders' conference is to discuss with prospective bidders the work to be performed and to allow prospective bidders an opportunity to ask questions regarding the RFP. The Department will not consider verbal discussions in the bidders' conference to be part of the RFP unless confirmed in writing by the Department and incorporated as an amendment to this RFP. The Department may defer questions that bidders ask at the conference that the Department cannot answer completely during the conference. The Department will post a copy of the questions and answers on the Department's web site at *www.ime.state.ia.us* in the resource library.

# 2.8 Letter of Intent to Bid

Submitting a letter of intent to bid is optional. If bidders choose to submit one, they may mail, send via delivery service, or hand deliver (by the bidder or the bidder's representative) a letter of intent to bid to the issuing officer by 3:00 p.m., Central Time, on the due date listed in RFP Section 2.1 Procurement Timetable. The letter of intent to bid should include:

- The bidder's name and mailing address
- Name and e-mail address for designated contact person
- Telephone and facsimile (fax) numbers for designated contact person
- A statement of intent to bid for the contract

The Department will not accept electronic mail and faxed letters of intent to bid. The Department's receipt of a letter of intent enables the bidder to submit questions that will receive answers and ensures the sender's receipt of written responses to bidders' questions in the formal question-and-answer process, comments, and any amendments to the RFP.

# 2.9 Questions and Clarification Requests

The Department invites bidders to submit written questions and requests for clarifications regarding the RFP. Any ambiguity concerning the RFP must be addressed through the question and answer process, as bidders are prohibited from including assumptions in their bid proposals. The issuing officer must receive the written questions or requests for clarifications before 3:00 p.m., Central Time by the due date in RFP Section 2.1 Procurement Timetable. The Department will not respond to verbal questions. If the question or request for clarification pertains to a specific section of the RFP, then the question or request for clarification must reference the RFP page and section numbers.

Bidders must submit questions and comments to the issuing officer by mail or electronic mail and not via fax. For questions via electronic mail, bidders should use the following e-mail address: *medicaidrfp@dhs.state.ia.us*. The Department will respond to questions and comments only from bidders who have submitted a letter of intent to bid.

The Department will send written responses to bidders' questions and responses to requests for clarifications on or before the date listed in RFP Section 2.1 Procurement Timetable to bidders who have submitted a letter of intent to bid or have submitted questions. Responses to questions will also be available on the Department's web site at *www.ime.state.ia.us* in the resource library.

The Department will not consider the written responses to be part of the RFP. If the Department decides to modify the RFP based on the written responses, the Department will issue an appropriate amendment to the RFP. The Department assumes no responsibility for verbal representations made by its officers or employees unless the Department confirms such representations in writing and incorporates them in the RFP.

# 2.10 Proposal Amendments and Withdrawals

The Department reserves the right to amend this RFP at any time. If the amendment occurs after the closing date for receipt of bid proposals, the Department may, in its sole discretion, allow bidders to amend their bid proposals in response to the Department's amendment if necessary.

The bidder may also amend its bid proposal prior to the proposal due date specified in RFP Section 2.1 Procurement Timetable. The bidder must submit the amendment in writing, sign it, and mail it to the issuing officer before the deadline for the final receipt of proposals (unless the Department extends this date). The Department will not accept electronic mail or faxed bid proposal amendments.

Bidders who submit bid proposals in advance of the deadline may withdraw, modify, or resubmit proposals at any time prior to the deadline for submitting proposals. Bidders that modify a bid proposal that has already been submitted must submit modified sections along with specific instructions identifying the pages or sections being replaced.

The Department will accept modifications only if bidders submit them prior to the deadline for final receipt of proposals. Bidders must notify the issuing officer in writing if they wish to withdraw their bid proposals. The Department will not accept electronic mail or faxed requests to withdraw.

# 2.11 Proposal Submission

The Department must receive the bid proposal, addressed as identified below, before 3:00 p.m., Central Time on the due date in RFP Section 2.1 Procurement Timetable.

Mary Tavegia, Issuing Officer
RFP MED-10-001
Iowa Department of Human Services
Iowa Medicaid Enterprise
200 Army Post Road, Suite 2
Des Moines, Iowa 50315

The Department will not waive this mandatory requirement. The Department will reject any bid proposal received after this deadline and return it unopened to the bidder. Bidders must allow ample delivery time to ensure timely receipt of their bid proposals. It is the bidder's responsibility to ensure that the Department receives the bid proposal prior to the deadline. Postmarking by the due date will not substitute for actual receipt of the bid proposal by the Department. The Department will not accept electronic mail and faxed bid proposals.

Bidders must furnish all information necessary to evaluate the bid proposal. The Department will disqualify bid proposals that fail to meet the mandatory requirements of the RFP. The Department will not consider verbal information from the bidder to be part of the bidder's proposal.

# 2.12 Proposal Opening

The Department will open bid proposals on the date specified in RFP Section 2.1 Procurement Timetable. While bid proposal opening by the issuing officer is an informal process, the bid proposals will remain confidential until the Evaluation Committee has reviewed all of the bid proposals submitted in response to this RFP and the Department has announced a Notice of Intent to Award a contract. Upon request, the Department may disclose the identity of bidders who have submitted letters of intent to bid or bid proposals.

# 2.13 Proposal Preparation Costs

The costs of preparation and delivery of the bid proposals are solely the responsibility of the bidders.

# 2.14 Proposal Rejection

The Department reserves the right to reject any or all bid proposals in response to this RFP, in whole or in part, and to cancel this RFP at any time prior to the execution of a

written contract. Issuance of this RFP in no way constitutes a commitment by the Department to award a contract.

# 2.15 Disqualification

The Department reserves the right to eliminate from the evaluation process any bidder not fulfilling all mandatory requirements of this RFP. Failure to meet a mandatory requirement shall be established by any of the following, as well the specifics outlined by RFP Attachment L Bid Proposal Mandatory Requirements Checklist:

a. The bidder fails to deliver the bid proposal by the due date and time.

b. The bidder fails to deliver the Cost Proposal in a separate, sealed envelope in the same box(es) with Technical Proposals.

c. The bidder states that a service requirement cannot be met.

d. The bidder's response materially changes a service requirement.

e. The bidder's response limits the rights of the Department.

f. The bidder fails to include information necessary to substantiate that the bidder will be able to meet a service requirement. A response of "will comply" or merely repeating the requirement is insufficient.

g. The bidder fails to respond to the Department's request for information, documents, or references.

h. The bidder fails to include a bid proposal security in its Cost Proposal.

i. The bidder fails to include any signature, certification, authorization, stipulation, disclosure, or guarantee requested in this RFP.

j. The bidder fails to comply with other mandatory requirements of this RFP.

k. The bidder presents the information requested by this RFP in a format inconsistent with the instructions of the RFP.

l. The bidder initiates unauthorized contact regarding the RFP with state employees.

m. The bidder provides misleading or inaccurate responses.

n. The bidder includes assumptions in its bid proposal. Any ambiguity concerning the Department's needs must be addressed through the question and answer process.

# 2.16 Material and Nonmaterial Variances

The Department reserves the right to waive or permit cure of nonmaterial variances in the bid proposal if the Department determines it to be in the best interest of the Department to do so. Nonmaterial variances include minor informalities that do not affect responsiveness, that are merely a matter of form or format, that do not change the

relative standing or otherwise prejudice other bidders, that do not change the meaning or scope of the RFP or that do not reflect a material change in the services.

In the event the Department waives or permits cure of nonmaterial variances, such waiver or cure will not modify RFP requirements or excuse the bidder from full compliance with RFP specifications or other contract requirements if the bidder is awarded the contract. The determination of materiality is in the sole discretion of the Department.

# 2.17 Reference Checks

The Department reserves the right to contact any reference provided in the bidder's response as a means to assist in the evaluation of the bid proposal, to verify information contained in the bid proposal, and to discuss the bidder's qualifications and the qualifications of any key personnel or subcontractors identified in the bid proposal.

# 2.18 Information from Other Sources

The Department reserves the right to obtain and consider information from other sources about a bidder, such as the bidder's capability and performance under other contracts.

# 2.19 Proposal Content Verification

The content of a bid proposal submitted by a bidder is subject to verification. Misleading or inaccurate responses shall result in disqualification.

# 2.20 Proposal Clarification

The Department reserves the right to contact a bidder after the submission of bid proposals for the purpose of clarifying a bid proposal to ensure mutual understanding. This contact may include written questions, interviews, site visits, a review of past performance if the bidder has provided goods or services to the Department or any other political subdivision wherever located, or requests for corrective pages in the bidder's proposal.

The Department will not consider information received if the information materially alters the content of the bid proposal or alters the services the bidder is offering to the Department. An individual authorized to legally bind the bidder shall sign responses to any request for clarification. Responses shall be submitted to the Department within the time specified in the Department's request.

# 2.21 Proposal Disposition

All bid proposals become the property of the Department. The Department will not return them to the bidder. At the conclusion of the selection process, the contents of all bid

proposals will be in the public domain and be open to inspection by interested parties subject to exceptions provided in Iowa Code Chapter 22 or other applicable law.

# 2.22 Public Records and Requests for Confidential Treatment

The Department may treat all information submitted by a bidder as public information following the conclusion of the selection process unless the bidder properly requests that information be treated as confidential at the time of submitting the bid proposal. Iowa Code Chapter 22 governs the Department's release of information. Bidders are encouraged to familiarize themselves with Chapter 22 before submitting a proposal. The Department will copy public records as required to comply with the public records laws.

Bidders must include any request for confidential treatment of information in the transmittal letter with the bidder's proposal. In addition, the bidder must enumerate the specific grounds in Iowa Code Chapter 22 that support treatment of the material as confidential and explain why disclosure is not in the best interest of the public. The request for confidential treatment of information must also include the name, address, and telephone number of the person authorized by the bidder to respond to any inquiries by the Department concerning the confidential status of the materials. RFP Section 7 Proposal Format and Content provides information about this request and other transmittal letter requirements.

The bidder must mark conspicuously on the cover sheet any bid proposal that contains confidential information, itemize all pages with confidential material under the above-referenced "request for confidential treatment of information" section of the transmittal letter, and conspicuously mark (in the footer) as containing confidential information each page upon which confidential information appears. The Department will deem identification of the entire bid proposal as confidential to be nonresponsive and disqualify the bidder.

If the bidder designates any portion of the bidder's proposal as confidential, the bidder will submit a "sanitized" copy of the bid proposal from which the bidder has excised the confidential information. The excised copy is in addition to the number of copies requested in RFP Section 7 Proposal Format and Content. The bidder must excise the confidential material in such a way as to allow the public to determine the general nature of the removed material and to retain as much of the bid proposal as possible. RFP Section 7 Proposal Format and Content provides Instructions for the "sanitized copy."

The Department will treat the information marked confidential as confidential information to the extent that such information is determined confidential under Iowa Code Chapter 22 or other applicable law by a court of competent jurisdiction. In the event that the Department receives a request for information marked confidential, written notice shall be given to the bidder at least seven days prior to the release of the information to allow the bidder to seek injunctive relief pursuant to Section 22.8 of the Iowa Code.

The Department will deem the bidder's failure to request confidential treatment of material as a waiver of any right to confidentiality that the bidder may have had.

# 2.23 Copyrights

By submitting a bid proposal, the bidder agrees that the Department may copy the bid proposal for purposes of facilitating the evaluation of the bid proposal or to respond to requests for public records. The bidder consents to such copying by submitting a bid proposal and represents/warrants that such copying will not violate the rights of any third party. The Department shall have the right to use ideas or adaptations of ideas that bid proposals present.

# 2.24 Release of Claims

By submitting a bid proposal, the bidder agrees that it will not bring any claim or cause of action against the Department based on any misunderstanding concerning the information provided herein or concerning the Department's failure, negligent or otherwise, to provide the bidder with pertinent information as intended by this RFP.

# 2.25 Oral Presentations

The Department will request bidder finalists to make an oral presentation of the bid proposal. RFP Section 8 Evaluation Process provides additional information on the oral presentations process and the subsequent best and final offer process.

The presentation will occur at a state office located in Des Moines, Iowa. The determination of participants, location, order, and schedule for the presentations (that the Department will provide during the evaluation process) is at the sole discretion of the Department. The presentation may include slides, graphics or other media that the bidder selects to illustrate the bidder's proposal. The presentation shall not materially change the information contained in the bid proposal.

# 2.26 Proposal Evaluation

The Department will review in accordance with RFP Section 8 Evaluation Process all bid proposals that bidders submit in a timely manner and that meet the mandatory submittal requirements of this RFP. The Department will not necessarily award any contract resulting from this RFP to the bidder offering the lowest cost to the Department. Instead, the Department will award a contract to the compliant bidder whose bid proposal receives the most points in accordance with the evaluation criteria set forth in RFP Section 8 Evaluation Process. Moreover, the Department may choose not to award a contract. The recommendations for award of contracts presented by the evaluation committees are subject to final approval and sign-off by the State Medicaid Director.

# 2.27 Financial Viability Review

The compliant bidder whose bid proposal receives the most points in accordance with the evaluation criteria is subject to a review for financial viability. The Department may designate a third party to conduct a review of financial statements, financial references, and any other financial information that the compliant bidder provides in the Company Financial Information section of the bid proposal.

# 2.28 Notice of Intent to Award

The Department will send by mail a notice of intent to award for the contract to all bidders who have submitted a timely bid proposal. The notice of intent to award is subject to execution of a written contract and, as a result, does not constitute the formation of a contract between the Department and the apparent successful bidder.

# 2.29 Acceptance Period

The Department and the apparent successful bidder will complete negotiation and execution of the contract by the due date that RFP Section 2.1 Procurement Timetable specifies. If an apparent successful bidder fails to negotiate and execute a contract, the Department (in its sole discretion) may revoke the award and award the contract to the next highest ranked bidder or withdraw the RFP. The Department further reserves the right to cancel the award at any time prior to the execution of a written contract.

# 2.30 Review of Award Decision

Bidders may request review of the award decision by filing a judicial review action pursuant to Iowa Code Chapter 17A.19.

# 2.31 Definition of Contract

The full execution of a written contract shall constitute the making of a contract for services. No bidder shall acquire any legal or equitable rights relative to the contract services until the Department and the apparent successful bidder have fully executed the contract.

# 2.32 Choice of Law and Forum

The laws of the State of Iowa govern this RFP and resultant contract, excluding the conflicts of law provisions of Iowa law. Changes in applicable laws and rules may affect the award process or the resulting contract. Bidders are responsible for ascertaining pertinent legal requirements and restrictions. Any and all litigation or actions commenced in connection with this RFP shall be brought in the appropriate Iowa forum.

# 2.33 Restrictions on Gifts and Activities

Iowa Code Chapter 68B restricts gifts which may be given or received by state employees and requires certain individuals to disclose information concerning their activities with state government. Bidders are responsible to determine the applicability of this chapter to their activities and to comply with the requirements. In addition, pursuant to Iowa Code Section 722.1, it is a felony offense to bribe or attempt to bribe a public official.

# 2.34 No Minimum Guaranteed

The Department anticipates that the selected bidder will provide services as the Department requests. The Department will not guarantee any minimum compensation to be paid to the bidder or any minimum usage of the bidder's services.

# 3 PROGRAM DESCRIPTION

The following sections provide an overview of the Iowa Medicaid Program:

- 3.1 Medicaid Program Administration
- 3.2 Overview of Present Operation
- 3.3 Summary of Program Responsibilities

# 3.1 Medicaid Program Administration

Multiple state and federal agencies administer the Iowa Medicaid Program. The following sections describe their roles.

- 3.1.1 Iowa Department of Human Services
- 3.1.2 United States (US) Department of Health and Human Services

## 3.1.1 Iowa Department of Human Services

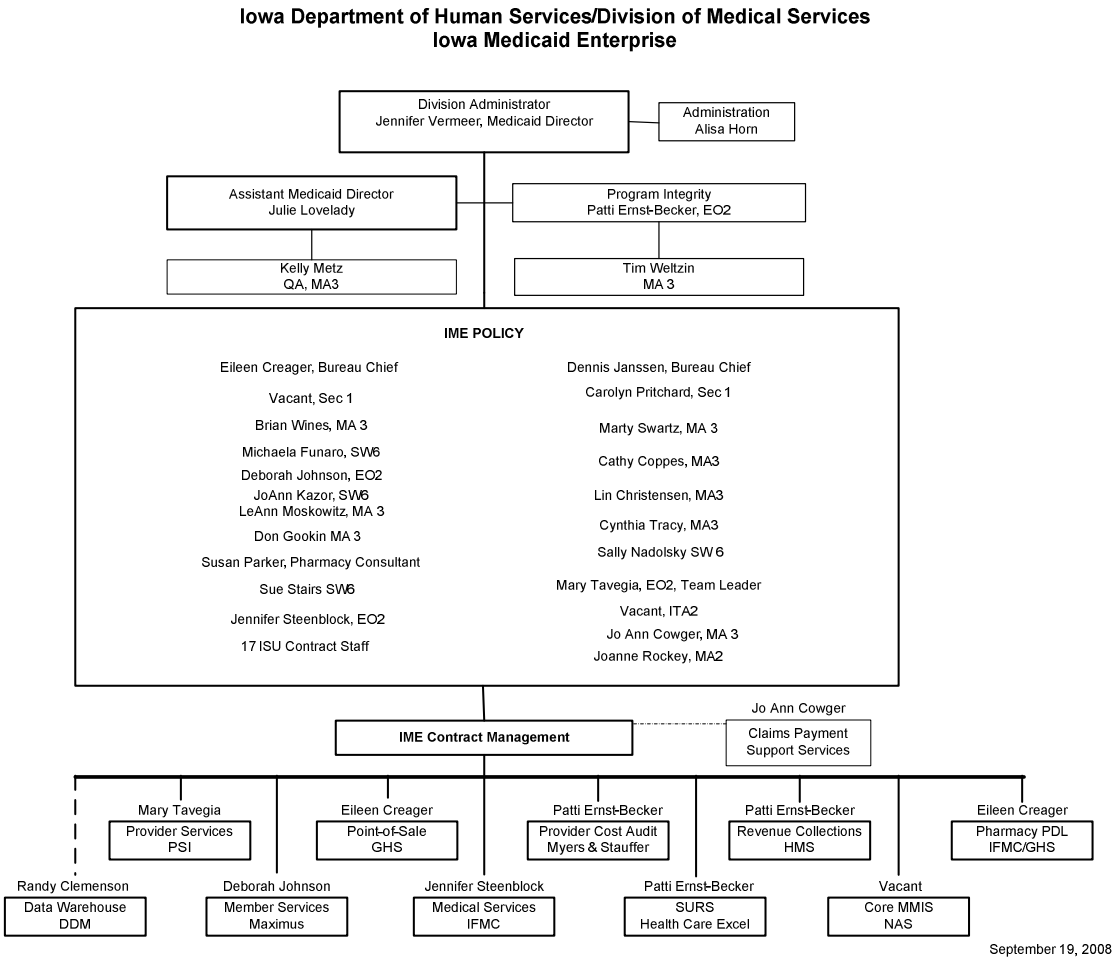
The Iowa Department of Human Services (DHS) is the single state agency responsible for the administration of the Iowa Medicaid Program. The Department has seven divisions, eight field services area offices, and nine state facilities that serve developmentally disabled, mentally ill or juvenile clients. The seven divisions of the Department of Human Services include:

- The Division of Fiscal Management
- The Division of Data Management
- The Division of Results Based Accountability
- The Division of Child Support Recovery, Case Management and Refugee Services
- The Division of Financial, Health and Work Supports
- The Division of Children and Family Services
- The Division of Mental Health and Disability Services
- The Division of Medical Services

The responsibilities for the Medicaid program have been dispersed within the Division of Children and Family Services, the Division of Financial, Health and Work Supports, the Division of Data Management, Division of Mental Health and Disability Services and the Division of Medical Services (led by the State Medicaid Director), all reporting to the Director for the Department of Human Services. The Division of Medical Services

governs the Bureau of Long Term Care and the Bureau of Managed Care and Clinical Services. The work of both bureaus has significant impact on the Medicaid policy. Primary responsibility for the Medicaid Management Information System (MMIS) rests with the Core MMIS contractor supported by the Department of Administrative Services Information Technology Division. Ancillary systems are supported by the Department's Division of Data Management (DDM). An illustration of the Department's organization is available at *www.dhs.state.ia.us/docs/DHS_TableOrganization.pdf*. The following chart illustrates the current organizational structure for the Iowa Medicaid Enterprise (IME).

**Figure 2: IME Organizational Structure**




# 3.1.2 US Department of Health and Human Services

Within the US Department of Health and Human Services, three agencies administer the Medicaid program. The following paragraphs describe their roles.

The Centers for Medicare and Medicaid Services (CMS) is responsible for promulgating Title XIX (Medicaid) regulations and determining state compliance with regulations. CMS also is responsible for certifying and recertifying all state MMIS operations.

The Office of Inspector General (OIG) is responsible for identifying and investigating instances of fraud and abuse in all state Medicaid programs. The Inspector General's office also performs audits of all state Medicaid programs.

The Social Security Administration is responsible for supplemental security income (SSI) eligibility determination. The Social Security Administration transmits this information via a state data exchange (SDX) tape to the state for updating the eligibility system. Information is also provided on Medicare eligibility through beneficiary data exchange and Medicare Parts A and B buy-in files. The Department then provides SSI and Medicare eligibility information to the Core MMIS contractor as part of the eligibility file update process.

# 3.2 Overview of Present Operation

This section includes the following topics:

- 3.2.1 Systems Responsibilities
- 3.2.2 Current MMIS Interfaces
- 3.2.3 Eligibility
- 3.2.4 Providers
- 3.2.5 Covered Services
- 3.2.6 Provider Reimbursement

## 3.2.1 Systems Responsibilities

The Iowa MMIS is a mainframe application with primarily batch processing for claims and file updates. Noridian Administrative Services (NAS) is the Core MMIS contractor that manages the system, as well as the workflow management process system known as OnBase. The Division of Data Management (DDM) manages the separate data warehouse/decision support (DW/DS) system. Goold Health Systems, which is the pharmacy point-of-sale (POS) contractor, manages the prescription drug POS system that provides real-time processing for pharmacy claims. More information about these applications and the current infrastructure is in RFP Section 5 Operating Environment.

The Iowa MMIS, as is the case with virtually all of the systems in operation today, is built around subsystems that organize and control the data files used to process claims and provide reports. The MMIS contains the eight standard subsystems [recipient, provider, claims, reference, Management and Administrative Reporting (MAR), Surveillance and Utilization Review (SUR), managed care and Third Party Liability (TPL)] as well as the supporting medically needy and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) subsystems.

# 3.2.2 Current MMIS Interfaces

A number of file interfaces exist between the MMIS and other computerized systems. The following systems interface with the Iowa MMIS:

a. Title XIX system – The Department provides recipient eligibility updates daily to the Core MMIS contractor with full file replacement provided monthly. Title XIX also provides managed health care notices of eligibility with these update files.

b. Individualized Services Information System (ISIS) – The Department provides facility, Home and Community-Based Services (HCBS) waiver, Targeted Case Management (TCM), Remedial Services, Habilitation Services, Money Follows The Person (MFP) and Program for All-Inclusive Care for the Elderly (PACE) eligibility and services data daily to the Core MMIS contractor.

c. The Core MMIS contractor provides a complete provider file to the Department daily.

d. The Core MMIS contractor provides a paid claims file weekly to the Department's Division of Fiscal Management.

e. Providers can opt to submit claims through a clearinghouse to the Core MMIS contractor.

f. The Iowa Plan contractor provides encounter data to the Core MMIS contractor monthly.

g. Medicare Crossover Claims – Medicare intermediaries and carriers submit Medicare Parts A and B crossover claims to the Core MMIS contractor.

h. Medically Needy Spenddown – The Core MMIS contractor accumulates claim information on potential medically needy participants and notifies the Department's Iowa Automated Benefit Calculation (IABC) system when the person has met their spend-down requirement.

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.

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.

k. Iowa Department of Public Health – EPSDT eligibility data, except pharmacy,

l. Automated license verification files from Iowa Board of Nursing, the Iowa Board of Medicine and the Iowa Dental Board.

# 3.2.3 Eligibility

Through its field offices, the Department determines eligibility for people in all eligibility categories except SSI, for which the Social Security Administration (SSA) determines eligibility. The Department produces and distributes all annual Medicaid eligibility cards.

The average number of Medicaid eligible members by fiscal year appears in the information contained in the resource library. The Iowa Medicaid Program recognizes both mandatory and optional eligibility groups, as described below.

This section includes the following topics:

- 3.2.3.1 Mandatory Title XIX Eligible Groups
- 3.2.3.2 Optional Title XIX Eligible Groups
- 3.2.3.3 IowaCare
- 3.2.3.4 Children's Health Insurance Program (CHIP)

# 3.2.3.1 Mandatory Title XIX Eligible Groups

The following groups are covered under the mandatory eligibility category:

a. Supplemental Security Income (SSI) recipients

b. Mandatory state supplementary assistance (SSA) recipients

c. Former SSI or SSA recipients who are ineligible for SSI or SSA due to widow/widower Social Security benefits and who do not have Medicare Part A benefits

d. Disabled adult children ineligible for SSI or SSA due to the parent's Social Security benefits

e. Persons ineligible for federal medical assistance percentages (FMAP) or SSI because of requirements that do not apply to Medicaid

f. Qualified Medicare beneficiaries for payment of Medicare premiums, deductible and coinsurance only

g. Specified low-income Medicare beneficiaries (SLIMBs) for payment of Medicare Part B premium

h. Qualifying individual 1 known as expanded specified low-income Medicare beneficiaries (E-SLIMBs) for payment of Medicare Part B premium only

i. FMAP recipients

j. Transitional Medicaid for 12 months for former FMAP recipients who lost eligibility due to earned income

k. Extended Medicaid for four months for former FMAP recipients who became ineligible due to recipient of child or spousal support

l. Newborn children of Medicaid-eligible mothers

m. Postpartum eligibility for pregnant women; eligibility continues for 60 days following delivery

n. Qualified FMAP-related children under seven years of age, eligible for the Children's Medical Assistance Program (CMAP)

o. Foster care Medicaid under Title IV-E

p. Qualified Disabled and Working Persons (QDWP) for payment of Medicaid Part A premiums

q. Pregnant women and infants (under one year of age) whose family income does not exceed 300 percent of the federal poverty level

r. Children ages 1 through 18 whose family income does not exceed 133 percent of the federal poverty level

s. Continuous eligibility for pregnant women that continues throughout the pregnancy once eligibility is established

# 3.2.3.2 Optional Title XIX Eligible Groups

Iowa Medicaid elects to extend its services to individuals in the following categories:

a. 300 percent group – Individuals in medical institutions who meet all eligibility criteria for SSI except for income, which cannot exceed 300 percent of the SSI standard

b. Those eligible for SSI, SSA, or FMAP except for residents in a medical institution

c. HCBS waivers for people living at home that would otherwise be eligible for Title XIX in a medical institution. This criteria includes waiver groups for: AIDS, Ill and handicapped, elderly, intellectually disabled, physically disabled, brain injury, and children's mental health.

d. Needy people in a psychiatric facility under age 21 or age 65 or over

e. SSA optional recipients who reside in residential care facility, reside in a family life home, receive in-home health-related care, have dependent people, or are blind people

f. Persons who are income- and resource-eligible for cash assistance but are not receiving cash assistance (SSI, FMAP, or SSA)

g. Qualified FMAP-related children over age 7 but under 21 are eligible for CMAP

h. Pregnant women with presumptive Medicaid eligibility, for whom authorized providers determine limited eligibility based on countable income not exceeding 300 percent of federal poverty

i. Women with presumptive Medicaid eligibility who have been diagnosed with breast or cervical cancer, as a result of a screen under Department of Public Health Breast and Cervical screening program, for whom authorized providers determine eligibility for the full range of Medicaid-covered services. (Eligibility is time-limited, usually not longer than three months. Women can be presumed eligible only once in a twelve-month period.)

j. Medically Needy Program – FMAP/SSI-related groups who meet all eligibility requirements of the cash assistance programs except for resources and income and those who spend down their income to not more than 133 percent of the FMAP payment

k. Medicaid for Employed People with Disabilities (MEPD)

l. Non IV-E foster care Medicaid

m. Non IV-E subsidized adoption Medicaid

n. Medicaid for independent young adults, which provides Medicaid eligibility for youth who age out of foster care whose income is below 200 percent of federal poverty level

o. Supplement for Medicare and Medicaid eligibility SSA coverage group, which provides cash to these individuals and requires mandatory Medicaid buy-in for their Medicare premiums

p. Reciprocity that covers non-IVE subsidized adoption Medicaid for children from other states

q. Iowa Family Planning Network for Medicaid coverage of specific family planning related services (Women who had a Medicaid-covered birth are eligible for 12 consecutive months following the 60-day postpartum period. Women who are at least 13 and under 45 years of age at or below 200 percent FPL are also eligible.)

r. Continuous eligibility for children who are under age 19 and have been determined to be eligible for ongoing Medicaid.

s. Medicaid for children with special needs that provides Medicaid to disabled children under the age of 19 whose family income no more than 300 percent of the federal poverty level

t. Presumptive eligibility for children effective January 1, 2010, for which authorized qualified entities determine eligibility based on countable income not exceeding 300 percent of the federal poverty level and citizenship.

# 3.2.3.3 IowaCare

IowaCare is an 1115 waiver that provides payment for limited benefits to individuals aged 19 through 64 using a limited provider network. To be eligible, individuals other than pregnant women must have countable income at or below 200 percent of the federal poverty level, not have access to other group health insurance, and pay premiums if income is above 100 percent of the federal poverty level unless a hardship is declared. Pregnant women and their newborn children are eligible for IowaCare if their gross countable income is below 300 percent of the federal poverty level and allowable medical expenses reduce their countable income to 200 percent of the federal poverty level or below. Services are available to IowaCare individuals at the University of Iowa Hospitals and Clinics in Iowa City, Iowa, and additionally (if a resident of Polk County) at Broadlawns Medical Center in Des Moines, Iowa.

# 3.2.3.4 Children’s Health Insurance Program (CHIP)

Iowa’s CHIP is a combination of a Medicaid expansion and a separate stand-alone program called ***hawk-i,*** which stands for Healthy and Well Kids in Iowa. The ***hawk-i*** program is administered independently from Medicaid, with eligibility determination, health and dental plan enrollment and premium payment collection performed by a separate contractor. Currently, no interfaces exist between the ***hawk-i*** program and the MMIS. Medicaid data and ***hawk-i*** data are available through the DW/DS system that the state maintains.

# 3.2.4 Providers

The Iowa Medicaid Program provides direct reimbursement to enrolled providers who have rendered services to eligible members. Providers may be reimbursed for covered services following application, enrollment, and completion of a provider agreement. The Iowa Medicaid Program currently recognizes a multitude of provider types with their corresponding MMIS code values, which can be found in the resource library.

# 3.2.5 Covered Services

The Iowa Medicaid Program covers all federally mandated services as well as a number of optional services. The services currently covered under the program are listed in the Medicaid Guide in the resource library.

# 3.2.6 Provider Reimbursement

This section includes the following topics:

- 3.2.6.1 Institutional Provider Reimbursement
- 3.2.6.2 Noninstitutional Provider Reimbursement
- 3.2.6.3 Specific Provider Categories and Basis of Reimbursement
- 3.2.6.4 Restrictions on Reimbursement

# 3.2.6.1 Institutional Provider Reimbursement

Providers are reimbursed on the basis of prospective and retrospective reimbursement based on reasonable and recognized costs of operation. Some providers receive retroactive adjustments based on submission of fiscal and statistical reports by the provider. The retroactive adjustment represents the difference between the amount received by the provider during the year for covered services and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services rendered to medical assistance members.

# 3.2.6.2 Noninstitutional Provider Reimbursement

Providers are reimbursed on the basis of a fixed fee for a given service. If product cost is involved in addition to service, reimbursement is based on the actual acquisition cost of the product to the provider, or the product cost is included as part of the fee. Increases in fixed fees may be made periodically, if funding is made available to do so.

# 3.2.6.3 Specific Provider Categories and Basis of Reimbursement

The Iowa Medicaid Program pays deductibles and coinsurance for services covered by Title XVIII (Medicare) of the Social Security Act. The program also pays the monthly premium for supplemental medical insurance (Medicare Part B) for most members age

65 or older and for certain blind or disabled people receiving medical assistance. Additionally, the Medicare Part A premium will be covered for members who qualify under the Qualified Medicare Beneficiary (QMB) Program. The Provider Reimbursement Categories table represents reimbursement methodologies for participating providers.

**Figure 3: Provider Reimbursement Categories**

| Institutional | Basis of Reimbursement |
|---|---|
| **Inpatient** | |
| Inpatient Hospital (General Hospital) | Prospective reimbursement system for inpatient hospital services based on diagnosis-related groups (DRGs) |
| Critical Access Hospital | Cost-based w/ cost settlement (in-state and out-of-state) |
| Psychiatric Medical Institution for Children (PMIC) | Cost-based per diem rate to a maximum established by the Iowa Legislature |
| State Mental Health Institution | Cost-based w/ cost settlement |
| Mental Hospital | Cost-based w/ cost settlement |
| Rehabilitation Hospital | Per diem rate |
| Psychiatric Hospital | Cost-based w/ cost settlement (in-state); Percentage of charges interim rate (out-of-state) |
| **Outpatient** | |
| Outpatient Hospital (general hospital; both in-state and out-of-state) | Ambulatory Payment Classifications (APC)-based |
| Critical Access Hospital | Cost-based w/cost settlement (in-state and out-of-state) |
| Laboratory Only | Fee schedule |
| Noninpatient Programs (NIPS) | Fee schedule |
| **Nursing Facilities** | |
| Special Population Nursing Facility | Cost-based per diem without case-mix factor; Without cap for state-owned |
| Nursing Facility (NF) | Modified price-based case-mix adjusted per diem |
| Nursing Facility for the Mentally Ill (NF-MI) | Modified price-based case-mix adjusted per diem; With cap for non-state owned, without cap for state-owned |
| State-Owned Nursing Facility | Cost-based per diem without case-mix factor, without a cap |
| Intermediate Care Facility for the Mentally Retarded (ICF/MR) | Per diem rate, capped at 80th percentile, except for state Resource Centers (Woodward and Glenwood) |
| **Other Institutional Reimbursements** | |
| Home Health Agency | Cost-based with cost settlement |
| Family Planning Clinic | Fee schedule |

| | |
|---|---|
| Rural Health Clinic (RHC) | Cost-based w/cost settlement |
| Federally Qualified Health Center (FQHC) | Cost-based w/cost settlement |
| Partial Hospitalization | APC or fee schedule |
| Rehabilitation Agency | Medicare fee schedule |
| Acute Rehab Hospital | Per Diem developed by submitted cost reports |
| **Non-Institutional** | **Basis of Reimbursement** |
| **Practitioners** | |
| Physician (Doctor of Medicine or Osteopathy) | Fee schedule – Resource-Based Relative Value Scale (RBRVS) |
| Dentist | Fee schedule |
| Chiropractor | Fee schedule (RBRVS) |
| Physical Therapist | Fee schedule (RBRVS) |
| Audiologist | Fee schedule (RBRVS) for professional services, plus product acquisition cost and dispensing fee |
| Psychiatrist | Fee schedule (RBRVS, to the extent rendered/billed by psychiatrist or psychologist and then only for CPT coded services) |
| Podiatrist | Fee schedule (RBRVS) |
| Psychologist | Fee schedule (RBRVS) |
| CRNA | Fee schedule (RBRVS) |
| Nurse Practitioner | Fee schedule (RBRVS) |
| Certified Nurse-midwife | Fee schedule (RBRVS) |
| Patient Manager (Primary Care Physician) | Capitated administrative fee |
| Optician | Fee schedule (RBRVS); Fixed fee for lenses. Frames and other optical materials at product acquisition cost. |
| Optometrist | Fee schedule (RBRVS); Fixed fee for lenses. Frames and other optical materials at product acquisition cost |
| Clinical Social Worker | Medicare deductibles/coinsurance |
| **Services/Supplies** | |
| Hospice | Medicare-based prospective rates, based on level of care provided |
| Clinics | Fee schedule |
| Ambulance Service | Fee schedule (Cost-based for critical access hospital-based ambulance) |
| Independent Laboratory | Fee schedule |
| X-Ray | Fee schedule (paid under either a Physician or Clinic billing) |

| | |
|---|---|
| Pharmacy/Drugs | Lower of: Average Wholesale Price (AWP) minus 12 percent, usual and customary, or the MAC price (state or federal), plus dispensing fee |
| Lead Investigations | Fee schedule |
| Hearing Aid Dealer | Fee schedule for professional services, plus product acquisition cost and dispensing fee |
| Orthopedic Shoe Dealer | Fee schedule |
| Medical Equipment and Prosthetic Devices Provider | Fee schedule |
| Supplies | Fee schedule |
| **Other Agency/Organization Reimbursements** | |
| Ambulatory Surgical Center | Fee schedule |
| Birthing Center | Fee schedule |
| Community Mental Health Center | Fee schedule |
| EPSDT Screening Center | Fee schedule |
| Maternal Health Center | Fee schedule |
| Area Education Agency | Cost based |
| Local Education Agency | Cost based |
| Targeted Case Management | Cost-based w/cost settlement |
| Health Maintenance Organization | Predetermined capitation rate |
| Managed Mental Health and Substance Abuse | Predetermined capitation rate |
| HCBS Waiver Service Provider | Negotiated rates or fee schedule |
| Adult Rehabilitation Option | Cost-based with cost settlement |
| Remedial Services | Cost based with cost settlement |
| Habilitation Services | Cost based with cost settlement |

# 3.2.6.4 Restrictions on Reimbursement

In an effort to control the escalating costs of the Iowa Medicaid Program, the following restrictions or limitations on reimbursement have been implemented.

## 3.2.6.4.1 Copayments

Copayments are applicable to certain optional services provided to all members, with the exception of the following:

a. Services provided to members under age 21

b. Family planning services or supplies

c. Services provided to members in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of

receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

d. Services provided to pregnant women

e. Services provided by an health maintenance organization (HMO)

f. Emergency services (as determined by the Department)

### 3.2.6.4.2 Preadmission Review

Some inpatient hospitalization admissions are subject to preadmission review by the Medical Services contractor. Payment is contingent upon the Medical Services contractor's approval of the stay.

### 3.2.6.4.3 Transplant and Preprocedure Review

The Medical Services contractor conducts a preprocedure review of certain frequently performed surgical procedures to determine medical necessity. They also review all requests for transplant services. Payment is contingent upon approval of the procedure by the Medical Services contractor.

### 3.2.6.4.4 Prior Authorization (PA) Requirements

The Iowa Medicaid Program requires PA for certain dental services, some durable medical equipment, eyeglass replacement if less than two years, hearing aids if over a certain price, various prescription drugs, and certain transplants. The Medical Services contractor performs prior authorizations.

## 3.3 Summary of Program Responsibilities

The following sections provide details of the present Iowa Medicaid Program responsibilities as defined in the Iowa Medicaid Enterprise (IME) Medicaid Information Technology Architecture (MITA) State Self-Assessment (SS-A) conducted in January 2009.

- 3.3.1 Determine Eligibility
- 3.3.2 Enroll Member
- 3.3.3 Disenroll Member
- 3.3.4 Inquire Member Eligibility
- 3.3.5 Manage Applicant and Member Communication
- 3.3.6 Manage Member Complaint and Appeal
- 3.3.7 Manage Member Information

- 3.3.8 Perform Population and Member Outreach
- 3.3.9 Enroll Provider
- 3.3.10 Disenroll Provider
- 3.3.11 Inquire Provider Information
- 3.3.12 Manage Provider Communication
- 3.3.13 Manage Provider Complaint, Grievance and Appeal
- 3.3.14 Manage Provider Information
- 3.3.15 Perform Provider Outreach
- 3.3.16 Produce Administrative or Health Services RFP
- 3.3.17 Award Administrative or Health Services Contract
- 3.3.18 Manage Administrative or Health Services Contract
- 3.3.19 Close-out Administrative or Health Services Contract
- 3.3.20 Manage Contractor Information
- 3.3.21 Manage Contractor Communication
- 3.3.22 Perform Contractor Outreach
- 3.3.23 Support Contractor Grievance and Appeal
- 3.3.24 Inquire Contractor Information
- 3.3.25 Authorize Referral
- 3.3.26 Authorize Service
- 3.3.27 Authorize Treatment Plan
- 3.3.28 Apply Claim Attachment
- 3.3.29 Apply Mass Adjustment
- 3.3.30 Edit Claim
- 3.3.31 Audit Claim
- 3.3.32 Price Claim-Value Encounter
- 3.3.33 Prepare Remittance Advice/Encounter Report
- 3.3.34 Prepare Provider EFT/Check
- 3.3.35 Prepare Coordination of Benefits (COB)/TPL
- 3.3.36 Prepare Explanation of Benefits (EOB)
- 3.3.37 Prepare HCBS Payments
- 3.3.38 Prepare Premium Capitation EFT/Check
- 3.3.39 Prepare Capitation Premium Payment

- 3.3.40 Prepare Health Insurance Premium Payments (HIPP)
- 3.3.41 Prepare Medicare Premium Payments
- 3.3.42 Inquire Payment Status
- 3.3.43 Manage Payment Information
- 3.3.44 Calculate Spend-Down Amount
- 3.3.45 Prepare Member Premium Invoice
- 3.3.46 Manage Drug Rebate
- 3.3.47 Manage Estate Recovery
- 3.3.48 Manage Recoupment
- 3.3.49 Manage Cost Settlement
- 3.3.50 Manage TPL Recoveries
- 3.3.51 Designate Approved Services and Drug List
- 3.3.52 Develop and Maintain Benefit Package
- 3.3.53 Manage Rate Setting
- 3.3.54 Develop Agency Goals and Objectives
- 3.3.55 Develop and Maintain Program Policy
- 3.3.56 Maintain State Plan
- 3.3.57 Formulate Budget
- 3.3.58 Manage Federal Financial Participation (FFP) for MMIS
- 3.3.59 Manage Federal Medical Assistance Percentages (F-MAP)
- 3.3.60 Manage State Funds
- 3.3.61 Manage 1099s
- 3.3.62 Generate Financial and Program Analysis Reports
- 3.3.63 Maintain Benefit/Reference Information
- 3.3.64 Manage Program Information
- 3.3.65 Perform Accounting Functions
- 3.3.66 Develop and Manage Performance Measures and Reporting
- 3.3.67 Monitor Performance and Business Activity
- 3.3.68 Draw and Report FFP
- 3.3.69 Manage FFP for Services
- 3.3.70 Manage Legislative Communication
- 3.3.71 Establish Business Relationship

- 3.3.72 Manage Business Relationship
- 3.3.73 Terminate Business Relationship
- 3.3.74 Manage Business Relationship Communication
- 3.3.75 Identify Candidate Case
- 3.3.76 Manage Program Integrity Case
- 3.3.77 Establish Case
- 3.3.78 Manage Care Management Case
- 3.3.79 Manage Medicaid Population Health

# 3.3.1 Determine Eligibility

The Determine Eligibility business process in Iowa is carried out by the Income Maintenance Workers and Administrators in the local field offices. Automated portions of the process are implemented in the IABC and Title XIX systems. The process receives an eligibility application data set from the receive inbound transaction process; checks for status (such as new, resubmission, duplicate); establishes type of eligible; screens for required fields; edits required fields; verifies applicant information with external entities; assigns an ID; establishes eligibility categories and hierarchy; associates with benefit packages, and produces a request for notification data set that is sent to the Manage Member Communication process (the notification can be in regards to the eligibility determination or a request for more information.) Note: Eligibility determinations requiring medical information are part of the Enroll Member business process.

# 3.3.2 Enroll Member

The Enroll Member business process receives eligibility data from the Determine Eligibility process, determines additional qualifications for enrollment in programs for which the member may be eligible (such as managed care or waiver programs), offers a choice of primary care providers for some programs, requests notifications to the member and the contractor be sent via the Manage Member Communication and Manage Contractor Communication processes, and sends the enrollment outcome data to the Manage Member Information process for loading the into the Member Information data store. Most enrollment steps are automated (via the Title XIX and ISIS systems) with those that are manual (such as medical screenings) handled by IME Policy or by Income Maintenance or Service Workers in the local field offices.

# 3.3.3 Disenroll Member

The Member Management Disenroll Member business process is responsible for managing the termination of a member’s enrollment in a program, including:

a. Processing of eligibility terminations and requests for disenrollment
    1. Submitted by the member, provider, or contractor

2. Disenrollment based on member's death; failure to meet enrollment criteria, such as a change in health or financial status, or a change of residency outside of service area
3. Request by another business area, such as Prepare Member Premium Invoice process for the failure to pay premiums
4. Program Integrity business area for fraud and abuse
5. Mass disenrollment

b. Validation that the termination meets state rules and/or policies

c. Requesting that the Manage Member Information process reference new and changed disenrollment information

d. Prompting the Manage Member Information process to provide timely and accurate notification or to make enrollment data required for operations available to all parties and affiliated business processes, including:

1. The Prepare Capitation Premium Payment and Prepare Member Premium Payment business processes for changes in Member Information and stored data for payment preparation
2. The appropriate communications and outreach and education processes, such as the Manage Applicant and Member Communication, Perform Population and Member Outreach, and Manage Member Grievance and Appeal business process for follow up with the affected parties, including informing parties of their procedural rights (Note: This may precede or follow termination procedures)

Enrollment brokers may perform some of the steps in this process.

# 3.3.4 Inquire Member Eligibility

The Member Management Inquire Member Eligibility business process receives requests for eligibility verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the Send Outbound Transaction process, which generates the outbound Eligibility Verification Response Transaction. This transaction will, at minimum, indicate whether the member is eligible for some health benefit plan coverage under Medicaid, in accordance with Health Insurance Privacy and Accountability Act (HIPAA). This transaction may include more detailed information about the Medicaid programs, specific benefits and services, and the providers from which the member may receive covered services.

# 3.3.5 Manage Applicant and Member Communication

The Manage Applicant and Member Communication business process is handled by various units throughout IME that may include Member Services, Medical Services, Pharmacy Services, field offices, and other units. This process receives requests for information and assistance from prospective and current members' communications such as inquiries related to eligibility, redetermination, benefits, providers, health plans and programs, and provides requested assistance and appropriate responses and

information packages. Communications are researched, developed and produced for distribution via Send Outbound Transaction process.

Inquires from applicants, prospective and current members are handled by the Manage Applicant and Member Communication process by providing assistance and responses to individuals, such as bidirectional communication. Also included are scheduled communications such as member ID cards, redetermination notifications, or formal program notifications such as the dispositions of complaints and appeals. The Perform Applicant and Member Outreach process targets both prospective and current Member populations for distribution of information about programs, policies, and health issues.

NOTE: There is a “no wrong door” policy for members. Any unit may receive communication from members which is then forwarded to the appropriate unit.

The Member Services and Income Maintenance Customer Service call centers are available during normal business hours. Responses are tracked to measure performance. The Medical Services call center will initiate and respond to member communications regarding pre-authorizations, prior authorizations and specialized managed care programs. Staff will track and monitor communications with workflow management system. The Pharmacy Services call center will receive questions from members regarding the preferred drug list. These calls are tracked and monitored with the pharmacy help desk application.

# 3.3.6 Manage Member Complaint and Appeal

The Manage Member Complaint and Appeal business process handles applicant or member (or their advocate’s) appeals of adverse decisions or communications of a complaint. The complaint process is informal and can be handled by any unit in the IME. The appeal process is more formalized and is handled primarily through DHS Office of Policy Analysis (OPA). A complaint or appeal is received by the Manage Applicant and Member Communication process via the Receive Inbound Transaction process. The complaint or appeal is logged and tracked, triaged to appropriate reviewers and researched. Additional information may be requested. A hearing may be scheduled and conducted in accordance with legal requirements. A ruling is made based upon the evidence presented. Results of the hearing are documented and relevant documents are distributed to the applicant or member and stored in the applicant or member information file. The applicant or member is formally notified of the decision via the Send Outbound Transaction Process.

This process supports the Program Quality Management Business Area by providing data about the types of complaints and appeals it handles; grievance and appeals issues; parties that file or are the target of the complaints and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to complaints and appeals.

In some states, if the applicant or member does not agree with the Agency’s disposition, a second appeal can be filed requesting a review of the disposition. If the health status or medical need of the applicant or member is urgent, the appeal may be expedited.

# 3.3.7 Manage Member Information

The Manage Member Information business process is responsible for managing all operational aspects of the member data store, which is the source of comprehensive information about applicants and members, and their interactions with the state Medicaid agency.

The member data store is the IME “source of truth” for member demographic, financial, socioeconomic, and health status information. A member’s data store record will include all eligibility and enrollment spans, and support flexible administration of benefits from multiple programs so that a member may receive a customized set of services.

In addition, the member data store includes records about and tracks the processing of eligibility applications and determinations, program enrollment and disenrollment; the member’s covered services, and all communications, such as outreach and EOBs, and interactions related to any grievance/appeal.

The member data store may store records or pointers to records for services requested and services provided; care management; utilization and program integrity reviews; and member payment and spend-down information.

Business processes that generate applicant or member information send requests to the member data store to add, delete, or change this information in data store records. The member data store validates data upload requests, applies instructions, and tracks activity.

The member data store provides access to member records, such as for Medicare crossover claims processing and responses to queries, such as for eligibility verification, and “publish and subscribe” services for business processes that track member eligibility, such as Manage Case and Perform Applicant and Member Outreach.

# 3.3.8 Perform Population and Member Outreach

The Perform Population and Member Outreach business process is handled by Member Services, DHS Eligibility, Policy Analysis, and Medical Services. This business process originates internally within the Agency for purposes such as:

a. Notifying prospective applicants and current members about new benefit packages and population health initiatives

b. New initiatives from Program Administration

c. Receiving indicators on underserved populations from the Monitor Performance and Business Activity process (Program Management)

It includes production of program education documentation related to the Medicaid program as well as other programs available to members such as EPSDT and the Children’s Health Insurance Program (CHIP).

Outreach information is developed for targeted populations that have been identified by analyzing member data. Outreach communications and information packages are distributed accordingly through various mediums via the Send Outbound Transaction

and the Manage Business Relationship Communication processes. All outreach communications and information package production and distribution is tracked and materials archived according to state archive rules. Outreach efficacy is measured by the Monitor Performance and Business Activity process.

NOTE: The Perform Population and Member Outreach process targets both prospective and current Member populations for distribution of information about programs, policies, and health issues. Inquires from applicants, prospective and current members are handled by the Manage Applicant and Member Communication process by providing assistance and responses to individuals, such as bi-directional communication.

NOTE: The Member Services unit will recruit candidates for specialized managed care programs, target cases from data warehouse reporting and referrals, and contact members to explain program advantages and constraints. Letters to members go through Member Services.

The Medical Services unit will perform individualized education and supply educational materials to members, recruit candidates for specialized managed care programs, target cases from data warehouse reporting and referrals, and contact members to explain program advantages and constraints.

DHS Policy Analysis is responsible for handling forms or form letters.

# 3.3.9 Enroll Provider

The Enroll Provider business process is responsible for managing providers' enrollment including:

a. Receipt of enrollment application data set from the Manage Provider Communication process.

b. Processing of applications, including status tracking (such as new, resubmission, duplicate) and validating application meets federal and state submission rules, such as syntax/semantic conformance.

c. Validation that the enrollment meets federal and state rules by:

    1. Performing primary source verification of provider credentials and sanction status with external entities, including but not limited to:

        i. Education and training/board certification

        ii. License to practice

        iii. Drug Enforcement Administration/Controlled Dangerous Substance (DEA/CDS) certificates

        iv. Medicare/Medicaid sanctions

        v. Disciplinary/sanctions against licensure which may include external states

        vi. National Provider Data Bank (NPDB) and Health Integrity Protection Data Base (HIPDB) disciplinary actions/sanctions

        vii. Verifying SSN or EIN and other business information

        viii. State/national accreditation

2. Performing policy requirements for atypical providers such as a nonemergency provider might include validation of transportation insurance and valid driver's license

d. Determination of contracting parameters, such as provider taxonomy, type, category of service for which the provider can bill.

e. Requesting that the Manage Provider Information process load initial and changed enrollment information

f. Prompting the Manage Provider Information process to provide timely and accurate notification or to make enrollment data required for operations available to all parties and affiliated business processes including:

   1. The capitation and premium payment area
   2. The prepare provider electronic file transfer (EFT)/check process
   3. The appropriate communications; outreach and education processes for follow-up with the affected parties, including informing parties of their procedural rights.

g. Performing scheduled user-requested:

   1. Credentialing reverification.
   2. Sanction monitoring.

External contractors such as quality assurance and credentialing verification services may perform some of these steps (as in the HCBS-ISU contract).

# 3.3.10 Disenroll Provider

The Disenroll Provider business process is responsible for managing providers' enrollment in programs, including:

a. Processing of disenrollment

   1. Requested by the provider
   2. Requested by another Business Area, such as the Manage Provider Communication, Monitor Performance and Business Activities, and Program Integrity Manage Case processes
   3. Due to receipt of information about a provider's death, retirement, or disability from the Manage Provider Communication process
   4. Based on failure in the Enroll Provider process, such as Provider fails to meet state enrollment requirements

      i. Provider fails enumeration or credentialing verification

      ii. Provider cannot be enumerated through National Plan and Provider Enumeration System (NPPES) or state assigned enumerator

b. Tracking of disenrollment requests and records, including assigning identifiers and monitoring status (such as new, resubmission, duplicate)

c. Validation that the disenrollment meets state rules and substantiating basis for disenrollment, such as checking death records

d. Requesting that the Manage Provider Information process load initial and changed disenrollment information into the Provider Registry

e. Prompting the Manage Provider Communication process to prepare disenrollment notifications and instructions for closing out provider contracts for generation and transmission by the Send Outbound Transaction process

f. Prompting the Manage Provider Information process to provide timely and accurate notification or to make disenrollment data required for operations available to all parties and affiliated business processes, including

   1. The Capitation and Premium Payment Area

   2. The Prepare Provider EFT/Check process

g. Prompting Manage Applicant and Member Communication process to notify and reassign, where necessary, members who are on the provider's patient panel, such as Primary Care Case Management (PCCM), Lock-in, HCBS and other waiver program, and fee-for service (FFS)

h. Prompting Perform Applicant and Member Outreach to provide appropriate outreach and educational material to displaced members

# 3.3.11 Inquire Provider Information

The IME Inquire Provider Information business process receives requests for provider enrollment verification from authorized providers, programs or business associates; performs the inquiry; and prepares the response data set for the Send Outbound Transaction process.

# 3.3.12 Manage Provider Communication

The IME Manage Provider Communication business process receives requests for information, provider publications, and assistance from prospective and current providers' communications such as inquiries related to eligibility of provider, covered services, reimbursement, enrollment requirements etc. Communications are researched, developed and produced for distribution via Send Outbound Transaction process.

Note: Inquires from prospective and current providers are handled by the Manage Provider Communication process by providing assistance and responses to individual entities, such as bi-directional communication. Also included are scheduled communications such as program memorandum, notifications of pending expired provider eligibility, or formal program notifications such as the disposition of appeals. The Perform Provider Outreach process targets both prospective and current provider populations for distribution of information about programs, policies, and health care issues.

# 3.3.13 Manage Provider Complaint, Grievance and Appeal

The Manage Provider Complaint, Grievance and Appeal business process handles provider appeals of adverse decisions or communications of a complaint or grievance. A

complaint, grievance or appeal is received by the Manage Provider Communication process via the Receive Inbound Transaction process. The complaint, grievance or appeal is logged and tracked; triaged to appropriate reviewers; researched; additional information may be requested; an appeals hearing is scheduled and conducted in accordance with legal requirements; and a ruling is made based upon the evidence presented. Results of the appeals hearing are documented and relevant documents are distributed to the provider information file. The provider is formally notified of the decision via the Send Outbound Transaction Process.

This process supports the Program Management Business Area by providing data about the types of complaints, grievances and appeals it handles; complaint, grievance and appeals issues; parties that file or are the target of the complaint, grievances and appeals; and the dispositions. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to complaints, grievances and appeals.

NOTE: This process supports complaints, grievances and appeals for both prospective providers and current providers. A non-enrolled provider can file a complaint, grievance or appeal, for example, when an application for enrollment is denied.

# 3.3.14 Manage Provider Information

The IME Manage Provider Information business process is responsible for managing all operational aspects of the provider data store, which is the source of comprehensive information about prospective and contracted providers, and their interactions with the state Medicaid program. The provider data store is the IME “source of truth” for provider demographic, business, credentialing, enumeration, performance profiles; payment processing, and tax information. The data store includes contractual terms, such as the services the provider is contracted to provide, related performance measures, and the reimbursement rates for those services. In addition, the provider data store stores records about and tracks the processing of provider enrollment applications, credentialing and enumeration verification; and most communications with or about the provider, including provider verification requests and responses; and interactions related to any grievance/appeal. The provider data store may store records or pointers to records for services requested and services provided; performance, utilization, and program integrity reviews; and participation in member care management. Business processes that generate prospective or contracted provider information send requests to the member data store to add, delete, or change this information in data store records. The provider data store validates data upload requests, applies instructions, and tracks activity. The provider data store provides access to provider records to applications and users via batch record transfers, responses to queries, and “publish and subscribe” services.

# 3.3.15 Perform Provider Outreach

The IME Perform Provider Outreach business process originates internally within the Medicaid Enterprise in response to multiple activities, such as identified gaps in medical service coverage, public health alerts, provider complaints, medical breakthroughs, changes in the Medicaid program policies and procedures.

Prospective Provider outreach information, also referred to as Provider Recruiting information, may be developed for targeted providers that have been identified by analyzing program data (for example, not enough dentists to serve a population, new immigrants need language-compatible providers)

Enrolled Provider outreach information may relate to corrections in billing practices, public health alerts, public service announcements, drive to sign up more Primary Care Physicians, and other objectives.

Outreach communications and information packages are distributed accordingly through various media. All outreach communications and information package production and distribution are tracked and materials archived according to state archive rules. Outreach efficacy is measured by the Monitor Performance and Business Activity process.

# 3.3.16 Produce Administrative or Health Services RFP

The Produce Administrative or Health Services RFP business process gathers requirements, develops a Request for Proposals (RFP), requests and receives approvals for the RFP, and solicits responses.

# 3.3.17 Award Administrative or Health Services Contract

The IME Award an Administrative or Health Services Contract business process utilizes requirements, advanced planning documents, requests for information, request for proposal and sole source documents. This process is used to request and receive proposals, verifies proposal content against RFP or sole source requirements, applies evaluation criteria, designates contractor/vendor, posts award information, negotiates contract, and notifies parties. In some states, this business process may be used to make a recommendation of award instead of the award itself.

# 3.3.18 Manage Administrative or Health Services Contract

The IME Manage Administrative or Health Services Contract business process receives the contract award data set, implements contract monitoring procedures, and updates contract if needed, and continues to monitor the terms of the contract throughout its duration.

# 3.3.19 Close-out Administrative or Health Services Contract

The IME Close-out Administrative or Health Care Services Contract business process begins with an order to terminate a contract. The close-out process ensures that the obligations of the current contract are fulfilled and the turn-over to the new contractor is completed according to contractual obligations.

NOTE: The contract may end with no succession.

# 3.3.20 Manage Contractor Information

The Manage Contractor Information business process receives a request for addition, deletion, or change to the contractor data store; validates the request, applies the instruction, and tracks the activity.

# 3.3.21 Manage Contractor Communication

The Manage Contractor Communication business process receives requests for information, appointments, and assistance from contractors such as inquiries related to changes in Medicaid program policies and procedures, introduction of new programs, changes to existing programs, public health alerts, and contract amendments, etc. Communications are researched, developed, and produced for distribution.

NOTE: Inquiries from prospective and current contractors are handled by the Manage Contractor Communication process by providing assistance and responses to individual entities, such as bi-directional communication. The Perform Contractor Outreach process targets both prospective and current contractor populations for distribution of information regarding programs, policies, and other issues.

Other examples of communications include:

a. Pay for performance communications – performance measures could effect capitation payments or other reimbursements.

b. Incentives to improve encounter data quality and submission rates

# 3.3.22 Perform Contractor Outreach

The Perform Contractor Outreach business process originates initially within the Department in response to multiple activities, e.g., public health alerts, new programs, and/or changes in the Medicaid program policies and procedures.

For prospective contractors, contractor outreach information is developed for prospective contractors that have been identified by analyzing Medicaid business needs.

For currently enrolled contractors, information may relate to public health alerts, public service announcements, and other objectives.

Contractor outreach communications are distributed through various mediums via Send Outbound Transaction. All contractor outreach communications are produced, distributed, tracked, and archived by the agency according to state archive rules. Outreach efficacy is measured by the Monitor Performance and Business Activity process.

# 3.3.23 Support Contractor Grievance and Appeal

The Support Contractor Grievance and Appeal business process handles contractor appeals of adverse decisions or communications of a grievance. A grievance or appeal is received by the Manage Contractor Communications process via the Receive Inbound Transaction process. The grievance or appeal is triaged to appropriate reviewers; researched; additional information may be requested; and a hearing is scheduled and conducted in accordance with administrative and legal requirements. The contractor is formally notified of the decision via the Send Outbound Transaction process.

This process supports the Program Management business area by providing data about the types of grievances and appeals it handles. This data is used to discern program improvement opportunities, which may reduce the issues that give rise to grievances and appeals.

NOTE: The grievance and appeal process is defined in the contract. In the procurement process, the grievance or appeal goes to the IA District Court.

# 3.3.24 Inquire Contractor Information

The Inquire Contractor Information business process receives requests for contract verification from authorized users, programs or business associates; performs the inquiry; and prepares the response data set for the send outbound transaction process.

# 3.3.25 Authorize Referral

The IME Authorize Referral business process is used when referrals between providers must be approved for payment, based on state policy. Examples are referrals by physicians to other providers for laboratory procedures, surgery, drugs, or durable medical equipment. This business process is primarily associated with Primary Care Case Management programs where additional approval controls are deemed necessary by the state. Most states do not require this additional layer of control.

The Authorize Referral business process may encompass both preapproved and post-approved referral requests. Post-approved referral requests can occur when immediate services are required. MediPASS and lock-in providers and members should request referrals prior to treatment. There is an approval process post-treatment.

Requests are evaluated based on urgency and type of service to ensure that the referral is appropriate and medically necessary. The availability of the provider and service is also considered during the referral process.

a. Ability to make the Authorize Referral after the service/treatment occurs

b. Also in Edit Claims/Encounter make sure the approval is present on the claim

c. Small percentage of audits afterwards to make sure the referral was given

# 3.3.26 Authorize Service

The IME Authorize Service business process encompasses both a pre-approved and post-approved service request. This business process focuses on specific types and numbers of visits, procedures, surgeries, tests, drugs, therapies, and durable medical equipment. It is primarily used in a fee-for-service setting.

Pre-approval of a service request is a care management function and begins when a care manager receives a referral request data set from a paper or fax. Requests are evaluated based on state rules for prioritization such as urgency as identified by the provider, validating key data, and ensuring that requested service is appropriate and medically necessary. After review, a service request is approved, modified, denied or pended for additional information. The appropriate response data set for paper/fax notifications/correspondence is sent to the provider using the Send Outbound Transaction through Manage Provider Communication and Manage Member Communication (denials only).

A post-approved service request is an editing function that requires review of information after the service has been delivered. A review may consist of verifying documentation to ensure that the services were appropriate to prior authorization; validating provider type and specialty information to ensure alignment with agency policies and procedures. Post-approved validation typically occurs in the Edit Claims/Encounter (claims only) processes.

NOTE: This business process is part of a suite that includes Service Requests for different service types and care settings including Medical, Dental, Drugs, and Off-label use of drugs.

# 3.3.27 Authorize Treatment Plan

The IME Authorize Treatment Plan business process encompasses both a pre-approved and post-approved treatment plan. The Authorize Treatment Plan is primarily used in care management settings where the care management team assesses the member's needs, decides on a course of treatment, and completes the Treatment Plan.

A Treatment Plan prior-authorizes the named providers or provider types and services or category of services. Individual providers can be pre-approved for the service or category of services and do not have to submit their own service request. A treatment plan typically covers many services and spans a length of time. (In contrast, an individual service request, primarily associated with fee-for-service payment, is more limited and focuses on a specific visit, services, or products, such as a single specialist office visit referral, approval for a specific test or particular piece of Durable Medical Equipment [DME]).

For remedial services the pre-approved treatment plan generally begins with the receipt of an authorize treatment plan request from the care management team, program waiting lists, and type of service (speech, physical therapy, home health, behavioral, social). It includes validating key data, and ensuring that requested plan of treatment is appropriate and medically or behaviorally necessary. After reviewing, the request is approved, modified, pended, or denied and the appropriate response data set is forwarded to the Care Management team and the Manage Provider Communication process and Manage Applicant and Member Communication process.

HCBS and habilitation services are established by case managers and then go through a workflow approval process. The process results in a treatment plan being approved/denied/modified and the appropriate response data set is forwarded to the Care Management team and the Manage Provider Communication process and Manage Applicant and Member Communication process.

A post-approved treatment plan is a random quality review to ensure the reviewed services were appropriate and in accordance with the treatment plan.

# 3.3.28 Apply Claim Attachment

This business process begins with receiving an attachment data set that has either been requested by the payer (solicited) or has been sent by the provider (unsolicited). The solicited attachment data sets can be in response to requests for more information from the following processes for example: Audit Claim/Encounter, Authorize Service, and Authorize Treatment Plan.

The attachment data set is then linked to the associated applicable transaction (claim, prior authorization, treatment plan, etc.) and is either attached to the associated transaction or pended for a predetermined time period set by state-specific business rules, after which it is purged. Next, the successfully associated attachment data set is validated using application level edits, determining whether the data set provides the additional information necessary to adjudicate/approve the transaction. If yes, the attachment data set is moved with the transaction to the approval process. If no, it is moved to a denial process or triggers an appropriate request for additional information, unless precluded by standard transaction rules.

# 3.3.29 Apply Mass Adjustment

The Apply Mass Adjustment business process begins with the receipt or notification of retroactive changes. These changes may consist of changed rates associated with Health Care Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT), Revenue Codes, or program modifications/conversions that affect payment or reporting. This mass adjustment business process includes identifying the payment transactions such as claims or capitation payment records by identifiers including, but not limited to, rates, provider type, claim/bill type, HCPCS, CPT, Revenue Codes, National Provider Identifier (NPI), or member ID that were paid incorrectly during a specified date range, applying a predetermined set or sets of parameters that may reverse or amend the paid transaction and repay correctly.

NOTE: This should not be confused with the claim adjustment adjudication process. A mass adjustment may involve many previous payments based on a specific date or date range affecting single or multiple providers, members, or other payees. Likewise, Mass Adjustment historically refers to large scale changes in payments as opposed to disenrolling a group of members from a Limited Service Organization (LSO).

# 3.3.30 Edit Claim

The Edit Claim business process receives an original or an adjustment claim/encounter data set from the Receive Inbound Transaction process and

a. Determines its submission status

b. Validates edits, service coverage (claims only), TPL (claims only), coding

c. Populates the data set with pricing information (claims only)

d. Sends validated data sets to the Audit Claim (claims) and Price Claim/Value Encounter (encounters) processes and data sets that fail audit to the Prepare Remittance Advice/Encounter Report process

All claim/encounter types must go through most of the steps within the Edit Claim/Encounter process with some variance of business rules and data.

NOTE: This business process is part of a suite. Claims flow through the: Edit Claim/Encounter, Audit Claim, Price Claim/Value Encounter, Apply Claim Attachment, and Prepare Remittance Advice/Encounter Report processes. Encounters flow through a subset of the above suite: Edit Claim/Encounter, Price Claim/Value Encounter, and Prepare Remittance Advice/Encounter Report.

NOTE: The Edit Claim/Encounter and Audit Claim processes are very closely related at IME and, in some cases, can happen simultaneously. The Audit process can be considered as a secondary edit.

NOTE: Waivers are received as paper claims (TMC –- converted to HCFA 1500) or electronically (837). They go through the standard claims adjudication process. Non-emergency medical transportation claims are processed by the IABC system – data never enters IME. Funding is an administrative cost of Medicaid.

# 3.3.31 Audit Claim

The Audit Claim business process receives a validated original or adjustment claim/encounter data set from the Edit Claim-Encounter process and checks payment history for duplicate processed claims/encounters and lifetime or other limits.

a. Verifies that services requiring authorization have approval, clinical appropriateness, and payment integrity.

b. Suspends data sets that fail audits for internal review, corrections, or additional information.

c. Sends successfully audited data sets to the Price Claim or Prepare Remittance Advice/Encounter Report process.

All claim/encounter types must go through most of the steps within the Audit Claim process with some variance of business rules and data.

Note: The Edit Claim/Encounter and Audit Claim processes are very closely related at IME and, in some cases, can happen simultaneously. The Audit process can be considered as a secondary edit.

# 3.3.32 Price Claim-Value Encounter

The Price Claim-Value Encounter business process begins with receipt of claim/encounter adjudicated data. Pricing algorithms are applied. Examples include calculating managed care and PCCM premiums, calculating and applying member contributions, DRG and/or APC pricing, provider advances, liens and recoupment. This process is also responsible for ensuring that all adjudication events are documented in

the Payment History Information data store by passing the appropriate data set to the Manage Payment Information process.

All claim types must go through most of the process steps but with different logic associated with the different claim types.

NOTE: An adjustment to a claim is on an exception use case to this process that follows the same process path except it requires a link to the previously submitted processed claim in order to reverse the original claim payment and associate the original and replacement claim in the payment history data store.

# 3.3.33 Prepare Remittance Advice-Encounter Report

The IME Prepare Remittance Advice-Encounter Report business process describes the process of preparing remittance advice/encounter Electronic Data Interchange (EDI) transactions that will be used by providers to reconcile their accounts receivable. This process begins with receipt of data resulting from the edit, audit, and pricing processes, performing required manipulation according to business rules and formatting the results into the required output data, which is sent to the Send Outbound Transaction technical process for generation into an outbound transaction. The resulting data set is also sent to Manage Payment Information to update the Payment Information data store.

NOTE: This process includes HCBS Payments. See Prepare Home and Community Based Services Payment process for details on the capabilities associated with that process.

NOTE: This process does not include sending the remittance advice/encounter EDI Transaction.

# 3.3.34 Prepare Provider EFT/Check

The IME Prepare Provider EFT/Check business process is responsible for managing the generation of electronic and paper based reimbursement instruments, including:

a. Calculation of payment amounts for a wide variety of claims including FFS Claims, Pharmacy POS, Long Term Care Turn Around Documents, and HCBS provider claims based on inputs such as the priced claim, including any TPL, crossover or client participation payment adjustments; retroactive rate adjustments; adjustments for previous incorrect payments; and performance incentives, recoupments, garnishments, and liens per data in the provider data store, Agency Accounting and Budget Area rules, including the Manage 1099 process

b. Disbursement of payment from appropriate funding sources per state and Agency Accounting and Budget Area rules

c. Associating the EFT with an X12 835 electronic remittance advice transaction is required under HIPAA if the Agency sends this transaction through the Automated Clearing House (ACH) system rather than sending it separately. Paper claims have an option to receive an EFT or a paper check.

d. Routing the payment per the provider data store payment instructions for EFT or check generation and mailing, which may include transferring the payment data set to Fiscal Management for actual payment transaction

e. Updates the Perform Accounting Function and/or State Financial Management business processes with pending and paid claims transaction accounting details, tying all transactions back to a specific claim and its history

f. Support frequency of payments

# 3.3.35 Prepare Coordination of Benefits (COB)/TPL

Currently, cost avoidance is conducted by rejecting claims that should first go to a third party. This process is not currently part of IME's operations. The description and steps noted below that relate to processing claims take place in the Edit Claim/Encounter or Audit Claim processes. Steps noted as TPL activities are part of the Manage TPL Recovery Process

The Prepare COB/TPL business process describes the process used to identify and prepare outbound EDI claim transactions that are forwarded to third party payers for the handling of cost avoided claims as well as performing post payment recoveries. The Prepare COB/TPL business process begins with the completion of the Price Claim/Value Encounter process. Full (paid/denied) claims file is provided at month end and moved to a COB/TPL file for coordination of benefit related activities based on predefined criteria such as error codes and associated disposition, service codes, program codes, third party liability information available from both the original claim and eligibility files (indicator for Medicare coverage). This process includes retrieval of claims data necessary to generate the outbound transaction including retrieval of any data stored from the original inbound transaction, formatting of claims data into the outbound EDI data set or paper form, validating that the outbound EDI transaction or paper form is in the correct format and forwarding to the Send Outbound Transaction.

Note: Receipt of COB from other payers is part of standard claims processing. For IME this includes receipt of a file from the Medicare FI (Wisconsin's Physicians Group) via a clearinghouse (837) and receipt of Part C claims (837) from Coventry (Medicare's Part C carrier)

# 3.3.36 Prepare Explanation of Benefits (EOB)

The Prepare EOB business process begins with a timetable for scheduled correspondence and includes producing explanation of benefits, distributing the EOBs, and processing returned EOBs to determine if the services claimed by a provider were received by the member. The EOBs must be provided to the members within 45 days of payment of claims.

This process includes identifying sample data using random sampling methodology, retrieving the sample data set, preparing the EOBs formatting the data into the required

data set, which is sent to the Send Outbound Transaction for generation. The resulting data set is also sent to Manage Applicant and Member Communication.

# 3.3.37 Prepare HCBS Payment

IME makes no distinction between HCBS payment report data sets and the production of Remittance Advice (RA) for medical claims. See the Prepare Remittance Advice process. If, as is noted in the To-Be for HCBS payments, the claims process is simplified for HCBS provider and the result is a payment report that is not an RA, then this process would come into play.

The processes have been documented separately in order to address the differing capability statements.

The IME Prepare Home and Community-Based Services Payment business process describes the preparation of the payment report data set. These will be sent on paper or electronically to providers and used to reconcile their accounts receivable. This process begins with receipt of data sets resulting from the edit, audit, and pricing processes, performing required manipulation according to business rules and formatting the results into the required output data set, which is sent to the Send Outbound Transaction process for generation into an outbound transaction. The resulting data set is also sent to Manage Payment Information process for loading into the Payment Information data store.

NOTE: Process is handled from the payment side in the same manner as payments for other services requiring prior authorization. This is a once/month billing process.

# 3.3.38 Prepare Premium Capitation EFT/Check

The IME Prepare Premium Capitation EFT/Check business process is responsible for managing the generation of electronic and paper based reimbursement instruments, including:

a. Calculation of:

    1 HIPP premium based on members' premium payment data in the contractor data store

    2. Medicare premium based on dual eligible members' Medicare premium payment data in the member data store

    3. PCCM management fee based on PCCM contract data re: different reimbursement arrangements in the contractor data store

    4. LSO premium payments based on LSO contract data re: different reimbursement arrangements, capitation rates, categories, and rules for each prepaid LSO and benefit package in the contractor data store

b. Application of automated or user defined adjustments based on contract, such as adjustments or performance incentives

c. Disbursement of premium, capitation or PCCM fee from appropriate funding sources per Agency Accounting and Budget Area rules

d. Associate the LSO premium payment EFT with an X12 820 electronic premium payment transaction required under HIPAA if the Agency sends this transaction through the ACH system rather than sending it separately.

e. Routing the payment per the contractor data store payment instructions for EFT or check generation and mailing, which may include transferring the payment data set to a Fiscal Management for actual payment transaction

f. Updates the Perform Accounting Function and/or Financial Management business processes with pending and paid premium, and fees transaction accounting details, tying all transactions back to a specific contractual payment obligation and its history

g. Support frequency of payments

# 3.3.39 Prepare Capitation Premium Payment

The Prepare Capitation Premium Payment business process is handled by CORE and IME Policy. This process includes premiums for MCO such a PCCM, LSO, and other capitated programs such as PACE. This process begins with a timetable for sending data stipulated by Trading Partner Agreement and includes retrieving enrollment and benefit transaction data from the member data store, retrieving the rate data associated with the plan from the Provider or contractor data store, formatting the payment data into the required data set, which is sent to the Send Outbound Transaction. The resulting data set is also sent to Manage Payment History for loading

NOTE: This process does not include sending the capitation payment.

# 3.3.40 Prepare Health Insurance Premium Payments (HIPP)

Medicaid agencies are required to pay the employer/individual health insurance premiums for any Medicaid eligible member in the household who may be covered by the health insurance plan if it is determined cost effective. In these circumstances, a cost effective determination is made and a premium is prepared and sent to the policy holder, employer, or health insurance company. Medicaid becomes the second payer.

The Prepare Health Insurance Premium Payments business process begins by screening as part of our standard Medicaid application process. The member's HIPP status is communicated to the policy holder regarding payment/eligibility status. The health insurance premiums are created with a timetable for scheduled payments. The formatted premium payment data set is sent to the Send Outbound Transaction and Prepare Premium Capitation EFT Check. The resulting data set is also sent to Manage Payment Information for loading and Manage Member Information for updating.

DHS Eligibility Policy is entirely responsible for this process. The related transactions take place entirely outside of IME systems and processes, other than the sharing of TPL data.

# 3.3.41 Prepare Medicare Premium Payments

State Medicaid agencies are required to assist low-income Medicare beneficiaries in Medicare cost-sharing, defined as premiums, deductibles, and co-insurance in a system referred to as buy-in. Under the buy-in process state Medicaid agencies, the Social Security Administration (SSA) and Department of Health and Human Services (DHHS) enter into a contract where states pay the Medicare beneficiary share of premium costs and in some instances deductibles and co-insurance.

The IME Prepare Medicare Premium Payments business process begins with a reciprocal exchange of eligibility information between Medicare and Medicaid agencies. This process is scheduled at intervals set by trading partner agreement. The process begins by receiving eligibility data from Medicare, performing a matching process against the Medicaid member registry, generating buy-in files for CMS for verification, formatting the premium payment data into the required output data set, which is sent to the Send Outbound Transaction. The resulting data set is also sent to Manage Payment History and Manage Member Information for loading.

NOTE: This process does not include sending the Medicare premium payments EDI transaction.

# 3.3.42 Inquire Payment Status

The IME Inquire Payment Status business process begins with receiving a 276 Claim Status Inquiry transaction or a request for information received through other means such as paper, phone, fax, web portal, e-mail, in person or Automated Voice Response (AVR) request for the current status of a specified claims, accessing the Payment Information data store, capturing the required claim status response data, formatting the data set into the 277 Claim Status Response or other mechanism for responding via the medium used to communicate the inquiry, and sending claim status response data set via the Send Outbound Transaction process.

# 3.3.43 Manage Payment Information

The IME Manage Payment Information business process is responsible for managing all the operational aspects of the Payment Information data store, which is the source of comprehensive information about payments made to and by the state Medicaid enterprise for health care services. This includes claims, encounters, AR, and capitation/premium payments.

The Payment Information data store exchanges data with Operations Management business processes that generate payment information at various points in their workflows. These processes send requests to the Payment Information data store to add, delete, or change data in payment records. The Payment Information data store validates data upload requests, applies instructions, and tracks activity.

In addition to Operations Management business processes, the Payment Information data store provides access to payment records to other Business Area applications and

users, such as the Program, Member, Contractor, and Provider Management business areas, via record transfers, response to queries, and “publish and subscribe” services.

# 3.3.44 Calculate Spend-Down Amount

A person that is not eligible for medical coverage when they have income and/or resources above the benefit package or program standards may become eligible for coverage through a process called “spend-down” (see Determine Eligibility).

The Calculate Spend-Down Amount business process describes the process by which spend-down amounts are tracked and a client’s responsibility is met through the submission of medical claims. Medical claims are automatically accounted for during the claims processing processes resulting in a change of eligibility status once spend-down has been met which allows for Medicaid payments to begin and/or resume. This typically occurs in situations where a client has a chronic condition and is consistently above the resource levels or income limits, but may also occur in other situations.

The eligibility determination process is completed using various categorical and financial factors, the member is assigned to a benefit package or program that requires a predetermined amount the member must be financially responsible for prior to Medicaid payment for any medical services. The Calculate Spend-Down Amount business process begins with the receipt of member eligibility data.

NOTE: The Eligibility Determination process is primarily a manual process. The Calculate Spend-Down Amount process is handled by the MMIS.

# 3.3.45 Prepare Member Premium Invoice

The IME Prepare Member Premium Invoice business process begins with a timetable for scheduled and unscheduled invoicing (billing statements). The process includes retrieving member premium data, performing required data manipulation according to business rules, formatting the results into required output data set, and producing member premium invoices which will be sent to the Send Outbound Transaction. The resulting data set is also sent to Manage Member Information process for updating.

NOTE: This process does not include sending the member premium invoice EDI transaction.

NOTE: This process is limited to IowaCare and MEPD.

# 3.3.46 Manage Drug Rebate

The Manage Drug Rebate business process describes the process of managing drug rebate that will be collected from manufacturers. The process begins with receiving quarterly drug rebate data from CMS and includes comparing it to quarterly payment history data, utilizing drug data based on manufacturer and drug code, applying the rebate factor and volume indicators, calculating the total rebate per manufacturer, preparing drug rebate invoices, sorting the invoices by manufacturer and drug code, sending the invoice data to the drug manufacturer via the Send Outbound Transaction Process sending to Perform Accounting Functions.

# 3.3.47 Manage Estate Recovery

The IME Manage Estate Recovery business process begins by receiving estate recovery data from multiple referrals (such as date of death matches, probate petition notices, tips from caseworkers and reports of death from nursing homes), opening estate recovery case based on a member's death and state criteria, determining value of estate claim, generating correspondence data set (such as demand of notice to probate court via Send Outbound Transaction process, to member's personal representative or generating a request letter and questionnaire) via the Manage Applicant and Member Communication process, conducts case follow-up, sending data set to track attempted recoveries vs. actual recoveries to Perform Accounting Functions (accounts receivable), releasing the estate claim when recovery is completed, updating member data store, and sending to Manage Payment Information for loading.

NOTE: This is not to be confused with settlements which are recoveries for certain Medicaid benefits correctly paid on behalf of an individual as a result of a legal ruling or award involving accidents.

# 3.3.48 Manage Recoupment

The Manage Recoupment business process describes the process of managing provider recoupment. Provider recoupments are initiated by the discovery of an overpayment, for example, as the result of a provider utilization review audit, receipt of a claims adjustment request, or for situations where monies are owed to the agency due to fraud/abuse.

The business thread begins with discovering the overpayment, retrieving claims payment data via the Manage Claims Information, initiating the recoupment request, or adjudicating claims adjustment request, notifying provider of audit results via the Manage Provider Communication, applying recoupments in the system via the Perform Accounting Functions, and monitoring payment history until the repayment is satisfied.

Recoupments can be collected via payment instrument sent by the provider or credited against future payments for services.

# 3.3.49 Manage Cost Settlement

The Manage Cost Settlement business process begins with requesting annual claims summary data from Manage Payment Information. The process includes reviewing provider costs and establishing a basis for cost settlements or compliance reviews, receiving audited Medicare Cost Report from intermediaries, capturing the necessary provider cost settlement data, calculating the final annual cost settlement based on the Medicare Cost Report, generating the data, verifying the data is correct, producing notifications to providers, and establishing interim reimbursement rates. In some states, cost settlements may be made through the application of Mass Adjustments.

# 3.3.50 Manage TPL Recoveries

The IME Manage TPL Recoveries business process begins by receiving third party liability data from various sources such as external and internal data matches, tips, referrals, attorneys, Program Integrity/Fraud & Abuse, Medicaid Fraud Control Unit,

providers and insurance companies, identifying the provider or TPL carrier, locating recoverable claims from Manage Payment History, creating post-payment recovery files, sending notification data to other payer or provider from the Manage Provider Communication process, receiving payment from provider or third party payer, sending receivable data to Perform Accounting Function, and updating payment history Manage Payment History.

# 3.3.51 Designate Approved Services and Drug List

The Designate Approved Services and Drug List business process begins with a review of new and/or modified service codes (such as Healthcare Common Procedure Coding System (HCPCS) and International Classification of Diseases 9th Edition Clinical Modification (ICD-9) or national drug codes (NDC) for possible inclusion in various Medicaid Benefit programs. Certain services and drugs may be included or excluded for each benefit package.

Service, supply, and drug codes are reviewed by an internal or external teams of medical, policy, and rates staff to determine fiscal impacts and medical appropriateness for the inclusion or exclusion of codes to various benefit plans. The review team is responsible for reviewing any legislation to determine scope of care requirements that must be met. Review includes the identification of any changes or additions needed to regulations, policies, and or state plan in order to accommodate the inclusion or exclusion of service/drug codes. The review team is also responsible for the defining coverage criteria and establishing any limitations or authorization requirements for approved codes.

NOTE: This does not include implementation of the Approved Services and Drug List codes..

# 3.3.52 Develop & Maintain Benefit Package

The Develop & Maintain Benefit Package business process begins with receipt of coverage requirements and recommendations through new or revised: federal statutes and/or regulations, state law, organizational policies, requests from external parties such as quality review organizations or changes resulting from court decisions.

Benefit package requirements are mandated through regulations or other legal channels and must be implemented. Implementation of benefit package recommendations is optional and these requests must be approved, denied or modified.

Benefit package requirements and approved recommendations are reviewed for impacts to state plan, budget, federal financial participation, applicability to current benefit packages and overall feasibility of implementation including:

a. Determination of scope of coverage

b. Determination of program eligibility criteria such as resource limitations, age, gender, duration, etc.

c. Identification of impacted members and trading partners.

# 3.3.53 Manage Rate Setting

The Manage Rate Setting Business Process responds to requests to add or change rates for any service or product covered by the Medicaid program.

# 3.3.54 Develop Agency Goals and Objectives

The Develop Agency Goals and Objectives business process periodically assesses and prioritizes the current mission statement, goals, and objectives to determine if changes are necessary for the Iowa Medicaid Enterprise. Changes to goals and objectives could be warranted for example, under a new administration; or in response to changes in demographics, public opinion, legislative directives or medical industry trends; or in response to regional or national disasters.

# 3.3.55 Develop and Maintain Program Policy

The Develop and Maintain Program Policy Business Process responds to requests or needs for change in the enterprise's programs, benefits, or business rules, based on factors such as: federal or state statutes and regulations; governing board or commission directives; Quality Improvement Organization's findings; federal or state audits; enterprise decisions; directors office and consumer pressure.

Note: There are two major groups of policy in IME: those related to the State Plan and those related to Administrative rules. The development and maintenance of the State Plan is documented in Maintain State Plan. The development and maintenance of Administrative Rules is documented in the Develop and Maintain Program Policy process. The area of IME primarily responsible for developing both groups of policy is the same (IME Policy). DHS Eligibility Policy participates in portions of the overall process of maintaining the Administrative Rules and independently creates policy related to eligibility. DHS Director's Office, DHS Council, and the Legislative Rules Committee also reviews and approves final policy.

# 3.3.56 Maintain State Plan

The Maintain State Plan business process responds to the scheduled and unscheduled prompts to update and revise the State Plan.

Note: There are two major groups of policy in IME: those related to the State Plan and those related to Administrative rules. The development and maintenance of Administrative Rules is documented in the Develop and Maintain Program Policy process. The area of IME primarily responsible for developing both groups of policy is the same (IME Policy). DHS Eligibility Policy participates in portions of the overall process of maintaining the State Plan and independently creates policy related to eligibility. DHS Director's Office and the Governor's Office also reviews and approves the final plan.

# 3.3.57 Formulate Budget

The IME Formulate Budget business process examines the current budget, revenue stream and trends, and expenditures, assesses external factors affecting the program, assesses agency initiatives and plans, models different budget scenarios, and periodically produces a new budget.

# 3.3.58 Manage Federal Financial Participation (FFP) for MMIS

The federal government allows funding for the design, development, maintenance, and operation of a federally certified MMIS.

The Manage FFP for MMIS business process oversees reporting and monitoring of Advance Planning Documents and other program documents necessary to secure and maintain federal financial participation.

# 3.3.59 Manage Federal Medical Assistance Percentages (F-MAP)

The IME Manage F-MAP business process periodically assesses current F-MAP for benefits and administrative services to determine compliance with federal regulations and state objectives.

# 3.3.60 Manage State Funds

The IME Manage State Funds business process oversees Medicaid state funds and ensures accuracy in the allocation of funds and the reporting of funding sources.

Funding for Medicaid services may come from a variety of sources, and often state funds are spread across state agency administrations such as Mental Health, Aging, Substance Abuse, physical health, and across state counties and local jurisdictions. The Manage State Funds monitors state funds through ongoing tracking and reporting of expenditures and corrects any improperly charged expenditures of funds. It also deals with projected and actual over and under allocations of funds.

# 3.3.61 Manage 1099s

The Manage 1099s business process is handled by CORE and Provider Services. This business process describes the process by which 1099s are handled, including preparation, maintenance and corrections. The process is impacted by any payment or adjustment in payment made to a single Social Security Number or federal tax ID number.

The Manage 1099s process receives payment and/or recoupment data from the Price Claim/Value Encounter Process or from the Perform Accounting Functions process.

The Manage 1099s process may also receive requests for additional copies of a specific 1099 or receive notification of an error or needed correction. The process provides

additional requested copies via the Send Outbound Transaction process. Error notifications and requests for corrections are received via Manage Provider Communications, are researched for validity, and result in the generation of a corrected 1099 or a brief explanation of findings.

Note: 1099s for Non-emergency transportation claims are processed by DHS.

# 3.3.62 Generate Financial & Program Analysis Report

It is essential for Medicaid agencies to be able to generate various financial and program analysis reports to assist with budgetary controls and to ensure that the benefits and programs that are established are meeting the needs of the member population and are performing according to the intent of the legislative laws or federal reporting requirements.

The Generate Financial & Program Analysis/Report process begins with a request for information or a timetable for scheduled correspondence. The process includes defining the required reports format, content, frequency and media, as well as the state and federal budget categories of service, eligibility codes, provider types and specialties (taxonomy), retrieving data from multiple sources, such as Manage Payment History; Manage Member Information; Manage Provider Information; and Maintain Benefits/Reference Information; compiling the retrieved data, compiling the data, and formatting into the required data set, which is sent to the Send Outbound Transaction.

# 3.3.63 Maintain Benefits/Reference Information

The Maintain Benefits/Reference Information process is handled by Core and DHS DDM. This process triggered by any addition or adjustment that is referenced or used during the Edit Claim/Encounter, Audit Claim/Encounter, or Price Claim/Encounter. It can also be triggered by the addition of a new program, or the change to an existing program due to the passage of new state or federal legislation, or budgetary changes. The process includes revising code information including HCPCS, CPT, NDC, and/or Revenue codes, adding rates associated with those codes, updating/adjusting existing rates, updating/adding member benefits from the Manage Applicant & Member Communication, updating/adding provider information from the Manage Provider Information, adding/updating drug formulary information, and updating/adding benefit packages under which the services are available from the Receive Inbound Transaction.

# 3.3.64 Manage Program Information

The Manage Program Information business process is handled by most units/departments in the Iowa MITA Medicaid Enterprise. This process is responsible for managing all the operational aspects of the Program Information data store, which is the source of comprehensive program information that is used by all Business Areas and authorized external users for analysis, reporting, and decision support capabilities required by the enterprise for administration, policy development, and management functions.

The Program Information data store receives requests to add, delete, or change data in program records. The data store validates data upload requests, applies instructions, and tracks activity.

The Program Information data store provides access to payment records to other Business Area applications and users, especially those in Program Management and Program Integrity Management, through communication vehicles such as batch record transfers, responses to queries, and “publish and subscribe” services.

# 3.3.65 Perform Accounting Functions

IME uses a variety of solutions including outsourcing to another Department or use of a commercial off-the-shelf (COTS) package. Activities included in this process can be as follows:

a. Periodic reconciliations between MMIS and the systems that performs accounting functions

b. Assign account coding to transactions processed in MMIS

c. Process accounts payable invoices created in the MMIS

d. Process accounts payable transactions created in Accounting System (gross adjustments or other service payments not processed through MMIS, and administrative payables, HIPP)

e. Load accounts payable data (check number, date, etc.) to MMIS

f. Manage cancelled/voided/stale dated checks

g. Perform payroll activities

h. Process accounts receivable in various systems (such as refunds, non-federal share from the counties, lien recovery, estate recovery, co-pay, drug rebate, recoupment, and Member premiums)

i. Manage cash receipting process

j. Manage payment offset process to collect receivables

k. Develops and maintain cost allocation plans

l. Manages draws on letters of credit

m. Manages disbursement of federal administrative cost reimbursements to other entities

n. Respond to inquiries concerning accounting activities

# 3.3.66 Develop and Manage Performance Measures and Reporting

The Develop and Manage Performance Measures and Reporting process involves the design, implementation, and maintenance of mechanisms and measures to be used to monitor the business activities and performance of the Medicaid enterprise’s processes and programs. This includes the steps involved in defining the criteria by which activities

and programs will be measured and developing the reports and other mechanisms that will be used by the Monitor Performance and Business Activity process to track activity and effectiveness at all levels of monitoring.

# 3.3.67 Monitor Performance and Business Activity

The Iowa Monitor Performance and Business Activity process begins with the receipt of data and/or the occurrence of a predetermined time to acquire data for the purposes of measuring performance and business activity. The data that defines a measurement and the format in which to record it is received from the Develop and Manage Performance Measures and Reporting process. Data needed to execute measurements may be received from other Enterprise processes, contractors, or external entities (such as Manage Program Integrity Case, Member Services contractor, etc.) Data is gathered either by accessing information in Enterprise data stores or by carrying out interviews, audits, or performance reviews and is processed into the required format. Results are distributed to predetermined users and processes such as Develop Agency Goals and Objectives, or Develop and Maintain Program Policy

# 3.3.68 Draw and Report FFP

The Draw and Report FFP business process involves the activities to assure that federal funds are properly drawn and reported to CMS. The state is responsible for assuring that the correct FFP rate is applied to all expenditures in determining the amount of federal funds to draw. When CMS has approved a State Plan, it makes quarterly grant awards to the state to cover the federal share of expenditures for services, training, and administration. The grant award authorizes the state to draw federal funds as needed to pay the federal share of disbursements. The state receives federal financial participation in expenditures.

CMS can increase or decrease grant awards because of an underestimate or overestimate for prior quarters.

Payment of a claim or any portion of a claim for FFP can be deferred or disallowed if CMS determines that the FFP claim is incorrectly reported or is not a valid expenditure.

# 3.3.69 Manage FFP for Services

The Manage FFP for Services business process applies rules for assigning the correct FMAP rate to service expenditures and recoveries documented by the Medicaid enterprise.

FFP for expenditures for medical services under the Medicaid enterprise is dependent on the nature of the service and the eligibility of the beneficiary. The FMAP rate applies to Medicaid expenditures for services covered under the State Plan with the exception of things such as:

a. Family planning services for which FFP is 90 percent

b. Services provided through Indian Health Service facilities for which FFP is 100 percent

c. Services provided to members eligible under the optional Breast and Cervical Cancer program for which FFP is based on CHIP Enhanced FMAP rate

d. Medicare Part B premiums for Qualified Individuals for which FFP is 100 percent unless the allotment is exceeded and then the FFP is 0 percent

e. Transportation provided per the requirements of 42 CFR 431.53 for which FFP is 50 percent

f. FFP for expenditures for medical services under the CHIP program is based on the enhanced federal medical assistance percentage" (enhanced FMAP).

g. Refugee Medical Services-100 percent FFP

h. Money follows the person-special enhanced FFP

Recoveries of expenditures are assigned the same FFP rate as the FFP rate in effect at the time of the expenditure.

# 3.3.70 Manage Legislative Communication

The Iowa Legislature plays a key role in setting the strategic and tactical direction for IME. IME (Unit Managers and the IME Policy Staff) and DHS Eligibility Policy are involved in:

a. Responding to all types of requests from the legislature (such as request for bill review, fiscal (note) information, general technical assistance).

b. Monitoring legislative activity for bills that address policy staffing or systems that impact IME. Requires the Tracking of bills as they move through the legislative process.

c. Giving input into the health and human services components of the governor’s proposals.

d. Developing the department priorities package for the budget process.

e. Development of legislative priorities and proposals for legislation originating within IME.

# 3.3.71 Establish Business Relationship

The Establish Business Relationship business process encompasses activities undertaken by the IME to enter into business partner relationships with other stakeholders for the purpose of exchanging data. These include Memoranda of Understanding (MOU) and Service Level Agreements (SLA) with other agencies (such as Department of Public Health, Licensing Boards); limited service organizations, and others; and CMS (such as MDS) and other federal agencies.

Note: EDI with providers is through clearing houses. IME does not have agreements with the EDI providers. The clearing house establishes these agreements.

# 3.3.72 Manage Business Relationship

The Manage Business Relationship business process maintains the agreement between the IME and the other party. This includes routine changes to required information such as authorized signers, addresses, terms of agreement, and data exchange standards.

Note: EDI with providers is through clearing houses. IME does not have agreements with the EDI providers. The clearing house establishes these agreements.

# 3.3.73 Terminate Business Relationship

The Terminate Business Relationship business process cancels the agreement between the Department and the business or trading partner.

# 3.3.74 Manage Business Relationship Communication

The Manage Business Relationship Communication business process produces routine and ad hoc communications between the business partners.

Note: EDI with providers is through clearing houses. IME does not have agreements with the EDI providers. The clearing house establishes these agreements.

# 3.3.75 Identify Candidate Case

The Identify Candidate Case business process uses criteria and rules to identify target groups (such as providers, contractors, trading partners or members) and establishes patterns or parameters of acceptable/ unacceptable behavior, tests individuals against these models, or looks for new and unusual patterns, in order to identify outliers that demonstrate suspicious utilization of program benefits. Responsibility for the process is centralized, for the most part in SURS. Medical Services and IME policy provide support. When a case is determined as resulting in a fraud or criminal situation, the case is turned over to either the Department of Inspections and Appeals (DIA) Bureau of Economic Fraud (Member) or the DIA MFCU (Provider), as appropriate.

While many cases are identified as a result of scheduled review activities information received from sources outside the unit can also trigger identification of a case. Such information can be forwarded to the SURS unit as a result of standard IME activities many of which are part of the Monitor Performance and Business Activity process (such as processing returned EOBs), from the Healthcare Task Force Unit, or from the DIA Fraud Hotline. In some instances, a case may be initiated by either the DIA Bureau of Economic Fraud (BEF) or the DIA MFCU without having been forwarded to them by the SURS unit. In such an instance, the BEF or the MFCU may also trigger the Identify Candidate Case process by requesting that the SURS unit provide support by conducting review activities that are a part of this process.

Candidate cases may be identified by:

a. Provider utilization review

b. Provider Inquiry

c. Provider compliance review
d. Contractor utilization review (includes MCOs)
e. Contractor compliance review
f. Member utilization review (includes member lock-in)
g. Member Inquiry
h. Investigation of potential fraud review
i. Drug utilization review
j. Quality review
k. Performance review
l. Erroneous payment
m. Contract review
n. Audit Review
o. Other state work plan review (SURS)
p. Other

Each type of case is driven by different IME criteria and rules, different relationships, and different data.

# 3.3.76 Manage Program Integrity Case

The Manage Program Integrity Case business process receives a case file from an investigative unit with the direction to pursue the case to closure. The case may result in civil or criminal charges, in corrective action, in removal of a provider, contractor, trading partner or member from the Medicaid program; or the case may be terminated or suspended. Responsibility for the process is centralized, for the most part in SURS. Medical Services and IME policy provide support. When a case is determined as resulting in a fraud or criminal situation, the case is turned over to either the DIA Bureau of Economic Fraud (Member) or the DIA MFCU (Provider), as appropriate.

Individual state policy determines what evidence is needed to support different types of cases:

a. Provider utilization review
b. Provider Inquiry
c. Provider compliance review
d. Contractor utilization review (includes MCOs)
e. Contractor compliance review
f. Member utilization review (includes member lock-in)
g. Member Inquiry
h. Investigation of potential fraud review
i. Drug utilization review

j. Quality review
k. Performance review
l. Erroneous payment
m. Contract review
n. Audit Review
o. Other state work plan review (SURS)
p. Other

Each type of case is driven by different criteria and rules, different relationships, and different data. Each type of case calls for different types of external investigation.

# 3.3.77 Establish Case

The IME Care Management, Establish Case business process uses criteria and rules to identify target members for specific programs, assign a care manager, assess client's needs, select program, establish treatment plan, identify and confirm providers, and prepare information for communication.

A case may be established for one individual, a family or a target population such as:

a. Medicaid Waiver program case management (IME Policy defines procedure guidelines. Medical Services, Income Maintenance Workers (IMWs), Case Managers (Local office, or case managers contracted as providers), HCBS specialists, County Central Point of Coordination (CPCs) – funding, Financial Management Service Agency
    1. HCBS
    2. Long Term Care
    3. Remedial Services
    4. Habilitation Services
    5. Children's Mental Health
    6. Money Follows the Person
    7. PACE
b. Disease management
c. EPSDT

Each type of case is driven by state-specific criteria and rules, different relationships, and different data.

Identification of care management touches more care management programs than does managing cases (such as TCM).

# 3.3.78 Manage Care Management Case

The IME Manage Care Management Case business process uses state-specific criteria and rules to ensure appropriate and cost-effective medical, medically related social and

behavioral health services are identified, planned, obtained and monitored for individuals identified as eligible for care management services under such programs as:

a. Medicaid Waiver program case management

b. HCBS waiver program

c. Other agency programs

d. Disease management

e. Catastrophic cases

f. EPSDT

These are individuals whose cases and treatment plans have been established in the Establish Case business process.

It includes activities to confirm delivery of services and compliance with the plan. Also includes activities such as:

a Service planning and coordination with the member

b. Brokering of services (finding providers, establishing limits or maximums, etc.)

c. Facilitating/Advocating for the member

Monitoring and reassessment of services for need and cost effectiveness. This includes assessing the member's placement and the services being received and taking necessary action to ensure that services and placement are appropriate to meet the member's needs

Note: Lock-in cases are identified in the Program Integrity, Identify Case process and are managed here in the Manage Care Management Case process.

# 3.3.79 Manage Medicaid Population Health

The Manage Medicaid Population Health business process designs and implements strategies to improve general population health by targeting individuals by cultural, diagnostic, or other demographic indicators. The inputs to this process are census, vital statistics, immigration, EPSDT reports, and other data sources. The outputs are educational materials, communications, and other media.

The Medicaid Value Management Project (MVM) carries out many of the activities involved in this process.

# 4 PROJECT MANAGEMENT

This section includes the following topics:

- 4.1 Procurement Approach
- 4.2 Regulatory Compliance
- 4.3 Contract Phases

# 4.1 Procurement Approach

The Department is interested in obtaining all the services required in this Request for Proposal (RFP) by making a contract award for the program integrity component. The RFP provides a complete description of the requirements for the program integrity component in Section 6.

The Department is retaining its existing Core Medicaid Management Information System (MMIS), workflow management system modules, and pharmacy point-of-sale (POS) system that are in use today under the contracts that support them. In addition, the state will continue to maintain the data warehouse/decision support (DW/DS) system that is in use. The Department is replacing the Siemens HiPath ProCenter v7.0 system (call center) with the Cisco Unified Contact Center Express contact management (call center) system and reporting tool, which the Department anticipates will be operational by December 4, 2009. Section 5 of the RFP describes these systems within the overall Iowa Medicaid Enterprise (IME) operating environment. The identification and explanation of any interfaces with other components that a bidder's solution requires is an important evaluation criterion. Likewise, the bidder should describe any additional systems that the bidder proposes, which must fit within this infrastructure.

The Department expects bidders to describe a complete solution, including a detailed work plan. The work plan must include tasks for any required interfaces to key data sources and any additional systems that the bidder's solution includes. The work plan must also identify tasks and subtasks, task durations, resources, milestones, deliverables and target dates for milestones and deliverables.

# 4.2 Regulatory Compliance

The program integrity component acquired through this procurement is expected to be fully compliant with state and federal requirements [including Health Insurance Portability and Accountability Act (HIPAA) requirements] in effect as of the date of release for this RFP and with any changes that subsequently occur unless otherwise noted. Bidders are responsible for describing how their proposed solution meets and will remain in compliance with state and federal requirements (including HIPAA requirements for transactions and code sets, national provider identifiers (NPI), privacy and security).

# 4.3 Contract Phases

The activities resulting from the program integrity contract will occur in the phases described in the following topics:

- 4.3.1 Transition Phase
- 4.3.2 Operations Phase
- 4.3.3 Turnover Phase

Each phase has specific objectives, tasks and deliverables, all of which are directed toward continual support of the Medicaid program as described in this RFP (irrespective of changes in contractors).

## 4.3.1 Transition Phase

This phase of the contract relates to all actions necessary for the new program integrity contractor to prepare for their operational responsibilities for the IME. The Department expects the bidder to explain clearly and succinctly their transition approach to meeting all requirements.

The following subtopics present the Department's view of required activities. However, bidders are responsible for describing all of the activities that are necessary to assure a successful transition to their new operations. The transition phase includes the following tasks:

- 4.3.1.1 Planning Task
- 4.3.1.2 Operational Prereadiness Task
- 4.3.1.3 Operational Readiness Task

## 4.3.1.1 Planning Task

During this activity, the contractor shall acquire knowledge of the Iowa medical assistance programs and the detailed requirements of the IME for program integrity. The contractor will also review the proposed transition plan with the Department's contract management staff and update the work plan to ensure complete understanding and integration of various transition tasks and activities.

### 4.3.1.1.1 Activities

The bidder must present a structured approach to begin the project. The net effect of the approach should be the transition of the IME functions in an efficient and timely manner with minimal impact on providers, members, and the Department. Planning task activities will include but are not limited to the following:

a. Establish contractor's Department-approved project team and establish reporting requirements and communication protocols with the Department's contract manager.

b. Prepare the transition plan with approval from the Department's contract manager.

#### 4.3.1.1.2 State Responsibilities

The Department's responsibilities for the planning task will be as follows:

a. Approve key personnel.

b. Provide access to all current systems and operational procedures documentation.

c. Provide responses to policy questions.

d. Review and approve contract deliverables.

e. Review and approve all plans.

f. Review and approve project control and status reporting protocols.

g. Provide official approval to proceed to the operational readiness activity upon completion of all planning task activities.

#### 4.3.1.1.3 Contractor Responsibilities

Contractor responsibilities for the planning task will be as follows:

a. Prepare and submit a project management plan for the transition phase to the Department for approval.

b. Prepare and submit transition and operations staffing plans to the Department for approval.

c. Prepare and submit modifications to the operational procedures as appropriate to the Department for approval.

d. Review the turnover plan from the current contractor.

#### 4.3.1.1.4 Deliverables

At a minimum, the bidder must provide the following deliverables:

a. Transition Project Plan

b. Transition Staffing Plan

c. Operations Staffing Plan

d. Operational Procedures Sign-Off

### 4.3.1.2 Operational Prereadiness Task

Operational prereadiness will focus on assessing the contractor's readiness to assume and start operations in some or all of the following areas:

a. Staffing

    1. Bidders are encouraged to leverage current staff experienced in IME operations.

b. Staff training

    1. Data and telephone systems

    2. Workflow process management

3. Operational procedures
4. Iowa Medicaid policy

c. Updated operations documentation

The operational readiness task will involve preparing for the onset of operations in the existing IME environment. This task will involve preparing checklists, acquiring staff and making them available for training, and assessing readiness to assume operational responsibility for the awarded program integrity component.

The Department will require that the Core MMIS contractor provide MMIS and workflow process management training. The Department will arrange contact management (call center) and tracking system training for the program integrity contractor staff members who interface with these systems. Likewise, the Department will provide DW/DS system training to the program integrity contractor staff members who will use the system.

# 4.3.1.2.1 Activities

The program integrity contractor will be responsible for tracking and responding to all problems related to the transition identified in their area of responsibility during the operational readiness phase and if necessary prepare a corrective action plan for resolution. The key components of the operational readiness task are:

a. Prepare and complete an operational readiness checklist.
b. Assess operational readiness.
c. Implement corrective action plan as necessary.
d. Prepare for installation, configuration and operation of data analytics tools and services.
e. Prepare weekly progress report.
f. Monitor operational readiness preparations.

# 4.3.1.2.2 State Responsibilities

The Department’s responsibilities for this task are:

a. Review and approve operational readiness checklist.
b. Respond to contractor inquiries related to program policy.
c. Assure provision of training in data and phone systems as appropriate for the contractor.
d. Review the weekly progress reports.
e. Approve corrective action plans developed by the contractor.
f. Approve requirements documents and project plans.

# 4.3.1.2.3 Contractor Responsibilities

At a minimum, the program integrity contractor will have the following responsibilities for this task:

a. Develop a comprehensive check-off list of its start-up activities.

b. Provide the Department assurance that all check-off activities have been satisfactorily completed and signed-off by the Department.

c. Develop and implement a corrective action plan for all outstanding activities for review and approval by the Department.

d. Conduct training for its staff.

e. Obtain a written sign-off from the Department to begin transition.

f. Gather and document all IME technical and operational requirements pertaining to data analytics services and tools.

g. Prepare project plans for development, configuration, testing and deployment of data analytics tools, including any system interfaces or modifications required for interoperability with IME data systems.

# 4.3.1.2.4 Deliverables

The program integrity contractor must provide the following deliverables, as appropriate to their responsibilities, for the Department's review and approval:

a. Completed checklist matrix for the contractor's operations.

b. Completed checklist matrix for all training activities.

c. Completed checklist matrix for all interface operations.

d. Completed weekly status report.

e. Updated operational procedures documents as appropriate.

f. Comprehensive requirement documents and project plans for data analytics tools and services.

# 4.3.1.3 Operational Readiness Task

The program integrity contractor must ensure that they are ready to meet their operational responsibilities under the IME and that they have obtained Department approvals to begin operations. To be ready for operations, the Iowa Medicaid Enterprise must satisfy all the functional requirements specified in the RFP and documented during the planning and operational readiness activities. Department staff must be given sufficient time to review all documentation for completeness prior to transition.

The Department requires that all contractors will locate all staff directly associated with the provision of contract services to the IME during the operations and turnover phases at the IME permanent facility. On June 30, 2010, after 5:00 p.m., new contractor staff will be able to move in to their assigned space in the IME permanent facility at 100 Army Post Road in Des Moines, Iowa, 50315. The Department expects the contractor to be ready to start work by their assigned start times on July 1, 2010.

The Department recognizes that additional time is necessary to install and prepare for operations any additional data analytics tools that the bidder proposes. Although all other program integrity operations will begin on July 1, 2010, the program integrity

contractor will implement data analytics services and tools no later than November 1, 2010.

# 4.3.1.3.1 Activities

The program integrity contractor will be responsible for tracking and responding to all problem conditions reported in their area of responsibility during the changeover task and preparing a corrective action plan for problem correction and resolution. The key components of the changeover task are:

a. Finalize operations documentation.

b. Finalize interfaces.

c. Occupy permanent space in IME facilities.

d. Execute operational readiness checklist.

e. Implement corrective action plan for any problems identified.

f. Monitor operational readiness preparations.

# 4.3.1.3.2 State Responsibilities

For operational readiness, the Department's responsibilities are:

a. Respond to contractor inquiries related to program policy and requirements.

b. Review, comment, test, and if correct, approve all deliverables associated with this task.

c. Approve the corrective action plan developed by the contractor.

d. Approve training completion.

# 4.3.1.3.3 Contractor Responsibilities

At a minimum, the contractor will have the following responsibilities for this task:

a. Prepare and obtain Department approval of end-user training plans and materials for data analytics services and tools and conduct end-user training.

b. Produce and update all operations documentation and obtain Department approval of each iteration.

c. Establish Department-approved interfaces, as necessary, to other component contractors and the Department.

d. Develop and obtain Department approval of operations schedule.

e. Complete all training and produce training report for Department review and approval.

f. Obtain written approval from the Department to start operations.

# 4.3.1.3.4 Deliverables

At a minimum, the following deliverables must be included for the Department's review and approval:

a. Completed operational readiness checklist
b. Final documentation and operational procedures
c. Data analytics tools (for data mining, data analytics, predictive modeling, postpayment review and fraud detection functions) that are operational and fully fit for use in conformance with IME's policies and requirements
d. Interfaces or other mechanisms required for full interoperability between the data analytics tools and IME data systems
e. Reports, dashboards, queries and other such data analytics output as may be required by IME
f. Training report following completion of data analytics tools and services training

# 4.3.2 Operations Phase

The operations phase is the daily performance of all required activities by the new contractor. Because of the risk created by the complexity of this procurement, vendors will need to describe required coordination and safeguards to assure a successful operation of the Iowa Medicaid Enterprise.

# 4.3.3 Turnover Phase

The turnover phase is activated when the state contractually transfers responsibility for the operations function to a new entity (such as a newly awarded contractor). The turnover phase is the time period near the end of the operations phase of the contract awarded by this RFP. All bidders will be required to provide a commitment for full cooperation during the turnover responsibility that comes at the end of the contract term awarded by this RFP, including preparation of a turnover plan when the Department requests it.

# 5 OPERATING ENVIRONMENT

This section highlights the tools that are in use in the Iowa Medicaid Enterprise (IME) operating environment. As part of their operation, all contractors operating within the IME will use existing, common managerial tools where necessary to perform their functions. Additionally, some contractors will use existing tools for functions that are specific to their components. Detailed information about all of the tools is available in the resource library. The following topics highlight these tools:

- 5.1 Iowa Medicaid Management Information System (MMIS)
- 5.2 Eligibility Verification Information System (ELVS)
- 5.3 Data Warehouse/Decision Support (DW/DS) System
- 5.4 Workflow Process Management System
- 5.5 Call Center Management System
- 5.6 Iowa Automated Benefit Calculation (IABC) System
- 5.7 Individual Services Information System (ISIS)
- 5.8 Title XIX
- 5.9 Medicaid Quality Utilization and Improvement Data System (MQUIDS)
- 5.10 Iowa Medicaid Electronic Records System (I-MERS)
- 5.11 IMEServices.org
- 5.12 Provider Incident Reporting (Iowa Medicaid Provider Access)
- 5.13 Medicaid IowaCare Premium System (MIPS)
- 5.14 Social Security Buy-In (SSBI)
- 5.15 Pharmacy Point-of-Sale (POS) System

# 5.1 Iowa MMIS

This overview of the Iowa MMIS includes the following topics:

- 5.1.1 Claims Processing Function
- 5.1.2 Recipient Function
- 5.1.3 Provider Function
- 5.1.4 Reference Function
- 5.1.5 Medically Needy Function
- 5.1.6 Management and Administrative Reporting (MAR) Function
- 5.1.7 Surveillance and Utilization Review (SUR) Function
- 5.1.8 Third-Party Liability (TPL) Function

- 5.1.9 Prior Authorization Function
- 5.1.10 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Function

# 5.1.1 Claims Processing Function

The claims processing subsystem is the most critical component of the Medicaid Management Information System (MMIS). It captures, controls, and processes claims data from the time of initial receipt (on hardcopy or electronic media) through the final disposition, payment, and archiving on claims history files. The claims processing subsystem edits, audits, and processes claims to final disposition consistent with the policies, procedures, and benefit limitations of the Iowa Medicaid Program. To accomplish this, the subsystem uses the data contained in the most current recipient eligibility file, provider master file, reference files, TPL resource file, and prior authorization (PA) file.

The claims processing subsystem maintains claims history including both paid and denied claims. The MAR and SUR subsystems use claims history in producing management and utilization reports, as does the claims processing subsystem in applying history-related edits and audits. Online inquiry is available for 36 months of adjudicated claims history, lifetime procedures, and any claims still in process. Service limitations for vision, dental, and hearing aid are displayed in the recipient eligibility subsystem key panel.

The claims processing subsystem processes, pays or disallows, and reports Medicaid claims accurately, efficiently, and in a timely manner. It accepts entry of claims through online examination and entry as well as from providers' submissions via magnetic tape, PC diskettes, and electronic transmission. The claims processing subsystem includes the ability to process Medicare crossover claims.

The claims processing subsystem provides up-to-date claims status information through online inquiry and provides data to the MAR, SUR, and EPSDT subsystems and other accounting interfaces used to generate administrative reports. It ensures accurate and complete processing of all input to final disposition. The claims processing subsystem offers many online features such as online, real-time claim credits and adjustments.

Outputs of the claims processing subsystem include detailed remittance advices for providers and member explanations of medical benefits (EOMBs). This subsystem also produces updates to the claims history files, prior authorization file, recipient eligibility file, and provider file.

The MMIS processes all Iowa claim forms and a variety of electronic media claims (EMC) including transfers from claims clearing houses, and direct computer data transfer. All claims entered into the subsystem are processed similarly according to claim type, regardless of the initial format of the claim document. Because of the number of various EMC formats required to support Iowa Medicaid billing, preprocessing is performed to reformat the various inputs into the MMIS claim layout.

The system determines to either pay or deny a service according to criteria on the exception control file. This parameter table, which is maintained online, enables the Department to control the disposition of edits and audits without any programming effort

involved. Separate exception codes are posted for each edit and audit exception for each line item. Each exception code can be set to several dispositions depending on such factors as input media (paper or magnetic tape) and claim type. Claim type is assigned by a combination of claim invoice and other indicators within the claim.

If all exceptions on a claim have a disposition of pay, deny, or pay and report, the claim is adjudicated, and the payment amount is computed according to the rules and regulations of the State of Iowa. If any exception for the claim is set to suspend, then the claim is either printed on a detail suspense correction report or listed for an online suspense correction, as dictated by parameters on the exception control file. A super-suspend disposition is used for edits so severe that no resolution short of correcting the error is possible (such as invalid provider data). The pay-and-report disposition allows the Department to test the impact of a new exception and decide how to treat the condition in the future (such as pay, deny, or educate providers). Claims with special exception codes are routed according to Department instructions. The specific unit responsible for correction of an exception is designated by the location code on the exception control file.

The MMIS also allows the detail and summary resolution text to be entered on the text file of the reference subsystem. This information is then available to the resolution staff during exam entry, suspense correction, and inquiry processes, thus providing an online resolution manual.

A remittance advice is produced for every claim in the system and shows the amount paid and the reasons for claim denial or suspense. The message related to each exception code is controlled by parameters on the exception control file. A different message can be printed according to claim submission media, claim type, and whether the claim is denied or suspended. The actual text of the message is maintained online on the text file.

The MMIS maintains 36 months of adjudicated claims history online. These claims, as well as all claims in process, are available for online inquiry in a variety of ways. Claims can be viewed by member ID, provider number, National Provider Identifier (NPI), claim transaction control number (TCN), or a combination of the above. These search criteria can be further limited by a range of service dates, payment dates, payment amounts, billed amounts, claim status, category of service, procedure codes, or diagnosis codes within a claim type. Claims can be displayed either in detail, one claim per screen, or in summary format, and several claims per screen. Additional inquiry capability allows the operator to browse the member, provider, or reference files from the claim screen to obtain additional information related to the claim. A summary screen is also available for each provider containing month-to-date, year-to-date, and most recent payment information. The claims processing subsystem has the capability to suspend or deny claims based on TPL information carried in the MMIS files.

The MMIS supports cost containment and utilization review by editing claims against the prior authorization record to ensure that payment is made only for treatments or services which are medically necessary, appropriate, and cost-effective. The Utilization Review (UR) criteria file provides a means of placing program limitations on service frequency and quantity, as well as medical and contraindicated service limits. It provides a means for establishing prepayment criteria, including cross-referencing of procedure and diagnosis combinations.

The claims processing subsystem contains a claims processing assessment system (CPAS) module designed to provide claim sampling and reporting capability required to support the Department in conducting CPAS reviews.

Each step in document receipt processing and disposition includes status reporting and quality control. The Iowa MMIS generates several reports useful in managing claim flow and resolution. Reports are used to track the progress of claims at each resolution location, identify potential backlogs, pinpoint specific claims that have suspended, monitor workload inventories, and ensure timely processing of all pended claims. Meanwhile, quality control staff monitors all operations for adherence to standards and processing accuracy in accordance with contractual time commitments and error rates.

# 5.1.2 Recipient Function

The recipient subsystem is the source of all eligibility determination data for the MMIS, whether generated by the Department or by the MMIS. The information contained in the MMIS eligibility file is used to support claims processing, management and administrative reporting, surveillance and utilization review reporting and TPL. The recipient subsystem currently meets or exceeds all federal and state requirements for a Medicaid recipient subsystem.

The MMIS recipient subsystem is designed to provide the flexibility required to accommodate the Department’s changing approach to the management of its public assistance programs. To minimize the impact of future changes, the MMIS' recipient subsystem uses a single recipient database that includes eligibility, lock-in, health maintenance organization (HMO), MediPASS, nursing home, waiver, client participation and Medicare data.

The recipient subsystem accepts data only from the Title XIX system for eligibility and facility data. The recipient subsystem receives daily transmissions of eligibility updates from the Title XIX system, which are used for batch updates of the recipient eligibility file.

The MMIS’ batch file update methodology is supplemented with online, real-time updates to the recipient record. The guardian effective date and ID are added or updated through the online feature of the recipient subsystem. All online updates to the recipient eligibility file are thoroughly controlled to ensure the accuracy of the updates before they are applied to the file. Once data has been added or changed on a screen and the “Enter” key pressed, each field is edited, and the full screen is displayed with any errors highlighted. When all errors have been corrected, the screen is redisplayed to allow for final verification of update activity. Pressing the “Enter” key a second time applies the updates to the recipient file.

Hard-copy audit trails are supported through the use of the online transaction log file. The transaction log file records a before and after image of each MMIS master file record updated online. The transaction log file is then used to support daily online update activity reporting and is retained for historical purposes.

The Department and the Core MMIS contractor share the responsibility for the operation of the recipient subsystem. The Department determines which individuals are eligible to receive benefits under the Iowa Medical Assistance program and sets limitations and eligibility periods for those individuals. The Department is responsible for transmitting (either electronically or by other approved media) eligibility data elements required to maintain the MMIS recipient eligibility file on both a daily and monthly basis.

The Core MMIS contractor is responsible for operating the MMIS recipient subsystem. The recipient subsystem will process the Department's daily and monthly update transmissions and submit all balancing and maintenance reports to the Department. Any discrepancies discovered during the update process are promptly reported to the Department.

The Core MMIS contractor provides reports from the recipient subsystem files in the format specified by the Department. These reports include the detailed recipient eligibility updates, recipient update control and update error reports. Several reports are created from monthly recipient processing, such as the recipient list reports; the possible duplicate reports and the recipient purge report.

# 5.1.3 Provider Function

The provider subsystem maintains comprehensive provider-related information on all providers enrolled in the Iowa Medicaid Program to support claims processing, management reporting, surveillance and utilization review. The provider subsystem processes provider applications and information changes interactively using online screens. This capability for immediate entry, verification and updating of provider information ensures that only qualified providers complying with program rules and regulations are reimbursed for services rendered to eligible Medicaid members. The provider subsystem currently meets or exceeds all federal and state requirements for a Medicaid provider subsystem.

The provider subsystem retains provider-related data on six files: provider master file, the provider group file, provider intermediary file, Medicare-to-Medicaid cross-reference file, provider HMO plan file and the National Association of Boards of Pharmacy (NABP)-to-Medicaid cross-reference file. These files are used to interface with the claims processing, recipient, MAR, SUR, TPL and EPSDT subsystems to supply provider data for claims processing and provider enrollment and participation reporting. Major subsystem features include the following:

a. Online maintenance: Because additions and changes to the provider master file are processed online and in real-time, they can be verified immediately upon entry. They are also immediately available for use in processing claims and other system functions. Once all data is added or changed on a screen and the "Enter" key is pressed, the provider subsystem edits each field and redisplays the full screen with any errors highlighted. When all errors are corrected, the screen is redisplayed a final time to allow for visual verification of update activity. Pressing the "Enter" key a second time results in the updates being applied to provider subsystem files.

b. Online inquiry: A powerful access capability allows inquiry to providers by various search paths including provider number, Social Security or federal employer identification number, provider name, unique physician identification number (UPIN), provider type, provider county, provider type within county and Drug Enforcement Administration (DEA) number. The inquiry can also be limited to only actively enrolled providers or can include all providers.

c. Enrollment: The online software is used to enroll providers of service, which formalizes the procedure for application, verification of state licensure, authorization for claim submission and payment.

d. Identification: The provider subsystem provides a method of identifying each provider's type and specialty as well as the claim types the provider is allowed to submit.

e. Cross-referencing: The system provides the following methods of cross-referencing provider numbers:

   1. Relate provider to as many as ten provider groups.
   2. Identify an infinite number of member providers for a provider group.
   3. Relate provider to as many as ten billing agents.
   4. Identify member providers for a billing agent.
   5. Maintain previous provider number.
   6. Maintain new provider number.
   7. Relate to alternative practice locations or billing entities.
   8. Identify lien-holder provider number.
   9. Identify provider as managed care along with maximum enrolled number of members.
   10. Identify all Medicaid provider IDs related to an NPI.

f. Institutional rates: The provider subsystem maintains institutional rates by charge mode, level of care and effective dates.

g. Hold/review: The provider subsystem maintains six occurrences of provider review indicators for the review and suspension of claims for specific dates of service, procedures, diagnoses or type of service codes.

h. Language indicator: On screen one, this indicator identifies the different languages spoken in the provider’s office, including Spanish, Bosnian, Serb/Croatian, Vietnamese and Lao.

i. Special units/programs: The provider subsystem maintains the certified units used in hospital pricing.

j. Diagnosis related group (DRG)/ambulatory patient classification (APC) pricing information: The provider subsystem maintains ten occurrences of DRG and APC base rates and add-ons by effective date.

k. Reports: The provider subsystem produces various provider listings, mailing labels and processing reports daily, monthly, and on-request. Provider address labels may be requested by a number of different selection criteria.

l. Audit trails: Hard-copy audit trails are supported through the use of the online transaction log file. This system component logs both a "before" and "after" image of each master file record updated online. The transaction log file is then used to support daily update activity reporting and is retained for historical needs.

# 5.1.4 Reference Function

The reference subsystem's function is to provide critical information to the claims processing and MAR subsystems. The data to support claims pricing and to enforce

state limits on services resides in the reference subsystem. The basic design of the MMIS reference subsystem offers the Department flexibility in meeting changing program requirements.

Real-time file updating allows for the immediate editing and correcting of update transactions to all of the reference subsystem files. Once a transaction has been applied, it is effective immediately for claims adjudication. The subsystem provides many user-maintained parameters that allow the IME to fine-tune the edits and audits of the Iowa MMIS.

While the basic design of the system stresses online file updates and inquiries, the reference subsystem also incorporates batch updating of key files. The reference subsystem accepts batch procedure, diagnosis, DRG, and APC updating.

The system accommodates mass adjustments due to retroactive price changes. The adjusted claim is priced against the policy in effect on the date of service, even if the price is established after the date that the claim was originally processed.

The MMIS reference subsystem supports the following files:

a. Procedure file: This file contains records for all Healthcare Common Procedure Coding System (HCPCS) procedure codes; International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) procedure codes; Iowa-unique codes; national drug codes (NDCs) and revenue codes. Each record carries the following data:

    1. Procedure name
    2. Age, sex, provider type, provider specialty, place of service, and procedure code modifier limitations
    3. Twenty segments, with beginning and ending dates containing pricing, prior authorization indicator, and coverage by Medicaid control indicator (no control, deny, suspend for review, suspend for the Department review, EPSDT only)
    4. Clinical labs, multiple description coding (MDC) diagnosis compatibility indicators, cross-reference indicators
    5. Covered by Medicare indicator
    6. Tooth number required, tooth surface required, and tooth quadrant required indicators
    7. Family planning, sterilization, hysterectomy, and abortion indicators
    8. Pre- and postoperation days, laboratory certification codes, and maximum units
    9. Elective surgery, visit/surgery, surgical tray, and MediPASS-override indicators
    10. Lifetime, trauma, EPSDT, referral, copayment, multiple surgery, ambulatory surgical center, nursing home, and duplicate check indicators
    11. Provider charge indicators for category of service attached, provider type attached, and provider attached
    12. Conversion and scratchpad indicators
    13. Claim type and scratchpad

14. HCPCS update, cross-reference type of services, and prescribing provider

b. Drug file: This file contains records for all drug codes. Each record carries the following data:

1. Eleven-digit NDC code
2. Previous eleven-digit NDC code
3. Obsolete date
4. Drug name and manufacturer name (brand name)
5. Age and sex limitations
6. Drug generic grouping and generic name
7. Specific therapeutic class (three character)
8. 30-day policy, unit quantity, unit measure
9. Max unit day supply, route code
10. Strength description
11. Package size pricing indicator
12. Three segments of unit dose package size
13. Drug package size, activity counter
14. Prior authorization high dose, prior authorization maintenance dose
15. High dose exempt period
16. Six month approval date, new use approval indicator, new use approval date
17. Drug pricing data [begin date, end date, over-the-counter (OTC) minimum units, minimum supply, maximum supply, maximum days, catalog price, drug average wholesale price (AWP), drug estimated acquisition cost (EAC), and drug maximum allowable cost (MAC)]
18. DEA, dialysis, nursing home, family planning indicators
19. Dispensing fee indicator, over the counter indicator
20. Six segments with drug class, drug efficacy study implementation (DESI) indicator, drug control code, prior authorization indicator, and begin and end dates
21. Six segments of rebate effective dates and rebate indicators

c. Diagnosis file: This file contains records for all diagnosis codes. Each record carries the following data:

1. Diagnosis code
2. Diagnosis name
3. Age and sex limitations
4. Medicaid control code (deny, suspend for review, not specific, suspend for the Department review, EPSDT only, no control)

5. Family planning, sterilization, abortion, prior authorization, emergency, and accident indicators
6. Diagnosis compatibility indicator and codes, diagnosis cross-reference indicators and codes

d. DRG file: This file contains DRG records with the following data:
   1. DRG code
   2. Unit code
   3. Age code
   4. Major diagnosis category
   5. Medical/surgery indicator
   6. DRG description
   7. DRG pricing (begin date, end date, average length of stay, inlier end day, outlier begin day, weight, mean log length of stay, standard deviation log length of stay)
   8. Control code

e. APG file: This file contains APG records with the following data only for claims prior to 10/01/2008:
   1. APG code
   2. APG description
   3. APG pricing data (begin date, end date, weight)
   4. Batch bill flag, non-covered flag, and condition flag

f. APC file: This file contains APC records with the following data for claims effective 10/01/2008:
   1. APC code
   2. APC description
   3. APC pricing data (begin date, end date, weight)

g. Prepayment utilization review criteria file: This file contains parameters to define program limitations on service frequency and quantity as well as medical and contraindicated service limits.

h. Provider charge file: This file contains records for procedures that require individual prices by specific provider, provider type, or provider category of service.

i. Text file: This file contains records for various narratives required in the claims processing subsystem:
   1. Provider text
   2. Exception code text
   3. Explanation of benefits (EOB) text
   4. Location text

5. Carrier text
6. Remittance advice newsletter text
7. Prior authorization reason text
8. Procedure range text

j. Exception control file: This file contains records used to control the disposition of each edit or audit exception code. In addition to exception status (by type of claim and input media), this file carries such data as exception code description, indicator of whether to print a worksheet or a list, location code for review, EOB codes for denied or suspended services, and control data to allow or disallow force payment or denial of the exception code.

k. System parameter file: This file contains records that are used throughout the system to control different types of limits and values.

# 5.1.5 Medically Needy Function

The Iowa medically needy subsystem's function is to monitor income and resource levels for individuals who meet the categorical but not the financial criteria for Medicaid eligibility and who are described as medically needy. The purpose of the medically needy subsystem is to:

a. Receive case and member eligibility-related data from the IABC system, which is the system used for eligibility determination.

b. Create certification periods with spend-down amounts according files transferred from IABC

c. Prioritize medical expenses that have been submitted according to the Iowa Administrative Code and Code of Federal Regulations

d. Apply verified medical expenses against the unmet spend-down obligation and reject expenses that can not be applied to the spend-down obligation.

e. Notify the IABC system when the spend-down obligation has been met.

f. Track expenses that have been used for meeting spend-down.

g. Generate notification documents.

h. Update certification when requested by the Department's income maintenance (IM) workers.

Medically needy eligible individuals may be responsible for a portion of their medical expenses through the spend-down process. The Department's income maintenance IM workers determine initial eligibility and the spend-down obligation for these members. The Title XIX system sends a record to the MMIS unit identifying these potential medically needy eligible individuals, which allows the MMIS to accumulate claims toward their spend-down amount.

The medically needy subsystem serves as an accumulator of claims that apply toward the spend-down amount. The subsystem displays the medically needy spend-down amount, the amount of claims that have accumulated towards the spend-down amount, information for each certification period, the date that the spend-down obligation is met,

and information about claims used to meet the spend-down obligation. Department staff can access these medically needy screens online.

Once individuals become eligible by meeting their spend-down obligation, Medicaid pays the claims that were not applied to the spend-down for that certification period. The medically needy function of the Core MMIS consists of processing claims for members eligible for the medically needy program, tracking medical expenses to be applied to the spend-down, and providing reports of the spend-down activity.

Cases that have a spend-down obligation in either the retroactive or the prospective certification period have information passed from the IABC to the MMIS medically needy subsystem. Medically needy cases that are approved and have zero spend-down in both the retroactive and prospective certification periods are maintained by the IABC and are not passed to the MMIS medically needy subsystem. Individuals with active fund codes are automatically eligible for Medicaid. The IABC notifies the IME that the client is eligible for Medicaid.

The annual Medicaid ID card is issued through MMIS instead of the Title XIX system. Providers rely on the Core MMIS system's eligibility verification system (ELVS) that includes both a phone bank and web-based process for eligibility verification and service limitations. Members enrolled in the medically needy program are not eligible to receive an ID card until they have met spend-down obligations and their fund codes in the MMIS system have changed to eligible fund codes. Members receive an ID card when they become eligible.

Although the NPI implementation project made only minor modifications to the medically needy subsystem, the components of the system were significantly impacted. The medically needy subsystem makes extensive use of claim records and expenses are tracked using a transaction that is derived from a claim record.

# 5.1.6 Management and Administrative Reporting (MAR) Function

The MAR subsystem provides the Department management staff with a timely and meaningful reporting capability in the key areas of Medicaid program activity. MAR reports are designed to assist management and administrative personnel with the difficult task of effectively planning, directing and controlling the Iowa Medicaid Program by providing information necessary to support the decision-making process.

The MAR subsystem presents precise information that accurately measures program activity and ensures control of program administration. The MAR subsystem also provides historical, trend, and forecasting data that assists management in administering the Iowa Medicaid Program. In addition, the MAR subsystem provides necessary information to all levels of management to predict potential problems and plan solutions.

The MAR subsystem extracts key information from other subsystems for analysis and summarization. The MAR subsystem maintains this data in many different variations for use in producing its reports. This information can also be used as an extensive base of data for special or on-request reporting.

The Department and the Core MMIS contractor share responsibility for the ongoing operation of the MAR subsystem. The Department's responsibilities are to determine the

format, reporting categories, parameters, content, frequency, and medium of all routinely produced reports and special reports. The Department is also responsible for submitting information to be incorporated with MMIS data files for reporting, including budget data, buy-in premium data, and managed care encounter data. In addition, the Department determines policy, makes administrative decisions, transmits information, and monitors contractor duties based on MAR reports.

The Core MMIS contractor is responsible for operating the MAR subsystem and supporting all of the functions, files, and data elements necessary to meet the requirements of the RFP. All reports have uniform cutoff points so that consistent data is input to each MAR report covering the same time period. A complete audit trail is provided among the MAR reports and between reports generated by MAR and other subsystems for balancing within the cycle.

The Core MMIS contractor produces and makes available the MAR reports and other outputs in formats, media, and time frames specified by the Department. The Core MMIS contractor produces reports at different summary levels according to the Department specifications, and verifies the accuracy of all reports.

The Core MMIS contractor develops, provides, and maintains both system and user documentation for the Department personnel and its own staff. The Core MMIS contractor provides training for the Department personnel and contractors on an ongoing, as-needed basis.

The MMIS MAR subsystem has been designed and refined to run within a batch-processing environment. The system is able to handle large amounts of input data, to manage system input and output (I/O) resources efficiently, to minimize program execution and central processing unit (CPU) time requirements, and to provide reliable and effective restart and recovery capabilities. Following are some of the specific design features of the MMIS MAR subsystem:

a. Program coding techniques, which emphasize economical CPU usage and reduce paging and file I/O overhead

b. Modular program structure, which aids readability and minimizes maintenance learning time

c. Tabled valid values for all MMIS coding structures such as provider types, categories of service, and aid categories, which are maintained through an automated data dictionary that enables additions, changes, or deletions of code values without programmatic modifications

d. Extensive internal program documentation

e. Simplified design that emphasizes smaller, easily-coded programs, lending flexibility for maintenance and enhancements

f. Thorough backup and restart capability that minimizes hardware use

# 5.1.7 Surveillance and Utilization Review (SUR) Function

The SUR subsystem operating in Iowa is designed to provide statistical information on members and providers enrolled in the Iowa Medicaid Program. The subsystem features

effective algorithms for isolating potential misuse. Also, it produces an integrated set of reports to support the investigation of that potential misuse.

SUR provides extensive capabilities for managing data summarization, exception processing, and report content and format. Parameter controls also allow the user to limit the volume of printed material required for analysis. Parameter-driven data selection, sampling, and reporting features further enhance the capabilities of the subsystem.

SUR produces comprehensive profiles of the delivery of services and supplies by Medicaid providers and the use of these services by Medicaid members. Both summary and detail claim data are available to the reviewer, who is able to control the selection of claims and content of reports through parameters. Statistical indices are computed for selected items to establish norms of care so that improper or illegal utilization can be detected.

The SUR subsystem has had many enhancements since its initial development. These enhancements include the addition of a statistical claim-sampling module, which enables the user to review a random sample of claims from the total population and reduces the resources required for large-volume providers. A claim-ranking module provides the user with reports on the volume of usage of procedures, drugs, and diagnoses.

A parameter-controlled report writer allows the user to define the format in which the selected claims are to be displayed. The capability to print certain information from the procedure, drug, and diagnosis file is also available.

Nursing home summary profiles were enhanced with a member composite analysis feature. The profiles incorporate all services rendered on behalf of a member while resident in the facility, regardless of the provider of service. Referring, prescribing, and attending provider profiles, as well as group provider profiles, are made available to further enhance review capabilities for the user.

# 5.1.8 Third-Party Liability (TPL) Function

The TPL subsystem is a fully integrated part of the MMIS. A significant amount of TPL processing occurs within the recipient, claims processing and MAR subsystems.

For example, TPL coverage is maintained by member within the recipient subsystem. In the recipient subsystem, the TPL resource file contains member identification data, policy numbers, carrier codes, coverage types, and effective dates. An indicator on the recipient eligibility file is set for those members having verified policy information on the TPL resource file.

The claims processing subsystem identifies claims with potential TPL coverage by examining the TPL resource file and indicators from the claim form. Claims for services with third-party coverage may be paid, paid but reported, suspended, or denied based on the individual circumstances. The MAR subsystem produces various reports that support TPL activity.

The TPL subsystem uses data from various sources to perform the following functions:

a. Identify third party resources available to Medicaid members.

b. Identify third party resources liable for payment of services rendered to Medicaid members.

c. Avoid state costs for these services.

d. Recover third-party funds.

e. Report and account for related information.

# 5.1.9 Prior Authorization Function

The Core MMIS contractor is responsible for maintaining the prior authorization file, which contains procedures requiring prior authorization, and information identifying approved authorization, certification periods and incremental use of the authorized service. The Core MMIS contractor receives file updates from the Medical Services contractor for selected ambulatory and inpatient service authorization codes. These authorizations are loaded on the prior authorization file that is used by the MMIS for processing claims. For services requiring preprocedure review by the Medical Services contractor, the Core MMIS contractor must ensure that all claims are denied if a validation number indicating approval is not present on the PA file. In addition, the Core MMIS contractor is responsible for ensuring that in cases requiring preadmission review by the Medical Services contractor, payment is made only if an approval certification is present on the claim and that payment is made only for the approved number of days and at the specified level of care.

The Core MMIS contractor will also receive file updates from the Medical Services contractor on authorized services. These files will cover the array of services under the Medical Services contractor's responsibility.

The Core MMIS contractor uses ISIS as a prior authorization file to verify authorized services, members and rates for payment of home and community-based (HCBS) waiver services. ISIS is also used for prior authorization of facility, remedial services, habilitation services and targeted case management services. Approved authorizations are sent from ISIS to the prior authorization subsystem.

# 5.1.10 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Function

The EPSDT subsystem supports the Department in the timely initiation and delivery of services. It also supports care management, federal reporting, and follow-up treatment tracking by interfacing with MMIS paid claims history and recipient eligibility.

The MMIS EPSDT subsystem satisfies all the Department requirements for member notification, services tracking and reporting. The subsystem maintains EPSDT eligibility and screening information (as well as required demographic data) on the recipient eligibility file and the EPSDT master file. It generates notifications and referral notifications based on this information and a state-defined periodicity schedule. The EPSDT subsystem reports all screenings and referrals, and then tracks the treatments, which result from screening referrals. Extensive detail and summary reports are produced, as well as required Federal reporting and case documentation.

# 5.2 Eligibility Verification Information System

The Eligibility Verification Information System (ELVS) performs three primary request and response functions for providers and other authorized users:

a. Recipient eligibility request and response

b. Claims status request and response

c. Provider summary request and response

The system contains a telephone voice and touch-tone response component and a web portal.

# 5.3 Data Warehouse/Decision Support (DW/DS) System

The state-supported Data Warehouse/Decision Support (DW/DS) system provides data analysis and decision-making capabilities and access to information, including online access to flexible, user-friendly reporting, analysis, and modeling functions. IME staff from the Department and contractors use the DW/DS system. The Department's Division of Data Management (DDM) provides technical support and assistance in developing queries and reports to fulfill the analytical needs for the IME. The DW/DS system provides IME users with the flexibility to produce reporting without MMIS reprogramming in acceptable formats that do not require manual intervention or data manipulation.

The DW/DS system maintains the most recent 10 years of claims data from the MMIS. The DW/DS system's relational database includes the full claim record for adjudicated claims and other member, provider, reference and prior authorization data from the MMIS.

# 5.4 Workflow Process Management System

OnBase from Hyland Software is an enterprise content management (ECM) software suite that combines document imaging, electronic document management and records management and workflow. The IME utilizes the Workview module as the primary call log application for the call centers as well as a support application for the OnBase & MMIS helpdesk.

Other OnBase products in use include scanning, computer output to laser disk (COLD), Document Import Processor (DIP) and Report Services. The Scan module is used to bring all correspondence received into the OnBase system. COLD and DIP are modules that are used to import documents from the other systems in the IME, including reports from the MMIS and claims from the Emdion imaging system. Report Services is a

module used to give the users a customizable interface to standard and ad-hoc reports in the OnBase system. RightFax is used to accept fax information from providers and a connected tool uploads the fax to OnBase.

# 5.5 Call Center Management System

The Department is replacing the current call center system with the Cisco® Unified Contact Center Express 7.0. The Department anticipates that the new system will be operational on December 4, 2009. Please note the distinction in RFP Section 5.5.5 Optional Capabilities.

Cisco Unified Contact Center Express provides easy-to-deploy, easy-to-use, secure, virtual, highly available, and sophisticated customer interaction management for up to 300 agents. Its fully integrated self-service applications improve customer response with sophisticated and distributed automatic call distributor (ACD), interactive voice response (IVR), computer telephony integration (CTI), and agent and desktop services in a single-server, contact-center-in-a-box deployment while offering the flexibility to scale to larger, more demanding environments. It also supports business rules for inbound and outbound voice, email, web, and chat. Customer interaction management helps ensure that each contact is delivered to the right agent the first time. The following information highlights the system.

## 5.5.1 Features and Benefits

Routing Capabilities: Cisco Unified Contact Center Express routing supports a wide range of routing logic that can accurately target and selectively route different classes of contacts, or even single out individual contacts for customized, prioritized routing treatment. Cisco Unified Contact Center Express offers call-routing behaviors based on conditional events, such as time of day, day of week, or holiday routing, as well as the ability to specify service levels, move contacts between agent groups, and reprioritize contacts in the queue based on business rules. In addition, the application can give agents extensive information on a per-contact basis through a customer-relationship-management (CRM) or other application screen pop.

Outbound Dialing Capabilities: The Cisco Outbound Option complements the powerful inbound call-handling capability of the Cisco Unified Contact Center Express platform by offering blended preview outbound dialing capabilities. Users can use preview dialing that is integrated with inbound calls to provide a blended inbound/outbound solution. These blended functions let agents serve both inbound calls and outbound campaign tasks when the inbound queue is empty, allowing for the most efficient use of agent resources for both inbound calls and outbound campaigns.

Computer Telephony Integration: Cisco Unified Contact Center Express can integrate with any CRM or other application that can run on the agent's Microsoft Windows desktop. Integration is achieved using a powerful real-time programmable CTI workflow engine that invokes keystroke-macro emulation to automate the transfer of caller-entered information, or through an external application action. Cisco Unified Contact Center Express provides powerful integration tools through support for custom Java

classes and methods that can be invoked under real-time workflow control. These features facilitate the integration of Cisco Agent Desktop with other Windows and web-based applications with minimal software development. In addition, Cisco Unified Contact Center Express Premium enables application of HTTP integration to provide integration and a screen pop with browser-based applications such as Salesforce.com running in the Cisco Agent Desktop embedded browser. Finally, Cisco Unified Contact Center Express third-party CTI protocol provides for deep integration with ACD and IVR subsystems for traditional custom CTI integrations.

IVR and Self-Service Capabilities and Benefits: Cisco Unified Contact Center Express provides an integrated, ready-to-use IVR solution with an IVR queue point, custom call treatment, arbitrarily deep voice menus, custom voice prompts, and the ability to process customer phone-keypad presses through dual tone multifrequency (DTMF) processing to make routing decisions or to present a screen pop to the agent.

# 5.5.2 Agent Capabilities and Benefits

Each Cisco Unified Contact Center Express seat provides optimal flexibility to use the seat as either an agent or a supervisor seat. Cisco Unified Contact Center Express keeps the agent in touch with every call through critical data and call-state information by providing the ability to present a screen pop to the agent for each call. Information presented to the agent includes customer-entered data as well as call-state information describing how long the call has been connected to the ACD, how long the call has been in queue, and how long the agent has been talking with the caller.

Cisco Agent Desktop gives agents tools to access information and respond rapidly to customer requests. Voice contact workflows, the enterprise data pane, and the integrated browser display (screen pop) show agents customer data as calls are presented, preventing redirection of calls and the necessity for customers to repeat information. Task automation buttons and the personal phone directory allow agents to instantly activate frequently performed functions that shorten response time and automate after-call work to follow up on a customer inquiry. Collaboration tools such as chat and transfer of caller data help keep responses accurate. Additionally, Cisco Agent Desktop offers the ability to provide workflows that process business rules based on critical call-state events, the ability to invoke any CRM or other application able to run on the agent's Microsoft Windows desktop, and the ability to display information in the form of a screen pop from the ACD or IVR subsystem to that application.

# 5.5.3 Management Capabilities and Benefits

Supervisory Features: The ability of Cisco Supervisor Desktop to monitor critical performance metrics and actively chat, monitor, record, and send team messages allows managers to coach, train, and encourage agent behavior so that agents consistently perform their job function and process calls efficiently. The ability to send agents scrolling team messages and chat with individual members or the entire team allows supervisors to coach agents, resolve problems, and instantly communicate business changes. Supervisors can coach agents unobtrusively and help agents resolve customer situations. Within the supervisor desktop, contact center managers can see team

performance, agent statistics, and status at a glance by using easy-to-navigate tabbed pages and graphical reports. To coach agents, they can silently monitor calls and offer encouragement using chat. They can also initiate call recording for later review and training. Supervisors can interrupt an agent's call to create a three-way conference, and then interact with both the caller and the agent to help resolve a concern. A supervisor can remove the agent from a call using the Intercept feature, allowing the supervisor and caller to complete the call on their own while the agent handles another customer request. Supervisors can change an agent's state from their desktop. For example, agents may forget to make themselves available to take calls after a break or neglect to log out when they are away from their workstation for an extended period. With Cisco Supervisor Desktop, supervisors can easily log out missing agents or make unintentionally idle agents ready to take calls. This function is critical to highly distributed contact center deployments. Supervisors can also change an agent's skill profile in real time. This capability gives supervisors tactical tools to manage their agent teams and support contact center management objectives.

Cisco Agent Desktop Browser Edition for Enhanced and Premium Versions: The Cisco Agent Desktop Browser Edition executes as a thin client from within a commercial web browser, making it easy to deploy and maintain. The Cisco Agent Desktop Browser Edition also includes an agent toolbar, contact data, enterprise data, and agent status information, making it an ideal solution in thin-client applications.

Administration: The Cisco Unified Contact Center Express web-based administration provides a run-anywhere, enterprise-wide point of control for single- or multisite contact centers. Cisco Unified Contact Center Express transparently integrates information from Cisco Unified Communications Manager and integrates with the Cisco Unified Communications Manager web-based administration to provide cross access and a common interface. Cisco Unified Contact Center Express Administration allows a wide range of real-time reporting statistics across all activity within the contact center, regardless of agent or supervisor location and for all calls in process. In addition, supervisors can use administrative capabilities to dynamically re-skill agents.

Reporting: The Cisco Unified Contact Center Express solution provides the real-time and historical data necessary for mission-critical contact center reporting. Real-time reports are provided both at the supervisor level (integrated with the Cisco Supervisor Desktop) on a per-agent or per-team basis and also at the administration level, across the entire contact center. The reporting function provides accurate and timely reports on contact center activity, helping managers make informed decisions regarding staffing levels, contact-handling procedures, and technology investments. Standard reporting templates provide automatically operational functions for common reporting needs. Custom reports can extend the standard reporting package to meet specific reporting needs. Furthermore, the open software architecture of Cisco Unified Contact Center Express allows for export of reporting data in a variety of formats.

# 5.5.4 System Capabilities and Benefits

Open Systems: Cisco Unified Contact Center Express software takes full advantage of industry-standard hardware platforms, giving the benefits of many software functions. The open architecture of the system, which includes an Open Database Connectivity (ODBC)-compliant database as well as Java interfaces for CTI applications, can

integrate with existing contact center solutions, preserving investments in traditional systems and providing a platform for future applications.

Redundant High Availability: Cisco Unified Contact Center Express offers high-availability redundancy for dual server cluster deployments, including support for automatic failover of inbound voice ACD, IVR, and desktop services, as well as database replication and failover and load-balanced redundancy for historical reporting and on-demand recording.

Integrated Service-Creation Environments: The Cisco Unified Contact Center Express Workflow Editor is the service-creation and scripting environment for

mapping business rules to call-flow behavior and call treatments. It can operate from any location on the enterprise WAN, and workflows can be uploaded and run on the Cisco Unified Contact Center Express server. This environment is a visual editor that provides a simple, drag-and-drop, easy-to-understand interface for building powerful, custom, business-communication applications.

Scalability: Cisco Unified Contact Center Express can provide a contact-center-in-a-box for inbound and outbound voice on a single server for 1 to 300 agents. Dual server clusters provide a redundant, high-availability option across a virtual contact center. Cisco Unified Contact Center Express supports a Cisco Customer Interaction Network based on the Cisco Unified Intelligent Contact Management and Cisco IP Contact Center (IPCC) Peripheral Gateway, enabling prerouting, postrouting, and centralized reporting for multiple Cisco Unified Contact Center Express systems across a Cisco Unified Communications WAN.

Security: To help maintain network security in the contact center and throughout the enterprise, Cisco Unified Contact Center Express supports Cisco Security Agent, as well as virus-detection software from the major antivirus software vendors. Cisco Security Agent is a host-based intrusion detection system that provides security to mission-critical enterprise servers and hosts. It provides benefits beyond conventional endpoint security solutions, such as virus-scanning software and firewalls, by identifying and preventing malicious behavior before it can occur. This process helps remove potential known and unknown security risks that threaten enterprise networks and applications. By analyzing behavior rather than relying on signature matching, Cisco Security Agent complements the capabilities of the antivirus software; together, they provide a robust solution to protect the network and reduce operational costs.

# 5.5.5 Optional Capabilities

Email Management: This feature will require configuration labor from the vendor and the Department to integrate with the DHS email system, which is not planned at this time. Successful contractors that want to use this feature will need to work with the Department. Cisco Unified Contact Center Express offers the Agent E-Mail feature for email management. Agent E-Mail is a basic email queuing and response system, designed specifically for Cisco Agent Desktop for the Cisco Unified Contact Center Express platform. Agent E-Mail is a zero-footprint feature that is tightly integrated into the agent desktop embedded browser, with controls built into the toolbar and display. It provides contact centers with the ability to queue and route email messages to staff and skilled agents, helping strike a balance between email and call-handling activities.

Workforce Optimization and Quality Management: This capability is an additional package that can connect to the contact management system. Successful contractors that want to use this feature will need to work with the Department. Cisco Unified Workforce Optimization integrated with Cisco Unified Contact Center Express helps supervisors and other managers align contact center performance with business objectives by integrating workforce optimization within the team's daily workflow -- combining agent and supervisor desktop tools in a composite application with workforce optimization software to unify the entire customer interaction process. Directly integrated with Cisco Supervisor Desktop, Cisco Unified Workforce Optimization unifies the tactical tools that supervisors need to optimize team performance: Cisco Unified Workforce Optimization Workforce Manager and Quality Manager software. The Workforce Management component allows contact center managers to develop schedules for multiple sites, manage critical performance indicators, and manage real-time adherence to schedules. At the same time, the Quality Manager piece provides a voice-compliance and evaluation solution, with optional, advanced, quality-management features such as screen recording for agent performance optimization and dispute resolution.

# 5.6 Iowa Automated Benefit Calculation (IABC) System

The Iowa Automated Benefit Calculation (IABC) System is a computer-based system designed to gather, process, and store information about Department clients. It calculates benefit levels and issues state warrants, IowaCare cards, Food Assistance benefits, and client notices.

The IABC system can receive data from or send data to associated systems such as the Iowa Collection and Reporting (ICAR) system and the Family and Children’s Services (FACS) system to perform related functions. Workers provide source data by means of personal computers located in each local office in the state. Data input is processed daily. The Unit of Quality Assurance in the DDM keeps records of all entries on microfiche either electronically or in hard copy.

The IABC system stores information about individuals and cases separately. Each case is composed of eligibility units for various programs. Information for individuals is connected to the case using the state identification number. The individual information contains demographic and income data. It also contains data for programs for which the individual is considered and the cases associated with that individual.

Individuals are dropped from a case after one year of inactivity on that case. Cases that are closed are kept on the master file permanently. Individuals are retained on the state ID portion of the individual master file.

# 5.7 Individual Services Information System (ISIS)

The purpose of ISIS is to assist workers in the facility, HCBS waiver, remedial, habilitation and target case management programs in both processing and tracking applications and authorizations through approval or denial. The ISIS application is used

by IMWs, case managers, Medical Services contractor staff, child health specialty clinics, transition specialists, financial management service authorization staff, member and provider customer service representatives and Department policy staff. The information for the approved member is sent from ISIS to the prior authorization file in MMIS to create a prior authorization record in the MMIS to allow claims to pay at the assigned rates and units.

The process starts in ISIS upon receipt of information from IABC regarding a facility or waiver request. ISIS prompts each participant to perform key tasks, and each participant must respond by entering the appropriate information for that task before the process can move on to the next task. The final approval milestone must be completed (closed) before an approved service plan can be sent to the MMIS prior authorization subsystem.

# 5.8 Title XIX

The Title XIX system accepts eligibility from the IABC system, Family Planning Waiver System and Breast Cervical Cancer Treatment (BCCT) and presumptive eligibility from the QA system. The Title XIX system reviews eligibility and determines the eligibility that provides the most coverage for the member using hierarchical business rules. The Title XIX system also adds the funding codes and the grouping codes for MAR reporting.

Eligibility in the Title XIX system is stored on a full-month basis. The Title XIX system checks for premium payments before passing eligibility to MMIS. The Title XIX system passes this file daily to the Core MMIS, which uses it to update the recipient master file used for claims processing and other Core MMIS activities.

# 5.9 Medicaid Quality Utilization and Improvement Data System (MQUIDS)

The Medicaid Quality Utilization and Improvement Data System (MQUIDS) is a data entry and retrieval application designed to facilitate the Medical Services contractor's job functions. It provides common graphical user interfaces that mask the complexities of business rules associated with data entry and display of information for user analysis. The content is guided by the business and policy requirements of medical review. The medical services reviews frequently involve the documentation of health information on individual members that must be protected. Additional information is available in the resource library.

# 5.10 Iowa Medicaid Electronic Records System (I-MERS)

I-MERS is a web-based tool designed to help inform medical decisions by giving providers access to information about services Iowa Medicaid has paid for specific members. I-MERS is available to the following types of providers and administrative staff

enrolled in Iowa Medicaid: physician, advanced registered nurse practitioners (ARNP), hospital, federally qualified health center (FQHC), rural health clinic (RHC), community mental health center (CMHC), psychiatric medical institution for children (PMIC), home health agency, and pharmacy.

# 5.11 IMEServices.org

The Iowa Medicaid Enterprise Support web site, which is named IMEservices.org, supports four functions:

a. NPI verification

b. Provider enrollment renewal

c. Provider registration to receive IME mailings and announcements by e-mail

d. Provider registration to view electronic remittance advice statements.

# 5.12 Provider Incident Reporting (Iowa Medicaid Provider Access)

The Department has identified an immediate need for an improved incident reporting process for providers to HCBS consumers. All providers are legally required to report incidents. The current paper-based, labor-intensive method does not promote timeliness in quality management. Allowing intakes to be initiated and accepted electronically, securely through a web application will make the process more accessible to providers. It will also allow the Department to set up workflows to track and document the follow up actions electronically. The gathered information will be instantly and appropriately available through secured access. Metrics will be easier to compile, report upon demand, and trend quality over time. The scope of this project includes:

a. Create a web-based application to support providers. Include self-registration and password reset based upon known provider information for verification. Build the application using roles based security, planning for future growth and enhancements to the application.

b. Provide functionality for incident reporting regarding HCBS consumers, which includes allowing the provider to enter the incident, supporting a workflow that will notify the appropriate people as the incident is processed, and capturing measurable metric information.

c. Provide service authorization information specific to the provider, which will allow provider billing staff the ability to organize and follow up on authorized services.

d. Make it easier for consumer-directed attendant care (CDAC) individual providers to submit claims, eliminate paper claims, improve claim processing time, and reduce claim errors. This tool could benefit other waiver and long-term care providers. Claims should be generated using standard Health Insurance Portability and Accountability Act (HIPAA) transaction formats and forwarded to the appropriate MMIS service for processing. Add edits to eliminate duplicate claims or inappropriate units. Scheduled for implementation by July 1, 2010.

# 5.13 Medicaid IowaCare Premium System (MIPS)

MIPS is used to record premiums, billing statements, payments, and granting hardship claims made for each IowaCare member who is assessed a monthly premium payment.

# 5.14 Social Security Buy-In (SSBI)

The SSBI system displays Medicare Part A and B buy-in information and history. Buy-in is the payment of Medicare Part A and B premiums by the state for Medicaid-eligible members. Data transmitted by the state to CMS for buy-in is processed once a month, two business days before the IABC system's month-end processing. CMS then responds to this data in the second week of the following month.

# 5.15 Pharmacy Point-of-Sale (POS) System

The Pharmacy Point-of-Sale (POS) system supports two primary functions: pharmacy claims processing and drug rebate. The Pharmacy POS contractor interfaces with the Medical Services contractor to receive the pharmacy prior authorizations.

The pharmacy POS system operates on its own hardware platform. The pharmacy POS contractor is responsible for developing and maintaining interfaces and achieving technical integration with all other components that use pharmacy data.

The Pharmacy POS system provides for on-line, real time adjudication of pharmacy claims with edits and audits that support the Department's policies and objectives. The system includes the following functions:

1. Claims processing for pharmacy claims
2. Reference (formulary file)
3. Prospective drug utilization review (ProDUR)
4. Drug rebates
5. Verification of provider and client eligibility
6. Cost avoidance edits for third-party liability including private insurance and Medicare
7. Price determination utilizing all pricing sources required
8. Copayment calculation and tracking in accordance with state regulations
9. Dispensing fees requirements
10. Standard ProDUR and customized ProDUR interventions
11. Customized messaging

12. Acceptance of prior authorization data from multiple sources
13. Preferred drug list and recommend drug list enforcement through claims processing
14. Support for additional programs such as Medicare Part B and Medicare Transitional Assistance when they are initiated
15. Customized override functionality
16. Ability to implement smart PA edits using patient profiles and therapeutic classes
17. Administration of all aspects of federal and supplemental rebates excluding supplemental rebate negotiation and contracting
18. Patient restrictions or lock-ins
19. Physician exemptions from certain edits

# 6 PROGRAM INTEGRITY

The program integrity component in this Request for Proposal (RFP) includes those responsibilities directly in support of the claims processing and data retrieval components identified in Section 4. In addition, these activities promote the State's responsibilities for service assessment and quality indicators. The section includes the following topics:

- 6.1 General Requirements
- 6.2 Program Integrity Requirements

# 6.1 General Requirements

Following are the high-level general requirements.

a. The Department's intent in this procurement is to maintain the state's seamless delivery of all professional services for the Medicaid program. All contractors and the responsible Department administrators will continue to be located at a common state location as part of the Iowa Medicaid Enterprise (IME) administration.

b. The Department continues to emphasize the importance of coordination of efforts among state staff and all contractors. No single contractor can perform their required responsibilities without coordination and cooperation with the other contractors. The Department expects all contractors to maintain communication with each other and with state staff as necessary to meet their responsibilities.

c. The Department, through its unit managers, retains the role of contract monitor for all Request for Proposal (RFP) professional services contractors. The Department will favor in this procurement bidders who have demonstrated success in cooperative, collaborative environments.

d. All professional services contractors will interface with the IME data systems (Medicaid Management Information System (MMIS), Point of Sale (POS) system, Data Warehouse/Decision Support system (DW/DS), call center system and other state systems) as necessary to meet their responsibilities. Interfaces may be online updates to the IME data systems or file transfers among the respective professional services contractors' data systems and the IME data systems. A professional services contractor can have online access and authority to update files on the IME data systems (except systems that other state agencies operate) as necessary to perform their required responsibilities. These updates require ongoing effective communication between the respective contractors and the Department to assure timely maintenance that is transparent to the IME data systems. All professional services contractors must meet the interface requirements described in individual RFP component sections.

e. All professional services contractors will have access to the IME DW/DS system. To the extent that their responsibilities require analysis of data originating in the MMIS and POS system, the professional services contractors are required to bring skilled staff with demonstrated experience in querying Medicaid-related data and preparing reports for contractor and state use. Each professional services contractor will designate a primary contact for developing queries and requesting assistance from the DW/DS system manager.

f. All professional services contractors will require flexibility and balance to accommodate the program changes that are a natural occurrence in any health care program. The Department does not anticipate a need for contract amendments in such cases unless significant material changes occur in the scope of work. In such cases, the affected contractors must document the significance of the change and its impact on their ability to meet their service-level agreements and performance standards in their contracts.

g. All professional services contractors will respond to Department requests for information and other requests for assistance within the timeframe that the Department specifies.

h. All professional services contractors must meet all requirements within their areas of responsibility.

i. All professional services contractors will deliver accurate, on-time reports according to the report production requirements for their areas of responsibility.

j. All professional services contractors will develop, maintain, and provide access to records required by the Department and state and federal auditors.

k. All professional services contractors will provide to the Department reports regarding contractor activities for which the contractor will negotiate the content, format and frequency of these reports with the Department. The intent of the reports is to afford the Department and the contractor better information for management of the contractor's activities and the Medicaid program.

l. All professional services contractors will prepare and submit to the Department requests for system changes and notices of system problems related to the contractor's operational responsibilities.

m. All professional services contractors will prepare and submit for Department approval suggestions for changes in operational procedures, and implement the changes upon approval by the Department.

n. All professional services contractors will maintain operational procedure manuals in a format specified by the Department and update the manuals when changes occur.

o. All professional services contractors will ensure that effective and efficient communication protocols and lines of communication are established and maintained throughout the IME. The contractor will take no action that has the appearance or effect of reducing open communication and association between the Department and contractor staff.

p. All professional services contractors will meet regularly with other IME contractors and Department management to review account performance and resolve issues.

q. In situations where the Department permits contractors to use external data systems, the contractors must provide electronic interfaces from those external data systems to the IME data systems to support automated performance reporting.

# 6.1.1 Staffing

Bidders are expected to propose sufficient staff who have the requisite skills to meet all requirements in this RFP and who can attain a satisfactory rating on all performance standards. **The Department encourages bidders to leverage current IME staff. Bidders are required to include the number of proposed staff that they will use to fulfill the contract requirements.**

# 6.1.1.1 Named Key Personnel

The Department is requiring key positions to be named, consistent with the belief that the bidder should be in the best position to define the project staffing for the contractor’s

approach to the RFP requirements. The following named positions for the program integrity contractor require identified personnel and current resumes:

a. Account manager

b. Transition manager (may be same as account manager or operations manager)

c. Medical director

d. Operations manager

# 6.1.1.1.1 Key Personnel Requirements

General requirements for key personnel are as follows:

a. The bidder must employ the account manager when the bidder submits the proposal.

b. The bidder must employ all other key personnel or must have a commitment from them to join the bidder's organization by the beginning of the contract start date.

c. The bidder must commit key personnel named in the proposal to the project from the start date identified in the table below through at least the first six months of operation. The bidder may not reassign key personnel during this period.

d. The bidder must not replace key personnel during this period except in cases of resignation or termination from the contractor's organization or in the case of the death of the named individual.

The following table illustrates the qualifications, start date, and any special requirements for key personnel who must be named for the professional services components.

**Figure 4: Key Personnel for Program Integrity**

| KEY PERSONNEL | | | |
|---|---|---|---|
| **Key Person** | **Qualifications** | **Start Date*** | **Special Requirements** |
| Account manager | Required: Three years of account management or major supervisory role for government or private sector healthcare payer or provider; bachelor's degree or equivalent relevant experience to the account manager position.<br>Desired: Previous management experience with Medicaid and MMIS operations; knowledge of HIPAA rules and requirements | Contract signing date | May also serve as transition manager.<br>Must be 100 percent dedicated to the Iowa Medicaid project. Must be employed by bidder when proposal is submitted. |
| Transition manager | Required: Three years of account management or major supervisory role for government or private sector healthcare payer or provider; bachelor's degree or equivalent relevant experience to the transition manager position. | Contract signing date | May also serve as account or operations manager.<br>Must be 100 percent dedicated to Iowa Medicaid project until operations begin under new contract. |

| | | | |
|---|---|---|---|
| Medical director | Required: MD or DO with four years experience as medical director or senior manager for HMO, PRO or other administrative health care operation in a program of equivalent scope to Iowa.<br><br>Medical Services contractor's medical director will be the Chief Medical Director for the IME. | 30 days before operations phase | May not serve in any other capacity. |
| Operations managers | Required: Minimum four years experience managing a major component of a health care operation in an environment similar in scope and volume to the Iowa Medicaid Program. The experience could be in claims management, eligibility, financial controls, utilization review, managed care enrollment, call center management or provider services.<br>Desired: Bachelor's degree and four years' experience in managing health care operations. | 30 days before operations phase | May also serve as transition manager.<br>Must be 100 percent dedicated to the Iowa Medicaid project. |

*Date that successful contractor assigns employee to work on IME contract.

# 6.1.1.1.2 Key Personnel Resumes

Resumes must include the following information:

a. Employment history for all relevant and related experience

b. Names of employers for the past five years, including specific dates

c. All educational institutions attended and degrees obtained

d. All professional certifications and affiliations

# 6.1.1.1.3 Key Personnel References

References for key personnel must meet the following requirements:

a. Must include a minimum of three professional references outside the employee's organization who can provide information about the key person's work on that assignment.

b. Must include the reference's full name, mailing address, telephone number and e-mail address.

c. For any client contact listed as a reference, must also include the agency's or company's full name and street address with the current telephone number and e-mail address of the client's responsible project administrator or service official who is directly familiar with the key person's performance.

d. Must be available for the Department to contact during the proposal evaluation process.

e. Must reflect the key person's professional experience within the past five years.

The Department reserves the right to check additional personnel references at its option.

# 6.1.1.1.4 Department Approval of Key Personnel

a. The Department reserves the right of prior approval for all named key personnel in the bidder's proposal.

b. The Department also reserves the right of prior approval for any replacement of key personnel.

c. The Department will provide the selected contractor 45 days to find a satisfactory replacement for the position except in cases of flagrant violation of state or federal law or contractual terms. Extensions may be requested in writing and approved by the Department.

d. The Department reserves the right to interview any and all candidates for named key positions prior to approving the personnel.

# 6.1.1.1.5 Changes to Contractor's Key Personnel

a. The contractor may not replace or alter the number and distribution of key personnel as bid in its proposal without the prior written approval of the Department's project director during the transition phase or contract administration during operations, which shall not be unreasonably withheld.

    1. Replacement for key personnel will have comparable training, experience and ability to the person originally proposed for the position.

    2. Replacement personnel (whom the project director or contract administration have previously approved) must be in place performing their new functions before the departure of the key personnel they are replacing and for whom the project director or contract administration has provided written approval of their transfer or reassignment.

    3. The project director or contract administration may waive this requirement upon presentation of good cause by the contractor.

b. The contractor will provide the project director or contract administration with 15 days notice prior to any proposed transfer or replacement of any contractor's key personnel.

    1. At the time of providing such notice, the contractor will also provide the project director or contract administration with the resumes and references of the proposed replacement key personnel.

    2. The project director or contract administration will accept or reject the proposed replacement key personnel within 10 days of receipt of notice.

    3. Upon request, the project director or contract administration will have an opportunity to meet the proposed replacement key personnel in Des Moines, Iowa, within the ten-day period.

    4. The project director or contract administration will not reject proposed replacement key personnel without reasonable cause.

    5. The project director or contract administration may waive the 15-day notice requirement when replacement is due to termination, death or resignation of a key employee.

# 6.1.1.2 Special Staffing Needs

All contractors must meet the following special staffing needs:

a. All professional medical staff assigned to this account and working in Iowa must be licensed or certified for practice in the State of Iowa. In addition, professional medical staff must carry appropriate insurance.

b. The contractor will develop and maintain a plan for job rotation and cross-training of staff to ensure that all functions can be adequately performed during the absence of staff for vacation and other absences.

c. The contractor will designate staff who are trained and able to perform the functions of sensitive positions when the primary staff member is absent.

# 6.1.2 Facilities

The following topics describe the facility requirements for the professional services contractors during the operations phase.

# 6.1.2.1 Permanent Facilities

The Department expects that all staff directly associated with the provision of contract services to the IME during the Operations and Turnover Phases will be located at the IME permanent facility. Within the General Requirements section of the Technical Proposal, the bidder will provide the Department with the estimated total number of staff, specifying key personnel, other managers or supervisors, and staff.

## 6.1.2.1.1 State Responsibilities

a. At no cost to the vendor, the Department will provide the following:

    1. Office space for all IME staff
    2. Desks, chairs, and cubicles
    3. Network infrastructure and network connections
    4. Personal computers
    5. Telephones and facsimile (fax) machines
    6. Photocopiers and copier paper
    7. Network printers
    8. Licenses for contractor staff using the MMIS, OnBase, Cisco® Unified Contact Center Express, Pharmacy POS, and DW/DS applications; standard Microsoft Office packages; and other standard software packages (such as Visio or MS Project) as necessary for individual jobs that require them

b. The Department will provide conference rooms at the IME site for meetings among contractor personnel, state staff, providers, and other stakeholders.

c. The Department will also provide some additional workspace, desks, PCs, and telephones for state, federal, or contracted consultant staff members who are conducting reviews and assessments.

### 6.1.2.1.2 Contractor Responsibilities

The Department expects contractors to provide the following equipment:

a. Proprietary or other software that is not commercially available (other than the standard commercial packages provided by the Department) as approved by the Department

b. Personal workstation printers and associated cables and software, as approved by the Department, to connect them to and use them at the workstations for which the contractor must sign over ownership to the Department

c. Office supplies (except for copier paper and envelopes)

d. Any special needs equipment for ergonomic or other purposes

### 6.1.2.2 Courier Service

a. Because contractor and state staff are located at the IME facility during operations, contractors do not need to provide courier service. The Core MMIS contractor provides courier service and arranges for pick-up and delivery of IME material to and from specific external entities, specifically the Capitol complex and the United States Post Office.

b. All outgoing mail will go through the IME mailroom, including regular daily mail and small-volume mailings.

    1. For large-volume mailings, the Department will identify the most cost-effective way to print and mail.

    2. The contractor generating the mailing will be responsible for providing a print-ready copy of the documents to the printer the Department selects (such as the state print shop or a commercial print shop).

    3. The Core MMIS contractor will be responsible for the small-volume mailings, and the Department will identify the mailing entity for large-volume mailings.

    4. The Department will pay all postage and external entity mailing costs for IME operational costs.

## 6.1.3 Contract Management

The State of Iowa has mandated performance-based contracts. State oversight of contractors' performance and payments to the contractors are tied to meeting the performance standards identified in the contracts awarded through this RFP.

### 6.1.3.1 Performance Reporting and Quality Assurance

a. The contract awarded through this RFP will contain performance standards that reflect the performance requirements in this RFP.

    1. The standards will include timeliness, accuracy and completeness for performance of or reporting about operational functions.

2. These performance standards must be quantifiable and reported using as much automation as possible.
3. The Department will select a subset of the standards for the contractors to include in a quarterly public report.

b. Meeting the performance standard in the selected indicators will represent average performance.
   1. The Department and the contractor will finalize specific performance reporting and measurements during the first year of operations as listed in RFP Section 6.1.3.1.a.
   2. After the first full year of operations, liquidated damages can result from failure to meet the standards.
   3. The liquidated damages will comprise 1.5 percent of the monthly operations fee if a single performance measure or the total score falls more than five points below the acceptable standard for more than three months in a six-month period.

c. In addition, the contractor is responsible for internal quality assurance activities. The scope of these activities include the following functions:
   1. Identify deficiencies and improvement opportunities within the contractor's area of responsibility.
   2. Provide the Department with a corrective action plan within ten business days of discovery of a problem found through the internal quality control reviews.
   3. Agree upon timeframes for corrective actions.
   4. Meet all corrective action commitments within the agreed upon timeframes.

# 6.1.3.2 State Responsibilities

a. The Department's contract administration for the IME is the principal contact with the contractor and coordinates interaction between the Department and all contractors. Contract administration includes the Contract Administration Office (CAO) and the Department's designated unit manager for program integrity. The Department's contract administration is responsible for the following activities:
   1. Monitor the contract performance and compliance with contract terms and conditions.
   2. Serve as a liaison between the contractor and other state users.
   3. Initiate or approve system change orders and operational procedures changes.
   4. Assess and invoke damages for contractor noncompliance.
   5. Monitor the development and implementation of enhancements and modifications to the MMIS, DS/DW, workflow management, Pharmacy POS, and call center systems and inform the professional services contractors of the operational impact and scheduling of the system enhancements and modifications.
   6. Review and approve completion of the contractor's documentation as required by the Department.

7. With participation from the contractor, develop the report of the contractor's compliance with the performance standards, negotiate reporting requirements and measure compliance for the contractor's responsibilities.
8. Review and approve the contractor's invoices and supporting documentation for payment of services.
9. Coordinate state and federal reviews and assessments.
10. Consult with the contractor on quality improvement measures and determination of areas to be reviewed.
11. Monitor the contractor's performance of all contractor responsibilities.
12. Review and approve proposed corrective actions taken by the contractor.
13. Monitor corrective actions taken by the contractor.
14. Communicate and monitor facilities concerns.

# 6.1.3.3 Contractor Responsibilities

The contractor is responsible for the following contract management activities:

a. Develop, maintain, and provide access to records required by the Department and state and federal auditors.

b. Provide reports necessary to show compliance with all performance standards and other contract requirements.

c. Provide to the Department reports regarding the contractor's activities. The contractor is to propose and negotiate the content of these reports with the Department. The intent of the reports is to provide the Department and the contractor with better information for management of the contractor's activities and the Medicaid program.

d. Prepare and submit to the Department requests for system changes and notices of system problems related to the contractor's operational responsibilities.

e. Prepare and submit for Department approval suggestions for changes in operational procedures, and implement the changes upon approval by the Department.

f. Maintain operational procedure manuals and update the manuals when changes are made.

g. Ensure that effective and efficient communication protocols and lines of communication are established and maintained both internally and with Department staff. No action shall be taken which has the appearance of or effect of reducing open communication and association between the Department and contractor staff.

h. Meet regularly with all elements of the IME to review account performance and resolve issues between contractor and the state.

i. Provide to the Department progress reports on the contractor's activity as requested by the Department.

j. Meet all federal and state privacy and security requirements within the contractor's operation.

k. Work with the Department to implement quality improvement procedures that are based on proactive improvements rather than retroactive responses. The contractor must understand the nature of and participate in quality improvement procedures that may occur in response to critical situations and will assist in the planning and implementation of quality improvement procedures based on proactive improvement.

l. Monitor the quality and accuracy of the contractor's own work.

m. Submit quarterly reports (available electronically) of the quality assurance activities, findings and corrective actions (if any) to the Department.

n. Perform continuous workflow analysis to improve performance of contractor functions and report the results of the analysis to the Department.

o. Provide the Department with a description of any changes to the workflow for approval prior to implementation.

p. For any performance falling below a state-specified level, explain the problems and identify the corrective action to improve the rating.

    1. Implement a state-approved corrective action plan within the timeframe negotiated with the state.

    2. Provide documentation to the Department demonstrating that the corrective action is complete and meets state requirements.

    3. Meet the corrective action commitments within the agreed upon timeframe.

q. Provide a written response to the Department via e-mail within two business days of receipt of e-mail on routine issues or questions and include descriptions of resolution to the issues or answers to the questions.

r. Provide a written response to the Department via e-mail within one business day of receipt of e-mail on emergency requests as defined by the state.

s. Maintain Department-approved documentation of the methodology used to measure and report completion of all requirements and attainment of all performance standards.

# 6.1.3.4 Performance Standards

The following performance standards apply to the program integrity contractor.

## 6.1.3.4.1 Reporting Deadline

a. Provide the required reports within ten business days of the end of the reporting period.

## 6.1.3.4.2 Documentation

a. Update operational procedure manuals in the Department-prescribed format within ten business days of the implementation of a change.

b. Identify deficiencies and provide the Department with a corrective action plan within ten business days of discovery of a problem found through the internal quality control reviews.

c. Maintain Department-approved documentation of the methodology used to measure and report on all completed contract requirements and all performance standards. State the sources of the data and include enough detail to enable Department staff or others to replicate the stated results.

## 6.1.3.4.3 Annual Performance Reporting

a. The following performance standards are in addition to any performance standards required for individual components. Those individual requirements (if any) appear in the subsections of RFP Section 6.2 Program Integrity Requirements.

b. The contractor will provide annual performance reporting no later than October 15 of each contract base and option year for the state fiscal year (SFY) that ended in the prior month of June. (Example: Provide data by October 15, 2009, for the state fiscal year that ended on June 30, 2009.) The contractor will present the required data in Department-approved format and content for the following annually reported performance standards. DHS will publish the annual measurements by the following February 15.

c. Services performed by the program integrity contractor will result in measurable state savings as follows:

   1. $20 million in SFY 2011, $22.5 million in SFY 2012 and $25 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

# 6.1.4 Training

All contractor staff will receive appropriate training in the systems functions that they will use. The Department will require that the Core MMIS contractor provide MMIS and workflow process management training. The Department will arrange contact management (call center) and tracking system training for all contractor staff members who interface with these systems. Likewise, the Department will provide DS/DW system training to all contractor staff members who will use the system.

a. The contractor will be responsible for training its staff in the system and operational procedures required to perform the contractor's functions under the contract.

b. The contractor will designate a trainer for its component who will train the professional services contractor's staff.

c. The contractor will provide initial and ongoing training to its staff in its operational procedures. The training will occur when:

   1. New staff or replacement staff are hired

   2. New policies or procedures are implemented

   3. Changes to policies or procedures are implemented

# 6.1.5 Operational Procedures Documentation

a. The contractor must maintain operational procedures in the Department-prescribed format documenting the processes and procedures used in the performance of their IME functions. RFP Section 4 Project Management provides further detail on the expected deliverables.

b. The contractor will document all changes within 10 business days of the change in the format prescribed by the Department. The contractor will provide to the Department updated documentation within 10 business days of the date changes are installed. The contractor must use version control to identify current documentation.

c. All documentation must be provided in electronic form and made available online.

d. The contractor will maintain standard naming conventions in the documentation. The contractor will not reference the contractor's corporate name in any of the documentation.

# 6.1.6 Security and Confidentiality

a. When not occupying state space, the contractor must provide physical site and data security sufficient to safeguard the operation and integrity of the IME. The contractor must comply with the Federal Information Processing Standards (FIPS) outlined in the following publications, as they apply to the specific contractor’s work:

   1. Automatic Data Processing Physical Security and Risk Management (FIPS PUB.31)
   2. Computer Security Guidelines for Implementing the Privacy Act of 1974 (FIPS PUB.41)

b. In all locations, the contractor must safeguard data and records from alteration, loss, theft, destruction, or breach of confidentiality in accordance with both state and federal statutes and regulations, including but not limited to Health Insurance Portability and Accountability Act (HIPAA) requirements. All activity covered by this RFP must be fully secured and protected.

c. Safeguards designed to assure the integrity of system hardware, software, records, and files include:

   1. Orienting new employees to security policies and procedures
   2. Conducting periodic review sessions on security procedures
   3. Developing lists of personnel to be contacted in the event of a security breach
   4. Maintaining entry logs for limited access areas
   5. Maintaining an inventory of Department-controlled IME assets, not including any financial assets
   6. Limiting physical access to systems hardware, software, and libraries
   7. Maintaining confidential and critical materials in limited access, secured areas.

d. The Department will have the right to establish backup security for data and to keep backup data files in its possession if it so chooses. Exercise by the Department of this option will in no way relieve the contractor of its responsibilities.

# 6.1.7 Accounting

a. The contractor will maintain accounting and financial records (such as books, records, documents, and other evidence documenting the cost and expenses of the contract) to such an extent and in such detail as will properly reflect all direct and indirect costs and expenses for labor, materials, equipment, supplies, services, etc., for which payment is made under the contract. These accounting records will be maintained in accordance with generally accepted accounting principles (GAAP). Furthermore, the records will be maintained separate and independent of other accounting records of the contractor.

b. Financial records pertaining to the contract will be maintained for five years following the date of final payment for the contract.

# 6.1.8 Banking Policies

The contractor may receive checks or money orders related to the work that they perform. All IME contractors are to meet the following requirements for checks or money orders.

a. Any unit that receives checks or money orders will log and prepare all payments for deposit on the day of receipt and deliver them to the Revenue Collections contractor's designated point of contact for daily deposits.

b. Any unit that receives checks or money orders will assist in the maintenance and updating of the existing check classification code schematic, as necessary.

c. Any unit that receives checks or money orders will provide assistance to the Department, Division of Fiscal Management, in the reconciliation of the monthly Title XIX Recovery bank account if requested to do so.

Only the Revenue Collections contractor will make the deposits.

# 6.1.9 Payment Error Rate Measurement (PERM) Project

a. Pursuant to the Improper Payments Information Act (IPIA) of 2002 and federal regulations at 42 CFR Parts 431 and 457, all states are required to participate in the measurement of improper payments in the Medicaid and CHIP programs. Iowa's participation began in federal fiscal year 2008 (October 1, 2007, through September 30, 2008) and is scheduled to continue every three years. The PERM Project measures the following aspects of the Medicaid and CHIP programs:

    1. Eligibility – the eligibility of the Member for the program and, if applicable, enrollment in a managed care plan.

    2. Medical Review – the medical necessity and appropriate medical classification of the service that was provided.

3. Data Processing Review – the appropriate processing of the paid claim in the claims processing system, taking into account all necessary edits. This includes verifying the appropriate rate cell and payment for managed care (capitation) payments.

b. The Centers for Medicare and Medicaid Services (CMS) manage the PERM Project for all states, in which they contract certain aspects of the work. Required state involvement includes work that is performed by the IME and its contractors. During the course of the PERM Project, IME policy staff and contractors are responsible for the following:

1. Department Program Integrity Director and Manager (Department Policy) – Project coordination between all IME units and overall project management for IME-related work
2. DW/DS – Submission of paid claims data, including details associated with the claims that are selected for review
3. Provider Services – Issuance of general project notifications, assistance with ensuring that providers submit their documentation timely, and provision of copies of licenses or other enrollment documents upon request.
4. Provider Cost Audits and Rate Setting – Assistance with repricing claims in cases of potential findings of overpayments or underpayments and consultation related to reimbursement methodologies and pricing of claims
5. Medical Services – Re-review of providers' documentation related to potential medical review errors and recommendation as to potential disputes
6. Core – Claims processing and MMIS expertise and consultation related to pricing and payment of claims
7. Program Integrity – All follow-up provider recovery or repayment actions associated with findings of overpayments or underpayments

# 6.1.10 Subcontractors

a. Subcontractors must comply with all requirements of this RFP for all work related to the performance of the contract.

# 6.1.11 Regulatory Compliance

a. All services acquired through this procurement are expected to be fully compliant with state and federal requirements (including HIPAA requirements) in effect as of the date of release for the RFP and with any changes that subsequently occur unless otherwise noted.

b. Bidders are responsible for describing how their proposed solution meets and will remain in compliance with state and federal requirements (including HIPAA requirements for transactions and code sets, national provider identifiers (NPI), privacy and security).

# 6.1.12 Audit Support

a. The contractor is expected to support and provide assistance with any state and federal audits and certifications as the Department requests. Examples include but are not limited to the annual audit by the state auditor's office, the Medicaid Integrity Group (MIG) review and the Office of the Inspector General (OIG) audits.

# 6.1.13 No Legislative Conflicts of Interest

a. In the event that the bidder (prior to contract award) or contractor (after contract award) is directly involved with or otherwise supports legislation impacting the Medicaid program but outside the role as the IME contractor, notification to the Department is necessary.

b. If this situation exists prior to proposal delivery, the bidder should reflect this status in the response to the requirements in this section. If it exists prior to contract award, the bidder must notify the issuing officer in writing. If it exists after contract award, the contractor must notify contract administration prior to the next legislative session.

c. At all times, the bidder or contractor must ensure that the legislation does not pose a conflict of interest to IME work in their proposal and contract. If a conflict exists, the bidder or contractor must do one of these things: withdraw their support of the legislation; or withdraw from consideration for contract award (while a bidder) or terminate contract according to termination requirements in the contract (while a contractor). This ongoing restriction applies throughout all phases of the contract.

d. At no time will the contractor use its position as a contractor with the Department or any information obtained from performance of this contract to pursue directly or indirectly any legislation or rules that are intended to provide a competitive advantage to the contractor by limiting fair and open competition in the award of this contract upon its expiration or to provide advantage the contractor during the term of the contract resulting from this RFP.

# 6.1.14 No Provider Conflicts of Interest

a. The contractor warrants that it has no interest and agrees that it shall not acquire any interest in a provider that would conflict, or appear to conflict, in any manner or degree with the contractor's obligations and performance of services under this contract.

b. The contractor will meet the following specifications to preclude participation in prohibited activities:

    1. The contractor will subcontract with another firm to conduct any desk reviews or on-site audits of a provider if the provider is a client of the contractor and the provider also provides services for the Department. However, the subcontractor will not conduct desk review or on-site audit of provider if provider is a client of either the contractor or subcontractor when said entity also provides services for the Department.

    2. The contractor will not use any information obtained by virtue of its performance of this contract and its relationship with the Department to provide what would be

"inside information" to the contractor's clients who are providers of medical, social or rehabilitative treatment and supportive services on behalf of the Department or to the organizations that represent such providers.

3. The contractor will disclose its membership on any and all boards. The contractor will not use any information obtained by virtue of its contractual relationship with the Department to its advantage by voting, speaking to, or attempting to influence board members in the performance of services by that board's organization.
4. The contractor will not have ownership in any provider or provider organization that contracts with the Department or is approved by the Department to provide medical, social or rehabilitative treatment and supportive services on behalf of the Department.

# 6.2 Program Integrity Requirements

The program integrity contractor is generally responsible for all activities related to program integrity (except provider enrollment and member lock-in, which are performed by other IME contractors) as they pertain to the Iowa Medicaid Program. Program integrity in this contract encompasses postpayment provider claims reviews and preliminary and full investigations of providers.

As described in RFP Section 5 Operating Environment, Iowa's Medicaid Management Information System (MMIS) and Data Warehouse/Decision Support (DW/DS) system are the primary sources of claims-related data that drive program integrity functions. Further, as referenced in RFP section 6.1.d and 6.1.e, all contractors will interface with and have access to those systems. However, as noted in RFP section 6.1.r, bidders may propose the use of additional tools for program integrity functions so long as the bidders also provide automated electronic interfaces to the existing IME data systems. The Department will evaluate proposed tools as a facet of the bidders' total solution.

The program integrity component includes the following functions:

- 6.2.1 Surveillance and Utilization Review Services (SURS)
- 6.2.2 Data Analytics
- 6.2.3 Medical Necessity Reviews
- 6.2.4 Medicaid Value Management (MVM) Program
- 6.2.5 Investigation

# 6.2.1 Surveillance and Utilization Review Services (SURS)

The program integrity 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 program integrity 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 program integrity contractor will identify overpayments and send a request to the provider for refunds of the overpayments. When reviews indicate suspect practices, the program integrity contractor will refer the case to the Medicaid Fraud Control Unit (MFCU).

The SURS function includes use of claims data for overall program management and use of statistics to establish norms of care 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 program integrity contractor will perform other data mining activity through the use of the paid claims files in the data warehouse/decision support (DW/DS) system.

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 program integrity contractor will develop other algorithms for use in identifying aberrant provider billing practices.

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:

a. SUR subsystem reports produced by the Core MMIS contractor

b. MMIS paid claims data and any other provider or program statistics maintained by the Department

c. Medical record data collected during field reviews

# 6.2.1.1 State Responsibilities

a. Approve all policy including the criteria used for utilization review and edit resolution.

b. Initiate and interpret all policy and make administrative decisions regarding utilization review.

c. Advise program integrity contractor of providers to be placed on prepayment review or whose participation privileges are suspended or revoked.

d. Make provider referrals to peer review committees.

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.

# 6.2.1.2 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.

# 6.2.1.2.1 Profiling and Data Mining

a. Provide profiles of health care providers and members through which the quality, quantity and 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 long-term care and prescription 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 long-term care and prescription 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 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.

# 6.2.1.2.2 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).

# 6.2.1.2.3 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.

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.

i. Receive and review Explanations of Medical Benefits (EOMBs) and follow up as needed.

j. Adjust claims to recover inappropriate provider payments that result from optical character recognition (OCR) scanning errors.

k. Coordinate referrals of cases with and between the MFCU according to the following criteria.

   1. Refer all cases of suspected provider fraud to the MFCU

   2. Promptly comply with a request from the MFCU for the following:

      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.

l. Follow up on overpayments identified by the CMS Medicaid Integrity contractors (MICs).

m. Record payments received in the IME accounts receivable system for GAAP reporting and bank account reconciliation purposes.

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.

o. Maintain and update operational procedures as necessary and in a format designated by the Department.

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.

q. Meet the following reporting requirements.

1. Produce and submit monthly to the Department a report summarizing provider review activity, including the following information in the report at a minimum:

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.

## 6.2.1.2.4 Appeals

a. Prepare documents and assist in appeal hearings for all SURS cases that result in an appeal by the provider.

# 6.2.1.3 Performance Standards

a. In calculating recoveries from SURS and provider review activities, delineate the following:

1. Measurable and quantifiable recoveries, which are actual recoupments made and money received

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)

   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

b. Annually review a random minimum sample of .5 percent of paid claims.
   1. The reviews will involve performing both in-house and field reviews.
   2. Review cases must include providers who exceed calculated norms and a random sample of providers who do not exceed norms.

c. Open a minimum of 60 cases for provider reviews during each quarter according to the following criteria.
   1. All cases referred from the Department must be opened in the quarter referred.
   2. Review cases must include both providers who exceed calculated norms, and a random sample of providers who do not exceed norms.
   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.

d. On average for all cases, complete reviews within 90 days when all documentation required necessary to perform the review has been obtained.

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.

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.

# 6.2.2 Data Analytics

The Department intends for the program integrity contractor to monitor Medicaid claims to determine provider overpayments and underpayments; identify suspected fraud, abuse, or waste of program services; improve budget forecasting; and identify strategies to assist the Department in improving healthcare delivery to Medicaid program members.

The Department is seeking a comprehensive solution addressing this scope of work. This solution may be comprised of components using the IME data systems or using additional products that the contractor will have to interface with to the IME data systems. The Department will supply the data to be used for analytic purposes from its existing data warehouse/decision support (DW/DS) system, which is described in RFP Section 5.3 Data Warehouse/Decision Support (DW/DS) System. The bidder’s solution can include any data mining, data analytics, predictive modeling and postpayment review tools and/or services available within the healthcare market so long as the bidder agrees to interoperate them with the IME data systems and provide automated performance reporting.

# 6.2.2.1 State Responsibilities

a. Review any proposed external tools and interfaces to the IME data systems that the contractor will provide and approve their use by the contractor if appropriate.

b. Initiate, interpret, and approve all policy including the criteria used for utilization review and suspect detection and make administrative decisions regarding utilization review.

c. Advise program integrity contractor of criteria to be configured within the systems that the contractor uses.

d. Identify needed utilization and performance reports.

e. Determine the frequency of reports.

f. Approve parameters of reports.

g. Provide access to data for analytic purposes through Department-approved interface capability with the DW/DS system.

# 6.2.2.2 Contractor Responsibilities

a. Provide services, tools, or both that enable the contractor to perform the following functions:

   1. Data mining

   2 Data analytics

   3 Predictive modeling

   4 Automated claim overpayment and underpayment review

   5 Identification of suspected fraud, abuse or waste

   6. Dashboard displays of selected data and results of analyses on web pages

b. Provide actionable data and recommendations on opportunities for improving IME objectives.

c. Assist the Department in performing budget forecasting.

d. If proposing an external tool, provide a scalable solution that will support multiple health insurance related products and multiple types of users.

e. Provide at least one on-site data analyst solely dedicated to providing the Department with extensive standard and ad-hoc reporting and interpretation to meet IME and CMS requirements.

f. If proposing an external tool, include an interface to exchange data with the IME's DW/DS system in accordance with IME and CMS requirements.

g. Maintain full compliance with all HIPAA security and privacy provisions.

h. If using Department-approved external tools, provide the capability to use the new tools as fully functional, CMS-certifiable replacements that are proven to meet all federal requirements for the SUR and MAR functional areas.

j. Compile and analyze billing and payment data from processed and paid claims and develop predictive models for billings and payments for up to 24 months in the future.

k. Review three years of historical claims data and identify payment errors.

# 6.2.2.3 Performance Standards

a. At a minimum, contractor shall deliver a return on investment equal to 125 percent of the implementation cost and 200 percent of the operations costs of data analytics tools and services over the base and option years of the contract.

# 6.2.3 Medical Necessity Reviews

The Department desires that the program integrity contractor conduct postpayment medical necessity reviews. These reviews are beyond the scope of required SURS profiles and utilization reviews. The bidder should propose the scope of review criteria that will enable the contractor to drill down into finalized claim data to determine excessive or ineffective use of services. Examples could include using groupings of codes as the search criteria for more in-depth analysis that could enable the contractor to recommend policy changes or affirm current practices as effective.

# 6.2.3.1 State Responsibilities

a. Approve all policy including the criteria used for postpayment medical necessity review.

b. Initiate and interpret all policy and make administrative decisions regarding postpayment medical necessity review.

c. Advise the program integrity contractor of policy and criteria for postpayment medical necessity review.

d. Determine services requiring postpayment medical necessity review.

# 6.2.3.2 Contractor Responsibilities

a. Provide management with information to assist in overall program direction and supervision.

b. Have written procedures for all postpayment medical necessity review activities, including review criteria for all member populations and provider types.

c. Meet periodically with the Department staff to discuss data reviewed and determine action to be taken.

d. Refer providers requiring sanctions to be imposed against them to the Department in accordance with current Iowa Administrative Code rules on sanctions.

e. Initiate appropriate action to recover erroneous provider payments. Refer the cases to the program integrity staff that will take over the recovery or refund process as appropriate.

f. Provide professional medical staff to perform postpayment medical necessity review 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 program integrity contractor's medical director will coordinate with the Chief Medical Director in Medical Services as needed.

g. On a monthly basis, pull a random sample of 200 paid claims from the claims paid in the prior six months, targeting Department-approved claim types that yield the most savings. Identify the sample within 10 working days of the end of the prior month. Request records from the provider within five days of receipt of the sample and follow Iowa Administrative Code 441—79.4(3) for receipt of the records. Issue denial and pursue recovery for any claim where the medical record has not been received timely. Complete the review, on average, and recovery notice, when indicated, within 90 days when all documentation required necessary to perform the review has been obtained.

## 6.2.3.3 Performance Standards

a. Report to the Department the total number of claims reviewed, percentage and count of claims validated, percentage and count of claims denied, count and dollar amount of recoveries with accompanying detail each quarter within 15 days of the end of the quarter.

# 6.2.4 Medicaid Value Management (MVM) Program

The 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:

a. Compare nationally recognized benchmarks and data on utilization of services, gaps in care and to evaluate the Medicaid program and services in Iowa.

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.

c. Develop through analysis of data, recommendations to add value to programs and services for the Medicaid member.

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.

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.

# 6.2.4.1 State Responsibilities

a. Convene a monthly meeting with the MVM team to review and discuss status of the projects.

b. Select projects that meet the objectives of the MVM program.

c. Establish performance measures

d. Review and take action on recommendations.

# 6.2.4.2 Contractor Responsibilities

a. The IME Medical Director leads the MVM team in the evaluation and analysis of program date and developing project goals.

b. Convene and manage an MVM program team that includes Medical Services, policy staff, and other groups as necessary to perform MVM.

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.

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.

e. Develop tools and analyze Medicaid expenditures and trends over time to identify areas for possible savings or targeted interventions.

f. Prepare monthly reports that address the following:

    1. Evaluate the effectiveness of the projects selected for the MVM program.

    2. Analyze the effectiveness in meeting the MVM program goals.

    3. Conduct reviews that identify potential impact upon the MVM projects.

    4. Compare MVM results to industry standards and quality benchmark data.

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.

h. Conduct IME data systems searches that assist in the validation of project goals.

i. Perform analysis of data and develop recommendations to add value to programs and services for the MVM program.

j. Develop a comprehensive approach to improving quality and value for Iowa Medicaid members.

k. Provide quarterly results to the Department from the review of the claims checklist, including Iowa Medicaid norms, industry standards, and quality indicators.

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.

m. Participate in monthly MVM meetings.

n. Provide monthly reports prior to the monthly MVM meeting.

o. Develop recommendations for project improvements.

p. Identify trends that impact the operations or fiscal management.

# 6.2.4.3 Performance Standards

a. Develop a set of quality and performance measures that are reviewed regularly and to evaluate Iowa Medicaid's cost and quality with other benchmarks.

b. Identify, perform analysis and complete at least 5 new projects per quarter that identify areas for further analysis of IME performance, quality, or potential overutilization.

c. Achieve savings (through cost avoidance) of at least $1 million annually from the projects.

# 6.2.5 Investigation

The contractor will investigate information resulting from research and from referrals from its program integrity staff, the Department, other state agencies, other IME contractors, providers, and sources who share information that indicates suspicious billings that could indicate fraudulent, abusive or wasteful use of Iowa Medicaid Program resources. The contractor will document recommendations for responding to the facts resulting from the investigations.

# 6.2.5.1 State Responsibilities

a. Advise program integrity contractor of policy and criteria for referrals of suspected fraudulent, abusive or wasteful use of Iowa Medicaid Program resources.

b. Approve the criteria used for investigations.

c. Make decisions regarding follow-up actions resulting from the outcomes of investigations.

# 6.2.5.2 Contractor Responsibilities

a. Provide at least one qualified investigator to perform research.

b. Maintain written procedures and electronic records for all investigative activities.

c. Document each referral received with an internal tracking number for use on all documents and electronic records related to the case.

d. Provide a status report and recommendations to the Department in advance of regularly scheduled meetings to discuss individual cases and receive Department direction for action to take on each case.

e. Collect, prepare and deliver evidence (such as suspicious claims or groups of claims and all investigative documentation) to the appropriate party to follow up as directed by the Department. Appropriate parties include but are not limited to Provider Services, SURS, Medicaid Fraud Control Unit (MFCU), or Attorney General staff members.

f. Develop protocols for mining of claims data to yield other undetected situations potentially suspicious of billing practices.

g. Use criteria from other special projects throughout the IME for corrective actions of inappropriate billings to determine whether additional occurrences exist that were undetected previously and initiate investigations as appropriate.

# 6.2.5.3 Performance Standards

a. Initiate investigations within one business day of receipt of referrals.

b. Maintain sufficient detail in investigation documentation to support filing of sanctions, jury deliberations or other resulting actions that support the PI unit's position in the event of appeal.

# 7 PROPOSAL FORMAT AND CONTENT

These instructions describe the format and content of the bid proposal and are designed to facilitate the submission of a bid proposal that is easy to understand and evaluate. Failure to adhere to the bid proposal format shall result in the disqualification of the bid proposal. This section contains the following topics:

- 7.1 Instructions
- 7.2 Technical Proposal
- 7.3 Cost Proposal
- 7.4 Company Financial Information

# 7.1 Instructions

a. A bid proposal consists of three volumes with these titles: the Technical Proposal, the Cost Proposal, and Company Financial Information.

b. Each bid proposal shall be sealed in a box or boxes, with the Cost Proposal and Company Financial Information portions each sealed in separate, labeled envelopes inside the same box or boxes.

c. If multiple boxes for each bid proposal are used, the boxes shall be numbered in the following fashion: 1 of 4, 2 of 4, and so forth.

d. Boxes shall be labeled with the following information:

   1. Bidder's name and address
   2. Issuing officer’s name and delivery address:
      Mary Tavegia, Issuing Officer
      Iowa Department of Human Services
      Iowa Medicaid Enterprise
      200 Army Post Road, Suite 2
      Des Moines, Iowa  50315
   3. RFP title and reference number:
      Iowa Medicaid Enterprise Professional Services Procurement
      RFP MED-10-013
   4. RFP component for which the bid proposal is being submitted for consideration:
      i. Program Integrity

e. Bidders submitting bid proposals for more than one of the separate contract awards must box each bid proposal separately.

f. All bid proposal materials shall be printed two-sided on 8.5” x 11” paper.

g. The Technical Proposal materials shall be presented in a spiral, comb, or pasteboard binder separate from the sealed Cost Proposal and Company Financial Information

materials. Technical Proposals received in 3-ring, loose-leaf binders will not be accepted and will be returned without evaluation.

h. The Cost Proposal and Company Financial Information materials shall be submitted in separate spiral, comb, or pasteboard binders. Cost Proposals and Company Financial Information materials received in 3-ring, loose-leaf binders will not be accepted and will be returned without evaluation.

i. If the bidder designates any information in its bid proposal as confidential, the bidder must submit one sanitized copy of bid proposal materials from which any confidential or proprietary information has been excised or redacted. The confidential material must be excised in such a way as to allow the public to determine the general nature of the material removed and to retain as much of the bid proposal as possible. Bidders cannot designate their entire proposal as confidential or proprietary. Sanitized versions of bid proposals must provide a sufficient level of information to understand the full scope of services to be provided.

j. Bidders will submit one original, eight copies, and one sanitized copy of the Technical and Cost Proposals and Company Financial Information – each in a separate binder (or set of binders) – for each bid proposal submitted. As explained above, bidders submitting bid proposals for more than one of the separate contract awards would therefore submit one original, eight copies, and one sanitized copy of the Technical Proposal and Cost Proposal and Company Financial Information for each separate RFP Component contract under consideration.

k. All materials shall be submitted in a timely manner to the issuing officer.

l. The bound original bid proposal materials shall be labeled “Original.” The bound copy of the bid proposal materials shall be labeled “Copy.” The bound sanitized copy of the bid proposal materials shall be labeled “Sanitized Copy.”

m. The Technical Proposal and Cost Proposal must also be submitted on CD-ROM. The Company Financial Information should not be included on the CD-ROM. The Department is requiring two CD-ROM copies per bid proposal. One submitted CD-ROM will contain one full version of the Technical Proposal and the Cost Proposal. The second CD-ROM will contain the “sanitized” version of the Technical Proposal and a copy of the Cost Proposal. Electronic proposal files must be submitted as protected PDF files that individually identify the component name, proposal volume title, and full or excised status (such as Medical Services Cost Proposal Sanitized).

n. As much as possible, Technical Proposal sections should be limited to discussion of elements relevant to the proposed solution for Iowa. The “Executive Summary” and “Corporate Qualifications” sections of the Technical Proposal allow bidders to expound in greater detail about past or current projects.

# 7.2 Technical Proposal

The Technical Proposal will consist of the following sections in the order listed below and separated by tabs.

**Figure 5: Technical Proposal Sections**

| Section Title | Tab Number |
|---|---|
| Table of Contents | 1 |
| Transmittal Letter | 2 |
| Checklist and Cross-References | 3 |
| Executive Summary | 4 |
| General Requirements | 5 |
| Program Integrity | 6 |
| Project Plan | 7 |
| Project Organization | 8 |
| Corporate Qualifications | 9 |

# 7.2.1 Table of Contents (Tab 1)

The Table of Contents will identify all sections (which are separated by tabs), all subsections contained therein, and the corresponding page numbers. The Table of Contents found at the beginning of this RFP provides a representative example of what is expected for the Technical Proposal Table of Contents.

# 7.2.2 Transmittal Letter (Tab 2)

An individual authorized to legally bind the bidder shall produce and sign a transmittal letter on official business letterhead. Transmittal letters should be numbered in sequence with the remainder of the Technical Proposal.

The designated original copy of the Technical Proposal will include the original signed letter. A photocopy of the transmittal letter shall be included in each of the remaining copies of the Technical Proposal. The transmittal letter is evaluated as part of the screening for bid proposal mandatory submittal requirements and shall include:

a. The bidder's mailing address

b. Electronic mail address, fax number, and telephone number for both the authorized signer and the point of contact designated by the bidder

c. A statement indicating that the bidder is a corporation or other legal entity

1. All subcontractors should be identified, and a statement included that indicates the exact amount of work to be done by the prime contractor and each subcontractor, as measured by percentage of total contract price.
2. The technical proposal must not include actual price information.

d. A statement confirming that the prime contractor is registered or agrees to register to do business in Iowa and providing the corporate charter number (if currently issued), along with assurances that any subcontractor proposed is also licensed or will become licensed. to work in Iowa

e. A statement identifying the bidder's federal tax identification number

f. A statement that the bidder will comply with all contract terms and conditions as indicated in this RFP

g. A statement that no attempt has been made or will be made by the bidder to induce any other person or firm to submit or not to submit a proposal

h. A statement of affirmative action that the bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap

i. A statement that no cost or pricing information has been included in this letter or the Technical Proposal

j. A statement identifying all amendments to this RFP issued by the state and received by the bidder. If no amendments have been received, a statement to that effect shall be included

k. A statement that the bidder certifies in connection with this procurement that:

1. The prices proposed have been arrived at independently, without consultation, communication, or agreement, as to any matter relating to such prices with any other bidder or with any competitor for the purpose of restricting competition; and
2. Unless otherwise required by law, the prices quoted have not been knowingly disclosed by the bidder prior to award, directly or indirectly, to any other bidder or to any competitor.

l. A statement that the person signing this proposal certifies that he or she is the person in the bidder's organization responsible for or authorized to make decisions regarding the prices quoted and that he or she has not participated and will not participate in any action contrary to item k

m. If the use of subcontractors is proposed, a statement from each subcontractor must be appended to the transmittal letter signed by an individual authorized to legally bind the subcontractor stating:

1. The general scope of work to be performed by the subcontractor;
2. The subcontractor's willingness to perform the work indicated; and
3. The subcontractor's assertion that it does not discriminate in employment practices with regard to race, color, religion, age (except as provided by law), sex marital status, political affiliation, national origin, or handicap.

n. Any request for confidential treatment of information shall also be identified in the transmittal letter, in addition to the specific statutory basis supporting the request and an explanation why disclosure of the information is not in the best interest of the public.

o. The name, address and telephone number of the individual authorized to respond to the Department about the confidential nature of the information.

p. A statement that the submitted Bid Proposal Security shall guarantee the availability of the services as described throughout the bid proposal.

q. A statement that the bidder acknowledges the acceptance of all term and conditions stated in the RFP.

# 7.2.3 Checklist and Cross-References (Tab 3)

Bidders will complete three exhibits in each Technical Proposal to confirm their responsiveness to requirements:

- 7.2.3.1 Bid Proposal Mandatory Requirements Checklist
- 7.2.3.2 General Requirements Cross-Reference
- 7.2.3.3 Program Integrity Requirements Cross-Reference

## 7.2.3.1 Bid Proposal Mandatory Requirements Checklist

Bidders will complete a checklist of the mandatory submittal requirements. The Department will use this checklist to confirm that bidders have produced and submitted bid proposals according to Department specifications. The Mandatory Requirements Checklist form appears in RFP Attachment L Bid Proposal Mandatory Requirements Checklist.

## 7.2.3.2 General Requirements Cross-Reference

The Department requests that bidders complete a General Requirements Cross-Reference for each Technical Proposal under consideration using the sample RFP cross-reference form in RFP Attachment M Sample Cross-Reference. In Column A, bidders will list requirements by reference number from Section 6.1 General Requirements in the RFP (such as 6.1.3.3.c). In Column B, bidders will list the location within the Technical Proposal where the bidder's response to this requirement can be found (such as Tab 5, Page 5).

## 7.2.3.3 Program Integrity Requirements Cross-Reference

The Department requests that bidders develop a P Requirements Cross-Reference for each Technical Proposal under consideration based upon the sample RFP cross-reference form in RFP Attachment M Sample Cross-Reference. In Column A, bidders will list requirements by reference number (such as 7.2.3.3). In Column B, bidders will list the location within the Technical Proposal where the bidder's response to this requirement can be found (such as Tab 3, page 32).

# 7.2.4 Executive Summary (Tab 4)

The bidder shall submit an executive summary that provides the evaluation committees and state management with a collective understanding of the contents of the entire bid proposal. The Executive Summary should briefly summarize the strengths of the bidder and the key features of its proposed approach to meet the requirements of the RFP component toward which the individual bid proposal is targeted.

The Department expects bidders to provide a comprehensive overview of the services that they are proposing to provide to the state. For bidders who have submitted bid proposals for other components from RFP MED-10-001 as well as this program integrity RFP, this overview provides an opportunity to discuss how the services integrate with one another. Bidders may also articulate other added-value services that are relevant to the scope of services for the submitted bid proposals.

Due to the complex nature of this procurement, the Department requests that bidders describe within the Executive Summary their understanding of the Iowa Medicaid Enterprise (IME). The Department is looking for evidence that bidders understand how multiple contractors work together in a common, integrated environment, operating a unified Iowa Medicaid Program from a single location.

This section shall also include a summary of the bidder's project management plans for all phases of the resulting contract. In addition, it is expected that bidders will identify the risks inherent in the IME and identify the strategies that the bidder will use to mitigate each risk.

# 7.2.5 General Requirements (Tab 5)

In the General Requirements section, bidders will explain their approach to Section 6.1 General Requirements. For the General Requirements section of the Technical Proposal, the Department expects bidders to list the requirement numbers for addressed requirements above the paragraph or set of paragraphs that addresses them.

# 7.2.6 Program Integrity (Tab 6)

The bidder shall address each contract function (such as SURS) within RFP Section 6.2 Program Integrity Requirements. Bidders also will explain in detail how they plan to approach each contractor responsibility and operational requirement for the contract function.

This section should provide a comprehensive integrated narrative that describes how the contractor will meet the requirements, including a description of the bidder's processes, control procedures, and quality assurance procedures for each function. In addition, the bidder may provide process flow diagrams to supplement the narrative.

For the Program Integrity section of the Technical Proposal, the Department expects bidders to list the requirement numbers for addressed requirements above the paragraph or set of paragraphs that addresses them. The Department also expects that bidders will format the Program Integrity section of the Technical Proposal in a manner similar to the following outline:

**Figure 6: Section 6 Organization**

| Section 6 Numbering | Section 6 Content |
|---|---|
| 6.x | RFP component introduction |
| 6.x.1 | Name of contract function 1 |
| 6.x.2 | Name of contract function 2 |
| 6.x.3 | Name of contract function 3 |
| 6.x.4 | Name of contract function 4 |
| 6.x.5 | Name of contract function 5 |
| 6.x.6 | Name of contract function 6 |
| 6.y | etc. |

Bidders are free to organize subsections about each contract function as they see fit. Bidders are also given wide latitude in the degree of detail they offer or the extent to which they reveal plans, designs, examples, processes, and procedures.

Bid proposals must be fully responsive to the service requirements. Merely repeating the requirement statement will be considered nonresponsive and disqualify the bidder. Bid proposals must identify any deviations from the requirements of this RFP or requirements that the bidder cannot satisfy.

# 7.2.7 Project Plan (Tab 7)

The Department requires that bidders produce a project plan for each phase of the contract: transition phase, operations phase, and turnover phase.

Bidders should include their proposed approach for communication management, quality management, risk management, and time management as part of their overall project plan. The Department will need to consider this approach in determining the overall master project plan for the IME.

In addition to task lists and corresponding start and end dates, the project plans for each phase will include a calendar-year-based schedule for all tasks (including operational tasks), specify the allocation of resources by job for those tasks, and identify the timeframes in which the tasks will occur (expressed in weeks during transition and turnover and in quarters during operations). The bidder must be capable of updating and maintaining this information systematically throughout the contract.

# 7.2.8 Project Organization (Tab 8)

The proposed organization and staffing must meet the requirements of RFP Section 6.1.1 Staffing. Bidders respond to the project organization requirements in this section. This section of the proposal is the bidder's opportunity to describe the merits of its planned approach to the following topics:

- 7.2.8.1 Organization Charts
- 7.2.8.2 Staffing
- 7.2.8.3 Key Personnel
- 7.2.8.4 Subcontractors

# 7.2.8.1 Organization Charts

For each phase of the project, the bidder will provide a narrative description of the proposed organization, roles and responsibilities of key personnel, and representative job descriptions for all positions within the organization for all phases of the contract. Bidders will include an organization chart of proposed key personnel and counts of full-time equivalent (FTE) workers in each staff position in each organizational unit during each project phase.

Organization charts must identify the percentage of allocation of key personnel to the IME. Bidders may include separate charts for the transition phase to reflect staff loading in the individual tasks but must provide the FTE counts on each one for each organizational unit.

# 7.2.8.2 Staffing

Bidders are expected to propose sufficient staff who have the requisite skills to meet all requirements in this RFP and who can attain a satisfactory rating on all Performance Standards. Unless otherwise specified by the bidder and approved in advance by the Department, staff positions are effective for the entire duration of the project phase.

The Department encourages bidders to describe their approaches to acquiring qualified staff with experience in the IME. Special attention should be paid to retaining expertise that exists within the IME today.

# 7.2.8.3 Key Personnel

The bidder must provide resumes and references for all identified key personnel, including the bidder's account manager who will be involved in providing the services contemplated by this RFP. Resumes and references must meet the requirements of section 6.1.1 Staffing. All staff identified as key personnel must be employees of the bidder, unless specified otherwise by the key personnel subsections of the RFP.

# 7.2.8.4 Subcontractors

The bidder shall disclose the planned use of another company or individual staff member with which the bidder will contract to perform the services described in this RFP. The information that the bidder must provide includes:

a. Subcontractor name and address

b. Subcontractor qualifications

c. Work that the subcontractor will perform

d. The estimated percentage of total contract dollars for each subcontract

Special services project staff members that are hired on a retainer or as-needed basis (such as physicians, attorneys, and similar professional staff) are excluded from subcontractor percentage calculations.

# 7.2.9 Corporate Qualifications (Tab 9)

Information about contractor qualifications includes the following topics:

- 7.2.9.1 Corporate Organization
- 7.2.9.2 Corporate Experience
- 7.2.9.3 Corporate References
- 7.2.9.4 Felony Disclosures
- 7.2.9.5 Certifications and Guarantees

# 7.2.9.1 Corporate Organization

The bidder must provide an organization chart for the firm that is submitting the proposal. If the firm is a subsidiary of a parent company, the organization chart should be that of the subsidiary firm. The chart should display the firm's structure and the organizational placement of the oversight for the IME project. The bidder must identify the name of the person who will be responsible for signing the contract and indicate the signing person's relationship with the firm. The bidder must include the following information in the proposal:

a. History of the organization

b. Description of the executive, management and any other staff assigned to oversight of this project, their roles on this project, their expertise and experience in providing the services described in the RFP, and their tenure with the organization

c. Legal structure of the organization, names and credentials of the owners and executives, and state in which the organization is registered

d. Evidence of an Iowa business license and any necessary applicable professional license required by law

e. Any established partnership relationships with the community

f. Other projects in which the bidder is currently providing or has provided services similar to the services described in this RFP with names and contact information for the clients' contract administrators

g. Other contracts or projects currently undertaken by the bidder with names and contact information for the clients' contract administrators

# 7.2.9.2 Corporate Experience

Bidders will describe all relevant experience within the last five years, including all Medicaid contracts. As appropriate, bidders also will specify their participation as primary contractor or subcontractor on each project. Bidders will include projects that demonstrate at a minimum:

a. Relevant governmental experience with the functional areas and RFP requirements

b. Relevant commercial experience with the functional areas and RFP requirements

c. Other experience with governmental healthcare programs

d. For up to five projects in each category, the bidder shall provide the following items in the project summaries:

   1. Project title
   2. Client organization name
   3. Client reference contact name, title, and current telephone number
   4. Original contract start and end dates
   5. Total contract value to the bidder's organization
   6. Average staff hours in FTEs during operations
   7. Workload statistics
   8. Brief description of scope of work that demonstrates relevance to this contract

Project summaries are limited to one project per page. The state reserves the right to contact other references on the project.

# 7.2.9.3 Corporate References

The bidder shall provide letters of reference from three existing or previous clients knowledgeable of the bidder's performance in providing services similar to the services described in this RFP and a contact person and telephone number for each reference

# 7.2.9.4 Felony Disclosures

The bidder must state whether it or any owners, officers, or primary partners have ever been convicted of a felony. Failure to disclose such matters may result in rejection of the bid proposal or in termination of any subsequent contract. This disclosure must continue for the life of the contract. Any such matter commencing after submission of a bid proposal, and with respect to the successful bidder after the execution of a contract, must be disclosed in a timely manner in a written statement to the Department.

### 7.2.9.5 Certifications and Guarantees

The bidder must include signed copies of Attachments B through J inclusive. Signature must be from an individual authorized to bind the company.

# 7.3 Cost Proposal

The Cost Proposal will consist of the following sections in the order listed below and separated by tabs.

**Figure 7: Cost Proposal Sections**

| Section Title | Tab Number |
|---|---|
| Table of Contents | 1 |
| Bid Proposal Security | 2 |
| Pricing Schedules | 3 |

## 7.3.1 Table of Contents (Tab 1)

The Table of Contents will identify all sections (which are separated by tabs), all subsections contained therein, and the corresponding page numbers. The Table of Contents found at the beginning of this RFP provides a representative example of what is expected for the Technical Proposal Table of Contents.

## 7.3.2 Bid Proposal Security (Tab 2)

Each bidder's original copy of the Cost Proposal shall be accompanied by the original proposal bid bond payable to the Department or original letter of credit equal to five percent of the total costs listed in the pricing schedules in the Cost Proposal. Copies of the Cost Proposal can include copies of the bond or letter. If the bidder elects to use a bond, a surety licensed to do business in Iowa must issue the bond in a form acceptable to the Department.

The submitted Bid Proposal Security shall guarantee the availability of the services as described throughout the bid proposal. The Bid Proposal Security shall be forfeited if the bidder chosen to receive the contract withdraws its bid proposal after the Department issues a Notice of Intent to Award, does not honor the terms offered in its bid proposal, or does not negotiate contract terms in good faith. The Bid Proposal Security should remain in force and in the Department's possession until the firm-terms period for bid proposals expires (which is 120 days).

Upon the signing of contracts and approval of the contracts by CMS, the Bid Proposal Securities will be returned to unsuccessful bidders. In the event that all bid proposals are rejected or the RFP is cancelled, Bid Proposal Securities will be returned to the bidders.

### 7.3.3 Pricing Schedule (Tab 3)

Bidders are to include Pricing Schedule N-1 in RFP Attachment N. Fields on the pricing schedules are designated for pricing for transition, implementation (for any additional hardware and software that the bidder proposes for Department approval), and operations.

## 7.4 Company Financial Information

The bidder must submit the following documents to be used in the evaluation of financial viability:

a. Audited financial statements (annual reports) for the last three years

b. A minimum of three financial references (such as letters from creditors, letters from banking institutions, Dunn & Bradstreet supplier reports)

c. A description of other contracts or projects currently undertaken by the bidder

d. A summary of any pending or threatened litigation, administrative or regulatory proceedings or similar matters that could affect the ability of the bidder to perform the required services

e. A disclosure of all contracts during the preceding three-year period in which the bidder or any subcontractor identified in the bid proposal has defaulted, including a brief description of the incident, the name of the contract, a contact person and telephone number for the other party to the contract

f. A disclosure of all contracts during the preceding three-year period in which the bidder or any subcontractor identified in the bid proposal has terminated a contract prior to its stated term or has had a contract terminated by the other party prior to its stated term, including a brief description of the incident, the name of the contract, a contact person and telephone number for the other party to the contract

g. The company's five-year business plan that would include the award of the state's contract as part of the plan

The company financial information must be submitted in a separate sealed envelope and will be opened only for those bid proposals that are selected as apparent successful bidders during the proposal evaluation. This information will be used in the screening for financial viability. After a contract has been signed or if the Department elects not to award any components, the sealed corporate financial information will be returned unopened to unsuccessful bidders.

# 8 EVALUATION PROCESS

This section describes the evaluation process that will be used to determine which bid proposal provides the greatest benefits to the Department. The evaluation process is designed to award the contract to the bidder with the best combination of attributes to perform the required services. Request for Proposal (RFP) Section 7 Proposal Format and Content describes the content that the committee will evaluate. The evaluation process will ensure the selection of the best overall solution for the Iowa Medicaid Enterprise (IME). The evaluation process includes the following components:

- 8.1 Evaluation Committees
- 8.2 Mandatory Requirements
- 8.3 Technical Proposals
- 8.4 Points and Evaluation Criteria
- 8.5 Cost Proposals
- 8.6 Bid Proposal Security
- 8.7 Combined Score
- 8.8 Oral Presentations
- 8.9 Best and Final Offers
- 8.10 Financial Viability Screening
- 8.11 Recommendation
- 8.12 Notice of Intent to Award
- 8.13 Acceptance Period
- 8.14 Federal Approvals

# 8.1 Evaluation Committees

The Department intends to conduct a comprehensive, fair, and impartial evaluation of all bid proposals received in response to the component contract awards designated by this RFP. In making its award determinations, the Department will be represented by a set of evaluation committees; subject matter experts from Department staff, the project management office (PMO) and the technical assistance contractor will be assigned to the individual RFP components. Finally, an evaluation committee that will consist of members from the Department's Division of Fiscal Management will evaluate the financial stability and viability of the bidder.

# 8.2 Mandatory Requirements

As part of its initial screening, the Department will assess all bid proposals submitted in response to this RFP to assure that proposals have satisfied the mandatory requirements. Any one mandatory requirement that a proposal does not meet will cause

the Department to declare a bid proposal nonresponsive and return it to the bidder. The mandatory requirements checklist form appears in RFP Attachment L Bid Proposal Mandatory Requirements Checklist.

# 8.3 Technical Proposals

Members of the appropriate evaluation committees will evaluate independently each proposal that passes the mandatory submittal criteria. Committee members will score each proposal using criteria established by the Department and using the point values that appear in the technical proposal scoring table.

The evaluation committees will meet during their evaluation process to address any technical questions raised by their respective reviews and discuss the relative merits of each bidder's bid proposal.

## 8.3.1 Scoring Technical Proposals

Technical Proposal volumes meeting all mandatory requirements will be evaluated and scored by an evaluation committee. A weighted scoring system will be used. The weighted scoring system will provide numerical scores that represent the committee's assessment of the relative merits of the technical bid proposals. The Technical Proposal will be evaluated and a minimum score of 4,500 points out of the maximum of 7,500 points must be accumulated for the Technical Proposal to be considered competitive.

**Figure 8: Technical Proposal Scoring**

| Section | Points | Weight | Maximum Points |
|---|---|---|---|
| Executive Summary | 150 | 1-5 | 750 |
| General Requirements | 300 | 1-5 | 1,500 |
| Program Integrity Requirements | 500 | 1-5 | 2,500 |
| Project Management | 300 | 1-5 | 1,500 |
| Corporate Qualifications | 100 | 1-5 | 500 |
| Oral Presentations | 150 | 1-5 | 750 |
| **Total** | **1,500** | | **7,500** |

The Department will hold oral presentations for all bidders. Following oral presentations, the evaluation committees will convene to discuss the results of the oral presentations. After the meeting, each member of the evaluation committee will independently evaluate and score the proposals. After scoring the proposal, each evaluation committee will convene and average the bidder's scores (from each of its members) for each section of the bidder's technical proposal to facilitate a composite and final technical proposal score for each bidder.

# 8.3.2 Executive Summary

Each evaluation committee member will review the proposal's executive summary, the overall quality of the proposal (including appendices), and the general qualifications of the bidder. The evaluation will also include a review of subcontracting or joint venture arrangements and how these may affect the overall contract.

Also in the executive summary, each evaluation committee member will evaluate the bidder's understanding of the IME and the roles of the stakeholders, including the responsibilities of the Department and other agencies that are involved in administration of the Iowa medical assistance programs. In addition, each evaluation committee member will evaluate the overview of the proposed services and solutions to meet the Department's needs.

# 8.3.3 General Requirements

The evaluation committee member will evaluate how well the bidder explains their approach to RFP Section 6.1 General Requirements..

# 8.3.4 Program Integrity Requirements

The evaluation committee member will assess the bidder's approach to meeting all the functional, operational, and technological requirements of the RFP. The bidder's response will be evaluated based upon the functional description of the bidder's solution and how their proposal meets or exceeds the requirements listed in this RFP.

# 8.3.5 Project Management

The evaluation committee member will assess the bidder's approach to project management and evaluate the bidder's work plan and approach to the transition and operations phases. Also of interest to the evaluator will be the bidder's organization of the project teams and approach to quality control in all phases of the contract.

The evaluator will review proposed staffing levels at each phase of the project, job descriptions, roles, and responsibilities. The evaluation committee members will examine closely the resumes of all key personnel and verify references. Reference checking may not be limited to those references supplied by the bidder. Special attention will be given to the bidder's intended use of existing IME contractor staff.

# 8.3.6 Corporate Qualifications

The corporate background, organization, and relevant experience of the bidder and any subcontractors are significant factors in the evaluation process. The experience and reputation of the bidder in managing large projects of this nature and how the bidder's corporate local teams interact with its clients is important. Experience in Medicaid, large health care delivery systems, managed care operations, and recent technological advancements in the arena of healthcare systems will carry significant weight in the evaluation of submitted proposals.

# 8.4 Points and Evaluation Criteria

For the purposes of evaluation, points will be assigned for each component of the evaluation criteria as follows:

5 – Exceeds all requirements

4 – Exceeds many requirements

3 – Meets all requirements

2 – Meets most requirements

1 – Does not meet requirements

# 8.5 Cost Proposals

The evaluation committee will review and score the cost proposals, but a separate committee will review and score the cost proposals from all bidders meeting the mandatory requirements. This committee will note any bidder-imposed cost limitations that could prevent the Department from achieving the objectives of the procurement and report these limitations to the State Medicaid Director for a decision on the proposal.

## 8.5.1 Scoring Cost Proposals

Cost proposal points for each Program Integrity is allocated and determined as follows:

**Figure 9: Cost Proposal Scoring**

| Factor | Percentage of Points |
|---|---|
| Transition costs | 250 |
| Implementation costs for data analytics tools | 250 |
| Fixed-price operations costs | 2,000 |
| **Total** | **2,500** |

The bidder with the lowest price will receive the maximum points of 2,500.

Implementation costs apply only to the installation and preparation for operations of data analytics tools that the bidder proposes and configuration of Department-approved interfaces with the data warehouse/decision support (DW/DS) system.

To calculate every other bidder's score (other than the bidder who received the maximum points) for each Cost Proposal will be divided into the corresponding value of the lowest bidder and then multiplied by the maximum points. The formula for each is expressed as follows:

Bidder's cost score = (lowest cost / bidder cost) x maximum points

For an incumbent contractor for SURS and medical necessity review functions, there will be no transition price as these functions have not changed significantly. For scoring

purposes only, an incumbent contractor for those functions will be given the point score equal to the lowest bidder for the transition price.

# 8.6 Bid Proposal Security

The bid proposal security is evaluated on a pass/fail basis as part of the mandatory submittal requirements and is not considered in the scoring.

# 8.7 Combined Score

Technical and cost proposal scores will be combined to establish a final score for each bidder. The maximum total score is 10,000 points. Proposals will be ranked according to total score to facilitate a recommendation from the evaluation committees.

# 8.8 Oral Presentations

The Department will request oral presentations from each bidder and request a subsequent “best and final offer” (BAFO) from those bidders that have demonstrated to the evaluation committee their ability to satisfy the requirements of the RFP. Through the issuing officer, the evaluation committee will notify each bidder of their selection as a finalist and arrange for a presentation of their respective services.

Oral presentations will take place at a location to be determined and bidders are expected to have all designated key personnel on hand. The determination order and schedule for the presentations is at the sole discretion of the Department.

The presentation may include slides, graphics and other media selected by the bidder to illustrate the bid proposal. The presentation should not materially change the information contained in the bid proposal. At its option, the Department may require site visits by select Department staff to a bidder’s current client site to view current operations.

Upon completion of oral presentations, individual evaluation committee members may score bidder’s Technical Proposal based on any clarifications received during that bidder’s oral presentation.

# 8.9 Best and Final Offers (BAFO)

The Department may request a subsequent best and final offer from those bidders that have demonstrated to the evaluation committee their ability to satisfy the requirements of the RFP. At the end of each oral presentation, the presenting bidder will receive any debriefing instructions regarding the BAFO process if the Department requests any BAFOs. Bidders will have five business days after their individual oral presentations to develop and submit their best and final offers. Thus, a bidder presenting on Tuesday will deliver its BAFO on the following Tuesday, while a bidder who presents on Thursday will deliver its BAFO on the following Thursday.

Best and final offers must be submitted via delivery service (such as UPS, FedEx, or USPS Priority Mail) by 3:00 p.m. Central Time on the requisite business day. The BAFO must be in writing, accompanied by a transmittal letter binding the bidder to the financial

terms described therein. BAFOs are to be sent to the issuing officer of this RFP at the same address identified in RFP Section 2.11 Proposal Submission.

# 8.10 Financial Viability Screening

The Department's Division of Fiscal Management will evaluate the financial stability and viability of the bidder. The committee will review the bidder's financial stability to ensure that the State of Iowa will be fully covered against any financial difficulties that the company may experience during any period of the contract. After the oral presentations and the bidder's Technical and Cost proposal scores are combined, the bid proposal that receives the most points for each component will be reviewed for the bidder's financial stability and viability to sustain the operation and to assume the ongoing enterprise. This will include a review of the requested corporate financial information. The bidder's financials will be evaluated on a pass/fail basis.

# 8.11 Recommendation

Following the financial viability screening process, the evaluation committees will forward their final recommendations to the State Medicaid Director for a final decision and contracts award, if appropriate. The recommendations shall be based on all information received through the evaluation process and shall provide the evaluation committees' assessment of bidders that will provide the greatest benefit to the Department. The evaluation committees will recommend the bidder with the greatest total point value or a recommendation that no bidder be selected.

The Department reserves the right to take any additional steps deemed necessary in determining the final awards, which may include negotiations with the selected bidders. The State Medicaid Director may accept or reject the recommendation of the evaluation committees. If the State Medicaid Director rejects the recommendation of any of the evaluation committees, the RFP may be cancelled or rebid at the sole discretion of the Department.

The State Medicaid Director's decision is final for purposes of Iowa Administrative Code Chapter 17A.

# 8.12 Notice of Intent to Award

A notice of intent to award for each contract will be sent by mail to all bidders who have submitted a timely bid proposal. The notice of intent to award is subject to execution of a written contract and federal approval. As a result, the notice does not constitute the formation of a contract between the Department and the apparent successful bidder.

# 8.13 Acceptance Period

Negotiation and execution of the contracts shall be completed by the date specified in RFP Section 2.1 Procurement Timetable. If the apparent successful bidder fails to negotiate and execute a contract, the Department (in its sole discretion) may revoke the award and award the contract to the next highest ranked bidder or withdraw the RFP.

The Department further reserves the right to cancel the award at any time prior to execution of a written contract or receiving federal approval.

# 8.14 Federal Approvals

The contract award is subject to federal approval. The Department will make every effort to obtain and expedite federal approval. The Department reserves the right to not award a contract if federal approval is not obtained or does not receive enhanced federal financial participation (FFP).

# 9 ATTACHMENTS

This section includes the attachments to the RFP as listed in the following table.

**Figure 10: RFP Attachments**

| Identifier | Title of Attachment |
|---|---|
| A | Glossary of Acronyms and Terms |
| B | Proposal Certification |
| C | Certification of Independence and No Conflict of Interest |
| D | Certification Regarding Debarment Suspension Ineligibility and Voluntary Exclusion |
| E | Authorization to Release Information |
| F | Certification Regarding Registration, Collection and Remission of State Sales and Use Taxes |
| G | Certification of Compliance with Pro-Children Act of 1994 |
| H | Certification Regarding Lobbying |
| I | Business Associate Agreement |
| J | Proposal Certification of Available Resources |
| K | Resource Library Content |
| L | Mandatory Requirements Checklist |
| M | Sample Cross-Reference |
| N | Pricing Schedule |
| O | Sample Contract |

# Attachment A: Glossary of Acronyms and Terms

| Acronym | Definition |
|---|---|
| AAA | Area Agencies on Aging |
| ACH | Automated clearing house |
| AEA | Area education agency |
| AFSCME | American Federation of State, County and Municipal Employees |
| AI | American Indian |
| AIDS | Acquired immune deficiency syndrome |
| AN | Alaskan Native |
| APC | Ambulatory payment classifications |
| APG | Ambulatory patient groups |
| A/R system | Accounts receivable system that was instituted to track county financial obligations for support of the Medicaid program. County governments in Iowa are responsible for the nonfederal share of certain Medicaid service costs for persons age 18 and older. These services include ICF/MR, MR and BI waivers, and adult rehabilitation. |
| ARNP | Advanced Registered Nurse Practitioner |
| ARO | Adult rehabilitation option for individuals with chronic mental illness. |
| ASAP-AP | A PC-based EMC submission software package for submitting claims and claim adjustments. |
| AVR or AVRS | Automated voice response system |
| AWP | Average wholesale price, which is part of a calculation for one of the state's four pharmacy reimbursement methods. |
| BCBS | Blue Cross Blue Shield |
| BCCT | Breast and Cervical Cancer Treatment Program |
| BEF | Bureau of Economic Fraud |
| BENDEX | Beneficiary and Earnings Data Exchange System |
| BI | Brain-injured |
| Buy-in | See Medicare buy-in |
| CAC | Critical advisory committee |
| CCI | Correct coding initiative |
| CD | Compact disc |
| CDAC | Consumer-directed attendant care |
| CD-ROM | Compact disc with read-only memory |
| CFR | Code of Federal Regulations |

| Acronym | Definition |
|---|---|
| CHAMPUS | Civilian Health and Medical Programs of the Uniformed Services (Now TRI-CARE) |
| CHIP | Children's Health Insurance Program |
| CHSC | Child health specialty clinic |
| CICS | Customer Information Control System |
| CLIA | Clinical Laboratory Improvement Amendments |
| CMAP | Children's Medical Assistance Program |
| CMHC | Community mental health center |
| CMS | Centers for Medicare and Medicaid Services |
| CMS 64 report | The report that provides the state's Medicaid financial statistics tables to the federal government. |
| COLD | Computer output to laser disk, which is a form of image storage |
| COTS | Commercial, off-the-shelf |
| County of legal settlement | A status defined in Iowa law as being acquired by a person when a specific county is identified as having a financial responsibility for that person |
| County of residence | The county where the person is currently living, which the courts have interpreted broadly and which can be established without regard to length of time |
| CP | Client participation |
| CPAS | Claims Processing Assessment System |
| CPC | Central point of coordination |
| CPT-4 | Current Procedural Terminology, Version 4 |
| CPU | Central processing unit |
| CSR | Change service request, which is the process used when the Department or a contractor requests a change to the MMIS that may include production of a special report, modification to a system process, or a new requirement from the MMIS. |
| Crossover claims | Claims for members with both Medicare and Medicaid coverage |
| DAS | *See IDAS* |
| DDI phase | Design, development, and implementation phase of contract |
| DDM | Division of Data Management |
| DEA | Drug Enforcement Administration |
| DESI | Drug Efficacy Study Implementation |
| DHS | *See IDHS* |
| DHHS | Department of Health and Human Services |
| DIA | *See IDIA* |
| DIP | Document import processor |
| DME | Durable medical equipment |
| DO | Doctor of Osteopathy |

| Acronym | Definition |
|---|---|
| DPH | *See IDPH* |
| DRF | *See IDRF* |
| DRG | Diagnosis related groups |
| DSH | Disproportionate share hospital |
| DSS | Decision support system |
| DUA | Data use agreement |
| DUR | Drug utilization review |
| DW/DS | Data warehouse/decision support |
| EAC | Estimated acquisition cost |
| EDB | Enrollment database |
| EDI | Electronic data interchange |
| EEP | Extended enrollment period |
| EFT | Electronic funds transfer |
| EIN | Employer identification number |
| ELVS | Eligibility Verification System |
| EMC | Electronic media claim |
| EOB | Explanation of benefit |
| EPP | Extended participation period |
| EPSDT | Early and periodic screening, diagnosis, and treatment |
| EQRO | External quality review organization |
| ESLIMB or ESLMB | Expanded specified low-income Medicare beneficiaries |
| FACS | Family And Children's Services System, which is the payment and tracking system for protective services in Iowa, including family-centered, family foster care, foster group home care and family preservation services |
| FDA | Food and Drug Administration |
| FEIN | Federal employer identifying number |
| FFP | Federal financial participation |
| FFS | Fee for service |
| FIP | Family Investment Program, which is Iowa's TANF program |
| FIPS | Federal Information Processing Standards |
| FMAP | Family Medical Assistance Program |
| FPL | Federal poverty level |
| FQHC | Federally qualified health center |
| FTE | Full-time equivalent |

| Acronym | Definition |
|---|---|
| FUL | Federal upper limit |
| GAAP | Generally accepted accounting principle |
| GSD | General systems design |
| GUI | Graphical user interface |
| *hawk-i* | Healthy and Well Kids In Iowa, which is the name of the nonMedicaid portion of Iowa's Title XXI state children's health program. |
| HCBS | Home and community-based services waivers, of which Iowa has six for these situations: ill and handicapped, elderly, mentally retarded, physically disabled, brain injury, and AIDS/HIV. |
| HCFA-1500 | Health Care Financing Administration Form 1500, which is the form that CMS requires for claims from physicians and suppliers except for ambulance services |
| HCPCS | Healthcare Common Procedure Coding System |
| HEDIS® | Healthcare Effectiveness Data and Information Set, which is a set of standardized performance measures designed to ensure that purchasers and members have the information they need to reliably compare the performance of managed health care plans. |
| HIPAA | Health Insurance Portability and Accountability Act of 1996 |
| HIPDB | Health integrity protection data base |
| HIPP | Health insurance premium payment |
| HIT | Health information technology |
| HIV | Human immunodeficiency virus |
| HMO | Health maintenance organization |
| HRSA | Health Resource Services Administration |
| IABC | Iowa Automated Benefit Calculation System |
| IAC | Iowa Administrative Code |
| I-CAR | Individual Collections and Reporting |
| ICBS | Iowa County Billing System |
| ICD-9-CM | International Classification of Diseases, Ninth Edition, Clinical Modification |
| ICF | Intermediate care facility |
| ICF/MR | Intermediate care facility for the mentally retarded |
| ICN | Iowa Communications Network |
| ID | Identification (number) |
| IDAS | Iowa Department of Administrative Services *See DAS* |
| IDEA | Individual Disabilities Education Act |
| IDHS | Iowa Department of Human Services *See DHS* |
| IDIA | Iowa Department of Inspection and Appeals *See DIA* |
| IDPH | Iowa Department of Public Health |
| IDRF | Iowa Department of Revenue and Finance |

| Acronym | Definition |
|---|---|
| IFAS | Iowa Financial Accounting System |
| IFMC | Iowa Foundation for Medical Care |
| IGT | Intergovernmental transfer |
| IME | Indirect medical education |
| I-MERS | Iowa Medicaid Electronic Record System |
| IMW | Income maintenance worker (referred to as eligibility worker in some states) |
| Iowa Plan | The Iowa Plan for Behavioral Health (Iowa Plan), which is Iowa's statewide, managed behavioral health plan for mental health and substance abuse treatment services. |
| IPIA | Improper Payments Information Act of 2002 |
| IandSS | Implementation and support services |
| ISIS | Individualized Service Information System |
| ITE | Information technology enterprise |
| IV-E | Title IV-E that provides federal funding for FIP foster care and adoption subsidy |
| JCAHO | Joint Commission on Accreditation of Healthcare Organizations |
| LAN | Local area network |
| LEA | Local education agency |
| LI or lock-in | A special program administered by the Department for Medicaid members who have overutilized Medicaid services and who are issued a special identification card and assigned to a select group of lock-in providers to control claims |
| LOC | Level of care |
| LOS | Length of stay |
| LSO | Limited service organization |
| LTC | Long-term care |
| MAC | Maximum allowable cost |
| MAR | Management and administrative reporting |
| MARS | Management and Administrative Reporting Subsystem |
| MCO | Managed care organization, which the Department uses to describe HMOs and MediPASS providers |
| MD | Doctor of Medicine |
| MDC | Multiple description coding |
| MDS | Minimum data set |
| Medically needy | The program that provides medical assistance to individuals who meet the categorical but not the financial criteria for Medicaid eligibility and who may be responsible for a portion of their medical expenses in the amount referenced as their spend-down obligation |
| Medicare buy-in | Premium payments made to CMS on behalf of Iowa Medicaid members who are eligible for Medicare |
| MediPASS | Medicaid Patient Access to Service System, which is Iowa's PCCM program |
| MEPD | Medicaid for employed people with disabilities |

| Acronym | Definition |
|---|---|
| MEQC | Medicaid eligibility quality control |
| MEVS | Medicaid Eligibility Verification System |
| MFCU | Medicaid Fraud Control Unit, which is the Iowa business unit responsible for conducting federally-required Medicaid Provider Fraud Control Unit (MPFCU) activities as well as state-sponsored member fraud control activities |
| MHC | Managed health care |
| MHCAC | Managed health care advisory committee |
| MHEP | Member Health Education Program |
| MHI | Mental health institution |
| MIG | Medicaid integrity group |
| MIPS | Medicaid IowaCare Premium System |
| MITA | Medicaid Information Technology Architecture |
| MMIS | Medicaid Management Information System |
| MQC | Medicaid quality control program |
| MQUIDS | Medicaid Quality Utilization and Improvement Data System |
| MR | Mentally retarded (developmentally disabled) |
| MSIS | Medicaid Statistical Information System |
| MVM | Medicaid Value Management |
| NABP | National Association of Boards of Pharmacy |
| NCQA | National Committee for Quality Assurance |
| NDC | National Drug Code |
| NF | Nursing facility |
| NF-MI | Nursing facility for the mentally ill *See Specialty NF-MI* |
| NIPS | Noninpatient services |
| NOD | Notice of decision |
| NPI | National provider identifier number |
| NPDB | National provider data base |
| OCR | Optical character recognition |
| OIG | Office of the Inspector General, which is the federal authority for identifying and investigating instances of fraud and abuse for state Medicaid programs |
| Online | Accessible via a computer system or computer network |
| Operations phase | The contract phase in which contractors assume and maintain live operation of a Medicaid function from a current contractor or the state and in which incumbent contractors begin operation of newly implemented enhancements, services or features |
| OTC | Over the counter |
| PA | Prior authorization |

| Acronym | Definition |
|---|---|
| PACE | Program of All-Inclusive Care for the Elderly |
| PASRR | Preadmissions Screening and Resident Review |
| Pay and chase | The portion of funds paid to a provider for member services that are recoverable from liable third parties |
| PC | Personal computer |
| PCCM | Primary care case management, which is MediPASS in Iowa, in which providers are paid on a fee-for-service basis with an addition premium paid for care management |
| PCP | Primary care physician |
| PDD | Procedure, drug, and diagnosis |
| PDDDA | Procedure, drug, diagnosis, DRG and APG file |
| PDL | Preferred drug list |
| PERM | Payment error rate measurement |
| PIN | Personal identification number |
| PMIC | Psychiatric medical institutions for children |
| PMF | Provider master file |
| POS | Point-of-sale |
| PRO | Peer review organization |
| ProDUR | Prospective drug utilization review |
| P and T | Pharmaceutical and therapeutics |
| QA/UR | Quality assurance/utilization review |
| QDWP | Qualified disabled working person |
| QIO | Quality improvement organization |
| QMB | Qualified Medicare beneficiary |
| RA | Remittance advice |
| RBRVS | Resource-based relative value scale |
| RCF | Residential care facility |
| RCF/MR | Residential care facility for the mentally retarded |
| REOMB | Recipient explanation of Medicaid benefit *See EOB* |
| RetroDUR | Retrospective drug utilization review |
| REVS | Recipient Eligibility Verification System |
| RFI | Request for information |
| RFP | Request for proposal |
| RHC | Rural health clinic |
| RHEP | See MHEP |
| RTS | Rehabilitative treatment services |

| Acronym | Definition |
|---|---|
| RUG | Resource utilization group |
| RVS | Relative value scale (or schedule) |
| SCHIP | See CHIP. |
| SDX | State data exchange |
| SFY | State fiscal year |
| SID | State identification number |
| SIQ | Supplemental insurance questionnaire |
| SLA | Service-level agreement |
| SLIMB or SLMB | Specified low-income Medicare beneficiary |
| SLTF | Senior living trust fund |
| SMAC | State maximum allowable cost |
| SNF | Skilled nursing facility |
| SQL | Structured (or system) query language |
| Specialty NF-MI | Specialty nursing facilities for the mentally ill |
| Spend-down amount | The portion of their medical expenses that individuals must pay themselves if they meet the categorical but not the financial criteria for Medicaid eligibility |
| SSA | Social Security Administration |
| SSBI | Social Security Buy-In |
| SSI | Supplemental security income |
| SSN | Social Security number |
| Supplemental DSH | Supplemental disproportionate share hospitals, which is a reimbursement program that makes supplemental payment adjustments to qualifying DSH facilities in addition to the standard base payments for the purpose of further assisting hospitals that treat a disproportionate share of Iowa Medicaid members and other low-income families |
| Supplemental IME | Supplemental indirect medical education, which was created in the Balanced Budget Act of 1997 to provide supplemental payment to teaching hospitals for operating indirect medical education to help cover the increased operating or patient care costs that are associated with approved intern and resident programs |
| SUR | Surveillance and utilization review |
| SURS | Surveillance and Utilization Review Subsystem |
| TANF | Temporary Aid for Needy Families Program |
| TCM | Targeted case management |
| TCN | Transaction control number that is used to uniquely identify documents |
| TDD | Telecommunications device for the deaf |
| Title XIX | Title XIX of the Social Security Act, which established the state Medicaid programs |
| Title XVIII | Title 18 of the Social Security Act, which established the Medicare program |
| Title XXI | Title XXI of the Social Security Act, which provides funds to states to initiate and expand the provision of child health assistance to uninsured, low-income children |

| Acronym | Definition |
|---|---|
| TPA | Third-party administrator |
| TPL | Third-party liability |
| Turnover phase | The final phase of a contract in which the incumbent contractor turns over operations to a new contractor |
| UB-92 | Universal Billing Form 92 that CMS requires institutional and other selected providers to use to bill for inpatient services. |
| UPIN | Universal provider identification number |
| UPL | Upper payment limit |
| UR | Utilization review |
| USPS | United States Postal Services |
| Usual and Customary | The amount that a provider typically bills for a particular drug or service |
| WAC | Wholesale acquisition cost |
| Waiver programs | *See HCBS* |
| Work plan | The tasks and subtasks, duration, resources, milestones, deliverables, and their associated estimated and actual start and finish dates |
| X12 270/271 | ANSI ASC X12 270/271 transaction, which refers to the HIPAA healthcare eligibility benefit inquiry and response transactions |
| X12 275 | ANSI ASC X12 275 transaction, which refers to the HIPAA claims attachment transaction |
| X12 276/277 | ANSI ASC X12 276/277 transaction, which refers to the HIPAA healthcare claims status request and response transactions |
| X12 278 | ANSI ASC X12 278 transaction, which refers to the HIPAA referral certification and prior authorization requests transaction |
| X12 820 | ANSI ASC X12 820 transaction, which refers to the HIPAA premium payment transaction |
| X12 834 | ANSI ASC X12 834 transaction, which refers to the HIPAA HMO enrollment and disenrollment transaction |
| X12 835 | ANSI ASC X12 835 transaction, which refers to the HIPAA claims payment and remittance advice transaction |
| X12 837 | ANSI ASC X12 837 transaction, which refers to the HIPAA healthcare claim or encounter transaction |

# Attachment B: Proposal Certification

## PROPOSAL CERTIFICATION

### BIDDERS – SIGN AND SUBMIT CERTIFICATION WITH PROPOSAL.

I certify that I have the authority to bind the bidder indicated below to the specific terms, conditions and technical specifications required in the Department's Request for Proposal (RFP) and offered in the bidder's proposal. I understand that by submitting this bid proposal, the bidder indicated below agrees to provide services described in the Iowa Medicaid Enterprise Program Integrity Procurement RFP which meet or exceed the requirements of the Department's RFP unless noted in the bid proposal and at the prices quoted by the bidder.

I certify that the contents of the bid proposal are true and accurate and that the bidder has not made any knowingly false statements in the bid proposal.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

# Attachment C: Certification of Independence and No Conflict of Interest

## CERTIFICATION OF INDEPENDENCE AND NO CONFLICT OF INTEREST

By submission of a bid proposal, the bidder certifies (and in the case of a joint proposal, each party thereto certifies) that:

a. the bid proposal has been developed independently, without consultation, communication or agreement with any employee or consultant of the Department who has worked on the development of this RFP, or with any person serving as a member of the evaluation committee;

b. the bid proposal has been developed independently, without consultation, communication or agreement with any other bidder or parties for the purpose of restricting competition;

c. unless otherwise required by law, the information in the bid proposal has not been knowingly disclosed by the bidder and will not knowingly be disclosed prior to the award of the contract, directly or indirectly, to any other bidder;

d. no attempt has been made or will be made by the bidder to induce any other bidder to submit or not to submit a bid proposal for the purpose of restricting competition;

e. no relationship exists or will exist during the contract period between the bidder and the Department that interferes with fair competition or is a conflict of interest.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

# Attachment D: Certification Regarding Debarment Suspension Ineligibility and Voluntary Exclusion

## CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION -- LOWER TIER COVERED TRANSACTIONS

By signing and submitting this Proposal, the bidder is providing the certification set out below:

1. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the bidder knowingly rendered an erroneous certification, in addition to other remedies available to the federal government the Department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
2. The bidder shall provide immediate written notice to the person to whom this Proposal is submitted if at any time the bidder learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.
3. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principle, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this Proposal is submitted for assistance in obtaining a copy of those regulations.
4. The bidder agrees by submitting this Proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the Department or agency with which this transaction originated.
5. The bidder further agrees by submitting this Proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
6. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. A participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Nonprocurement Programs.
7. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The

knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

8. Except for transactions authorized under paragraph 4 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the federal government, the Department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

## CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND/OR VOLUNTARY EXCLUSION--LOWER TIER COVERED TRANSACTIONS

(1) The bidder certifies, by submission of this Proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.

(2) Where the bidder is unable to certify to any of the statements in this certification, such bidder shall attach an explanation to this Proposal.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

# Attachment E: Authorization to Release Information

## AUTHORIZATION TO RELEASE INFORMATION

_____ (name of bidder) hereby authorizes any person or entity, public or private, having any information concerning the bidder's background, including but not limited to its performance history regarding its prior rendering of services similar to those detailed in this RFP, to release such information to the Department.

The bidder acknowledges that it may not agree with the information and opinions given by such person or entity in response to a reference request. The bidder acknowledges that the information and opinions given by such person or entity may hurt its chances to receive contract awards from the Department or may otherwise hurt its reputation or operations. The bidder is willing to take that risk. The bidder agrees to release all persons, entities, the Department, and the Department of Iowa from any liability whatsoever that may be incurred in releasing this information or using this information.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

# Attachment F: Certification Regarding Registration, Collection and Remission of State Sales and Use Taxes

**CERTIFICATION REGARDING REGISTRATION, COLLECTION, AND REMISSION OF STATE SALES AND USE TAX**

By submitting a proposal in response to this Request for Proposal (RFP), the undersigned certifies the following: (check the applicable box):

☐ _____ [name of vendor] is registered or agrees to become registered if awarded the contract, with the Iowa Department of Revenue, and will collect and remit Iowa Sales and use taxes as required by Iowa Code chapter 423; or

☐ _____ [name of vendor] is not a "retailer" or a "retailer maintaining a place of business in the state" as those terms are defined in Iowa Code §§ 423.1(42) & (43) (2005).

_____ [name of vendor] also acknowledges that the Department may declare the Vendor's bid or resulting contract void if the above certification is false. The Vendor also understands that fraudulent certification may result in the Department or its representative filing for damages for breach of contract.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

# Attachment G: Certification of Compliance with Pro-Children Act of 1994

## CERTIFICATION OF COMPLIANCE WITH PRO-CHILDREN ACT OF 1994

The Contractor must comply with Public Law 103-227, Part C Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act). This Act requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees, and contracts. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities (other than clinics) where WIC coupons are redeemed.

The Contractor further agrees that the above language will be included in any subawards that contain provisions for children's services and that all subgrantees shall certify compliance accordingly. Failure to comply with the provisions of this law may result in the imposition of a civil monetary penalty of up to $1000 per day.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

# Attachment H: Certification Regarding Lobbying

## CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

a. No federal appropriated funds have been paid or will be paid on behalf of the Sub-Grantee to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of the Congress, an officer or employee of the Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan or cooperative agreement.

b. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of the Congress, or an employee of a Member of Congress in connection with this Contract, grant, loan, or cooperative agreement, the applicant shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

c. The Contractor shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C.A. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

# Attachment I: Business Associate Agreement

The following pages provide the Business Associate Agreement.

## ADDENDUM: Business Associate Agreement

THIS ADDENDUM supplements and is made a part of the Iowa Department of Human Services ("Agency") Contract (hereinafter, the "Underlying Agreement") between the Agency and the Contractor ("the Business Associate").

1. **Purpose.**
   The Business Associate performs certain services on behalf of or for the Agency pursuant to the Underlying Agreement that require the exchange of information about patients that is protected by the Health Insurance Portability and Accountability Act of 1996, as amended by Subtitle D of the Health Information Technology for Economic and Clinical Health Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5) (the "HITECH Act") and the federal regulations published at 45 C.F.R. parts 160 and 164 (collectively "HIPAA"). The Agency is a "Covered Entity" as that term is defined in HIPAA, and the parties to the Underlying Agreement are entering into this Addendum to establish the responsibilities of both parties regarding HIPAA-covered information and to bring the Underlying Agreement into compliance with HIPAA.

2. **Definitions.**
   Unless otherwise provided in this Addendum, capitalized terms have the same meanings as set forth in HIPAA.

3. **Obligations of Business Associate.**
   *a. Security Obligations.* Sections 164.308, 164.310, 164.312 and 164.316 of title 45, Code of Federal Regulations, apply to the Business Associate in the same manner that such sections apply to the Agency. The Business Associate's obligations include but are not limited to the following:
   - Implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that the Business Associate creates, receives, maintains, or transmits on behalf of the covered entity as required by HIPAA;
   - Ensuring that any agent, including a subcontractor, to whom the Business Associate provides such information agrees to implement reasonable and appropriate safeguards to protect the data; and
   - Reporting to the Agency any security incident of which it becomes aware.

   *b. Privacy Obligations.* To comply with the privacy obligations imposed by HIPAA, Business Associate agrees to:
   - Not use or further disclose information other than as permitted or required by the Underlying Agreement, this Addendum, or as required by law;
   - Abide by any Individual's request to restrict the disclosure of Protected Health Information consistent with the requirements of Section 13405(a) of the HITECH Act;
   - Use appropriate safeguards to prevent use or disclosure of the information other than as provided for by the Underlying Agreement and this Addendum;
   - Report to the Agency any use or disclosure of the information not provided for by the Underlying Agreement of which the Business Associates becomes aware;
   - Ensure that any agents, including a subcontractor, to whom the Business Associate provides Protected Health Information received from the Agency or created or received

by the Business Associate on behalf of the Agency agrees to the same restrictions and conditions that apply to the Business Associate with respect to such information;

- Make available to the Agency within ten (10) days Protected Health Information to comply with an Individual's right of access to their Protected Health Information in compliance with 45 C.F.R. § 164.524 and Section 13405(f) of the HITECH Act;
- Make available to the Agency within fifteen (15) days Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. § 164.526;
- Make available to the Agency within fifteen (15) days the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528 and Section 13405(c) of the HITECH Act;
- Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Agency, or created or received by the Business Associate on behalf of the Agency, available to the Secretary for purposes of determining the Agency's compliance with HIPAA;
- To the extent practicable, mitigate any harmful effects that are known to the Business Associate of a use or disclosure of Protected Health Information or a Breach of Unsecured Protected Health Information in violation of this Addendum;
- Use and disclose an Individual's Protected Health Information only if such use or disclosure is in compliance with each and every applicable requirement of 45 C.F.R. § 164.504(e);
- Refrain from exchanging any Protected Health Information with any entity of which the Business Associate knows of a pattern of activity or practice that constitutes a material breach or violation of HIPAA or this Addendum;
- To comply with Section 13405(b) of the HITECH Act when using, disclosing, or requesting Protected Health Information in relation to this Addendum by limiting disclosures as required by HIPAA;
- Refrain from receiving any remuneration in exchange for any Individual's Protected Health Information unless (1) that exchange is pursuant to a valid authorization that includes a specification of whether the Protected Health Information can be further exchanged for remuneration by the entity receiving Protected Health Information of that Individual, or (2) satisfies one of the exceptions enumerated in Section 13405(e)(2) of the HITECH Act or HIPAA regulations; and
- Refrain from marketing activities that would violate HIPAA, specifically Section 13406 of the HITECH Act.

c. *Permissive Uses.* The Business Associate may use or disclose Protected Health Information that is disclosed to it by the Agency under the following circumstances:

- Business Associate may use the information for its own management and administration and to carry out the legal responsibilities of the Business Associate.
- Business Associate may disclose the information for its own management and administration and to carry the legal responsibilities of the Business Associate if (1) the disclosure is required by law, or (2) the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

*d. Breach Notification.* In the event that the Business Associate discovers a Breach of Unsecured Protected Health Information, the Business Associate agrees to take the following measures within 30 calendar days after the Business Associate first becomes aware of the incident:

- To notify the Agency of any incident involving the acquisition, access, use or disclosure of Unsecured Protected Health Information in a manner not permitted under 45 C.F.R. part E. Such notice by the Business Associate shall be provided without unreasonable delay, except where a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security. For purposes of clarity for this provision, Business Associate must notify the Agency of any such incident within the above timeframe even if Business Associate has not conclusively determined within that time that the incident constitutes a Breach as defined by HIPAA. For purposes of this Addendum, the Business Associate is deemed to have become aware of the Breach as of the first day on which such Breach is known or reasonably should have been known to such entity or associate of the Business Associate, including any person, other than the individual committing the Breach, that is an employee, officer or other agent of the Business Associate or an associate of the Business Associate;
- To include the names of the Individuals whose Unsecured Protected Health Information has been, or is reasonably believed to have been, the subject of a Breach;
- To complete and submit the Breach Notice form to the Agency (see Exhibit A); and
- To include a draft letter for the Agency to utilize to notify the Individuals that their Unsecured Protected Health Information has been, or is reasonably believed to have been, the subject of a Breach. The draft letter must include, to the extent possible:
    1. A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;
    2. A description of the types of Unsecured Protected Health Information that were involved in the Breach (such as full name, Social Security Number, date of birth, home address, account number, disability code, or other types of information that were involved);
    3. Any steps the Individuals should take to protect themselves from potential harm resulting from the Breach;
    4. A brief description of what the Agency and the Business Associate are doing to investigate the Breach, to mitigate losses, and to protect against any further Breaches; and
    5. Contact procedures for Individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, web site, or postal address.

**4. Addendum Administration.**

*a. Termination.* The Agency may terminate this Addendum for cause if the Agency determines that the Business Associate or any of its subcontractors or agents has breached a material term of this Addendum. Termination of either the Underlying Agreement or this Addendum shall constituted termination of the corresponding agreement.

*b. Effect of Termination.* At termination of the Underlying Agreement or this Addendum, the Business Associate shall return or destroy all Protected Health Information received or created in connection with this Underlying Agreement, if feasible. If such return or destruction is not feasible, the Business Associate will extend the protections of this Addendum to the Protected Health Information and limit any further uses or disclosures. The Business Associate will provide the Agency in writing a description of why return or destruction of the information is not feasible.

*c.* *Compliance with Confidentiality Laws.* Business Associate acknowledges that it must comply with all laws that may protect the Protected Health Information received and will comply with all such laws, which include but are not limited to the following:

- *Medicaid applicants and recipients*: 42 U.S.C. § 1396a(a)(7); 42 C.F.R. §§ 431.300 - .307; Iowa Code § 217.30;
- *Mental health treatment*: Iowa Code chapters 228, 229;
- *HIV/AIDS diagnosis and treatment*: Iowa Code § 141A.9; and
- *Substance abuse treatment:* 42 U.S.C. § 290dd-3; 42 U.S.C. § 290ee-3; 42 C.F.R. part 2; Iowa Code §§ 125.37, 125.93.

*d.* *Indemnification for Breach Notification.* Business Associate shall indemnify the Agency for costs associated with any incident involving the acquisition, access, use or disclosure of Unsecured Protected Health Information in a manner not permitted under 45 C.F.R. part E.

*e.* *Amendment.* The Agency and the Business Associate agree to take such action as is necessary to amend this Addendum from time to time as is necessary for the Business Associate to comply with the requirements of HIPAA.

*f.* *Survival.* The obligations of the Business Associate shall survive this Addendum's termination.

*g.* *No Third Party Beneficiaries.* There are no third party beneficiaries to this agreement between the parties. The Underlying Agreement and this Addendum are intended to only benefit the parties to the agreement.

*h.* *Effective Date.* This Addendum is effective as of the Underlying Agreement's Effective Date.

## EXHIBIT A: NOTIFICATION TO THE AGENCY OF BREACH OF UNSECURED PROTECTED HEALTH INFORMATION

NOTE: The Business Associate must use this form to notify the Agency of any Breach of Unsecured Protected Health Information. Immediately provide a copy of this completed form to (1) the Contract Manager, in compliance with the Notice Requirements of the Underlying Agreement, and (2) the Agency Security and Privacy Officer at:

Iowa Department of Human Services
Attn: Security & Privacy Officer
1305 E. Walnut, 1st Floor, DDM
Des Moines, IA 50319

| Contract Information | |
|---|---|
| **Contract Number** | **Contract Title** |
| | |

| Contractor Contact Information | |
|---|---|
| **Contact Person for this Incident:** | |
| **Contact Person's Title:** | |
| **Contact's Address:** | |
| **Contact's E-mail:** | |
| **Contact's Telephone No.:** | |

Business Associate hereby notifies the Agency that there has been a Breach of Unsecured (unencrypted) Protected Health Information that Business Associate has used or has had access to under the terms of the Business Associate Agreement, as described in detail below:

| Breach Details | |
|---|---|
| **Date of Breach** | **Date of Discovery of Breach** |
| | |
| **Detailed Description of the Breach** | |
| | |
| **Types of Unsecured Protected Health Information involved in the Breach (such as full name, SSN, Date of Birth, Address, Account Number, Disability Code, etc).** | |
| | |
| **What steps are being taken to investigate the breach, mitigate losses, and protect against any further breaches?** | |
| | |
| **Number of Individuals Impacted** | **If over 500, do individuals live in multiple states?** |
| | YES \| NO |

**Signature:** _____ **Date:** _____

# Attachment J: Proposal Certification of Available Resources

**PROPOSAL CERTIFICATION OF AVAILABLE RESOURCES**
**BIDDERS – SIGN AND SUBMIT CERTIFICATION WITH PROPOSAL.**

I certify that the bidder organization indicated below has sufficient personnel resources available to provide all services proposed by this Bid Proposal. I duly certify that these personnel resources for the contract awarded will be available on and after July 1, 2010.

In the event that we, the bidder, have bid more than one component contract specified by this RFP, my signature below also certifies that the personnel bid for this component Bid Proposal are not personnel for any other component Bid Proposal. If my organization is awarded more than one component, I understand that the State may agree to shared resource allocation if the bidder can prove feasibility of shared resource.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

# Attachment K: Resource Library Content

The documents listed below are available in the Iowa Medicaid Enterprise resource library located at *www.ime.state.ia.us*

a. RFP MED 04-015 Systems and Professional Services for the Iowa Medicaid Enterprise
   1. IME Bidders Proposals
   2. IME Contracts
   3. Quarterly Reports (SFY 06, 07, 08, 09)

b. RFP MED 04-034 Medical Services with Preferred Drug List
   1. IME Bidders Proposals
   2. IME Contract
   3. Quarterly Reports (SFY 06, 07, 08, 09)

c. RFP MED 04-037 Implementation and Support Services
   1. IME Bidders Proposals
   2. IME Contract
   3. Quarterly Reports (SFY 06, 07, 08, 09)

d. RFP MED 04-085 Medicaid Claims Payment Support Services
   1. IME Bidders Proposals
   2. IME Contract

e. RFP MED 09-010 Iowa Plan for Behavioral Health
   1. IME Bidders Proposals
   2. IME Contract

f. RFP MED 09-006 Technical Assistance and Support for Iowa Medicaid Enterprise Services Procurement
   1. IME Bidders Proposals
   2. IME Contracts

g. RFP MED 09-016 Claims Editing and Correct Coding Initiative (CCI)
   1. IME Bidders Proposals
   2. IME Contract

h. IME Policies
   1. Iowa Administrative Code
   2. State Medicaid Plan

i. IME Operational Procedures
   1. Provider Services

2. Member Services
3. Pharmacy Medical Services
4. Medical Services
5. Pharmacy POS
6. Revenue Collections (includes Estate Recovery currently)
7. Data Warehouse
8. Core MMIS
9. SURS
10. Provider Cost Audits and Rate Setting (PCA)

j. IME Operational Tools:
   1. OnBase
   2. Mailroom-verification/scanning
   3. MQUIDS
   4. Data Warehouse
   5. Decision Support Documentation
   6. MMIS Valid Values Booklet (Iowa Medicaid Guide)

k. Provider Manuals

l. Provider Information Releases

m. Workflow Process Maps

n. System Interface Diagram

o. Iowa Department of Human Services, Division of Medical Services, Iowa Medicaid Enterprise Table of Organization

p. Iowa Medicaid Workload Statistics

q. Consumer Directed Attendant Care (CDAC) Memorandum of Understanding (MOU)

r. Quarterly Revenue Summary Reports (SFY 06, 07, 08, 09)

# Attachment L: Bid Proposal Mandatory Requirements Checklist

The Department has provided the following template to submit with the Technical Proposal. Bidders are expected to confirm compliance by marking the “Yes” box in the “Bidder Check” column. Upon receipt of bid proposals, the Department will confirm compliance by marking “Yes” in the “DHS Check” column. Bidders’ failure to complete mandatory requirements will result in the bidders’ disqualification for this procurement as described in RFP Section 2.15 Disqualification.

**Figure 11: Mandatory Requirements Checklist**

| Bidder Check | Requirement | Confirmed by DHS |
|---|---|---|
| ☐ Yes<br>☐ No | 1. Did the issuing officer receive the bid proposal by 3:00 p.m., Central Time, on the date specified in RFP Section 2.1 Procurement Timetable? | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 2. Does each bid proposal consist of three distinct parts? | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | a. Technical Proposal | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | b. Cost Proposal | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | c. Company Financial Information | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 3. Is each bid proposal sealed in a box (or boxes), with the Cost Proposal and Company Financial Information volumes sealed in separate, labeled envelopes inside the same box or boxes? | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 4. Are packing boxes numbered in the following fashion: 1 of 4, 2 of 4, and so forth for each bid proposal that consists of multiple boxes? | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 5. Are all boxes containing bids labeled with the following information? | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | a. Bidder's name and address | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | b. Issuing officer and department's address as identified by RFP Section 7.1.d.2 | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | c. RFP title (Iowa Medicaid Enterprise Program Integrity Procurement) and RFP reference number (MED-10-013) | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | d. RFP component name specified as Program Integrity | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 6. Are separate boxes utilized for each bid proposal if submitting bid proposals for more than one of the individual contract awards? | ☐ Yes<br>☐ No |

| Bidder Check | Requirement | Confirmed by DHS |
|---|---|---|
| ☐ Yes<br>☐ No | 7. Are all bid proposal materials printed on 8.5" x 11" paper (two-sided)? | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 8. Is Technical Proposal presented in a spiral, comb, or pasteboard binder separate from the sealed Cost Proposal and Company Financial Information volumes?<br>(Note: Technical Proposals in 3-ring binders will not be accepted.) | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 9. Is each Cost Proposal in a spiral, comb, or pasteboard binder separate from the sealed Technical Proposal and Company Financial Information volumes?<br>(Note: This status will be determined when Cost Proposals are opened after Technical Proposals have been evaluated. 3-ring binders will not be accepted ) | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 10. Is each Company Financial Information in a spiral binder, or comb, or pasteboard binder separate from the sealed Technical Proposal and Cost Proposal volumes?<br>(Note: This status will be determined when Company Financial Information volumes are opened for the financial viability screening. 3-ring binders will not be accepted ) | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 11. Is one sanitized copy of the proposal volumes and Company Financial Information included if any bid proposal information is designated as confidential?<br>(Note: Bidders cannot designate their entire proposal as confidential or proprietary.) | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 12. Does each Technical Proposal package include: | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | a. One original | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | b. Eight copies | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | c. One sanitized copy (if applicable) in a separate binder (or set of binders) | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | d. Are the original, copies, and sanitized copy correctly marked? | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 13. Does each Cost Proposal package include: | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | a. One original | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | b. Eight copies | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | c. One sanitized copy of Cost Proposal in separate, sealed envelope | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | d. Are the original, copies and sanitized copy correctly marked? | ☐ Yes<br>☐ No |

| Bidder Check | Requirement | Confirmed by DHS |
|---|---|---|
| ☐ Yes<br>☐ No | 14. Does each Company Financial Information package contain one original of Company Financial Information (in a separate sealed envelope)?<br>(Note: This status will be determined when Company Financial Information volumes are opened for the financial viability screening.) | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 15. Are all bid proposals also submitted on CD-ROM copies per bid proposal? | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 16. Does one submitted CD-ROM contain one full version of the Technical Proposal and Cost Proposal and the other submitted CD-ROM contain one sanitized version of the Technical Proposal and Cost Proposal? | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 17. Are all electronic files in read-only PDF format? | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 18. Are all electronic files individually identified by: | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | a. Component name | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | b. Bid proposal part (technical, cost, or company financial information) | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | c. Status (original, copy or sanitized) | ☐ Yes<br>☐ No |
| | **Technical Proposal Content** | |
| ☐ Yes<br>☐ No | 19. Does each Technical Proposal consist of the following sections separated by tabs with associated documents and responses presented in the following order? | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | a. Table of Contents (Tab 1) | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | b. Transmittal Letter (Tab 2) | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | c. Checklists and Cross-References (Tab 3) | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | d. Executive Summary (Tab 4) | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | e. General Requirements (Tab 5) | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | f. Program Integrity (Tab 6) | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | g. Project Plan (Tab 7) | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | h. Project Organization (Tab 8) | ☐ Yes<br>☐ No |

| Bidder Check | Requirement | Confirmed by DHS |
|---|---|---|
| ☐ Yes ☐ No | i. Corporate Qualifications (Tab 9) | ☐ Yes ☐ No |
| ☐ Yes ☐ No | 20. Does the Table of Contents in Tab 1 of the Technical Proposal identify all sections, subsections, and corresponding page numbers? | ☐ Yes ☐ No |
| ☐ Yes ☐ No | 21. Does the Transmittal Letter in Tab 2 include the following? | ☐ Yes ☐ No |
| ☐ Yes ☐ No | a. The bidder's mailing address | ☐ Yes ☐ No |
| ☐ Yes ☐ No | b. Electronic mail address, fax number, and telephone number for both the authorized signer and the point of contact designated by the bidder | ☐ Yes ☐ No |
| ☐ Yes ☐ No | c. A statement indicating that the bidder is a corporation or other legal entity | ☐ Yes ☐ No |
| ☐ Yes ☐ No | d. Identification of all subcontractors and a statement included that indicates the exact amount of work to be done by the prime contractor and each subcontractor, as measured by a percentage of the total work? | ☐ Yes ☐ No |
| ☐ Yes ☐ No | e. No actual price information | ☐ Yes ☐ No |
| ☐ Yes ☐ No | f. A statement confirming that the prime contractor is registered or agrees to register to do business in Iowa and providing the corporate charter number (if currently issued), along with assurances that any subcontractor proposed is also licensed or will become licensed to work in Iowa | ☐ Yes ☐ No |
| ☐ Yes ☐ No | g. A statement identifying the bidder's federal tax identification number | ☐ Yes ☐ No |
| ☐ Yes ☐ No | h. A statement that the bidder will comply with all contract terms and conditions as indicated in this RFP | ☐ Yes ☐ No |
| ☐ Yes ☐ No | i. A statement that no attempt has been made or will be made by the bidder to induce any other person or firm to submit or not to submit a proposal | ☐ Yes ☐ No |
| ☐ Yes ☐ No | j. A statement of affirmative action that the bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap | ☐ Yes ☐ No |
| ☐ Yes ☐ No | k. A statement that no cost or pricing information has been included in this letter or the Technical Proposal | ☐ Yes ☐ No |
| ☐ Yes ☐ No | l. A statement identifying all amendments to the RFP issued by the state and received by the bidder. (Note: If no amendments have been received, a statement to that effect shall be included.) | ☐ Yes ☐ No |
| ☐ Yes ☐ No | m. A statement that the bidder certifies in connection with this procurement that: | ☐ Yes ☐ No |
| ☐ Yes ☐ No | n. The prices proposed have been arrived at independently, with consultation, communication, or agreement, as to any matter relating to such prices with any other bidder or any competitor for the purpose of restricting competition; and | ☐ Yes ☐ No |

| Bidder Check | Requirement | Confirmed by DHS |
|---|---|---|
| ☐ Yes<br>☐ No | o. Unless otherwise required by law, the prices quoted have not been knowingly disclosed by the bidder prior to award, directly or indirectly, to any other bidder or to any competitor | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | p. A statement that the person signing this proposal certifies that he/she is the person in the bidder's organization responsible for or authorized to make decisions regarding the prices quoted and that he/she has not participated and will not participate in any action contrary to items m, n and o | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | q. A statement that the submitted Bid Proposal Security shall guarantee the availability of the services as described throughout the bid proposal. | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | r. A statement that the bidder acknowledges the acceptance of all term and conditions stated in the RFP. | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 22. If the use of subcontractors is proposed, a statement from each subcontractor must be appended to the transmittal letter signed by an individual authorized to legally bind the subcontractor stating: | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | a. The general scope of work to be performed by the subcontractor | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | b. The subcontractor's willingness to perform the work indicated; and | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | c. The subcontractor's assertion that it does not discriminate in employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 23. Any request for confidential treatment of information shall also be identified in the transmittal letter, in addition to the specific statutory basis supporting the request and an explanation why disclosure of the information is not in the best interest of the public | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 24. The name, address and telephone number of the individual authorized to respond tothe Department about the confidential nature of the information (if applicable) | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 25. Is a completed copy of the Checklist and Cross-References included in Tab 3? | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | a. Mandatory Requirements Checklist | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | b. General Requirements Cross-Reference | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | c. Program Integrity Requirements Cross-Reference | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 26. Is a General Requirements Cross-Reference in Tab 3 included for each Technical Proposal under consideration based upon the sample provided in RFP Section 9? | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 27. Is a Program Integrity Requirements Cross-Reference in Tab 3 included for each Technical Proposal under consideration based upon the sample provided in RFP Section 9? | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 28. Are requirements numbers listed above the paragraph or set of paragraphs for all addressed requirements in? | ☐ Yes<br>☐ No |

| Bidder Check | Requirement | Confirmed by DHS |
|---|---|---|
| ☐ Yes ☐ No | 29. Does information in Tab 9 (Contractor Qualifications) include the following? | ☐ Yes ☐ No |
| ☐ Yes ☐ No | a. Description of the Contractor Organization (Section 7.2.9.1) | ☐ Yes ☐ No |
| ☐ Yes ☐ No | b. Description of the Contractor Experience (Section 7.2.9.2) | ☐ Yes ☐ No |
| ☐ Yes ☐ No | c. Contractor References (Section 7.2.9.3) | ☐ Yes ☐ No |
| ☐ Yes ☐ No | d. A signed copy of each of Attachments B through J inclusive with signature from an individual authorized to bind the company. | ☐ Yes ☐ No |
| | **Cost Proposal Content** | |
| ☐ Yes ☐ No | 30. Does the Cost Proposal include the following sections: | ☐ Yes ☐ No |
| ☐ Yes ☐ No | a. Table of Contents (Tab 1) | ☐ Yes ☐ No |
| ☐ Yes ☐ No | b. Bid Proposal Security (Tab 2) | ☐ Yes ☐ No |
| ☐ Yes ☐ No | c. Pricing Schedules (Tab 3) | ☐ Yes ☐ No |
| ☐ Yes ☐ No | 31. Does Tab 1 include a Table of Contents of the Cost Proposal? | ☐ Yes ☐ No |
| ☐ Yes ☐ No | 32. Does the Table of Contents identify all sections, subsections, and corresponding page numbers? | ☐ Yes ☐ No |
| ☐ Yes ☐ No | 33. Is a proposal bid bond or proposal guarantee in the form of a cashier's check, certified check, bank draft, treasurer's check, bond or a original letter of credit payable to DHS in an amount equal to five percent of the total implementation and operations costs identified by Pricing Schedule N of the Cost Proposal included in Tab 2? | ☐ Yes ☐ No |
| ☐ Yes ☐ No | 34. Are photocopies of the proposal bid bond included in Tab 2 in all other copies of the Cost Proposal submitted by the bidder? | ☐ Yes ☐ No |
| ☐ Yes ☐ No | 35. If a bond is used, is it issued by a surety licensed to do business in Iowa? | ☐ Yes ☐ No |
| ☐ Yes ☐ No | 36. Are pricing schedules as specified in the RFP included in Tab 3? | ☐ Yes ☐ No |
| | **COMPANY FINANCIAL INFORMATION** | |

| Bidder Check | Requirement | Confirmed by DHS |
|---|---|---|
| ☐ Yes<br>☐ No | 37. Does the Company Financial Information include audited financial statements (annual reports) for the last 3 years? | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 38. Does the Company Financial Information include at least three financial references (such as letters from creditors, letters from banking institutions, Dun & Bradstreet supplier reports)? | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 39. Does the Company Financial Information include a description of other contracts or projects currently undertaken by the bidder? | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 40. Does the Company Financial Information include a summary of any pending or threatened litigation, administrative or regulatory proceedings or similar matters that could affect the ability of the bidder to perform the required services? | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 41. Does the Company Financial Information include a disclosure of any contracts during the preceding three year period, in which the bidder or any subcontractor identified in the bid proposal has defaulted? Does it list all such contracts and provide a brief description of the incident, the name of the contract, a contact person and telephone number for the other party to the contract? | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 42. Does the Company Financial Information include a disclosure of any contracts during the preceding three-year period in which the bidder or any subcontractor identified in the bid proposal has terminated a contract prior to its stated term or has had a contract terminated by the other party prior to its stated term.? | ☐ Yes<br>☐ No |
| ☐ Yes<br>☐ No | 43. Does the Company Financial Information include the company's five-year business plan that would include the award of the state's contract as part of the work plan? | ☐ Yes<br>☐ No |

# Attachment M: Sample Cross-Reference

The following table provides a sample of the necessary cross-reference for general and professional services requirements. The bidder is expected to produce a similar table with the same column headings.

**Figure 12: RFP Cross-Reference**

| RFP Requirement | Location of Response in Bid Proposal |
|---|---|
| 6.1.1.1, item a | Section 5.x, pg. yyy |
| 6.2.3.2, item k, number 2 | Section 6.y, pg. zzz |
| | |

# Attachment N: Pricing Schedules

This section includes the following pricing schedules for this procurement.

**Figure 13: IME Program Integrity Pricing Schedules**

| Identifier | Title of Pricing Schedule |
|---|---|
| N-1 | Pricing Schedule |

# Attachment N-1

## Figure 14: Pricing Schedule

**Component: Program Integrity**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Transition** | **$** | | | | | | |
| | | | | | | | |
| **Implementation** | **$** | | | | | | |
| | | | | | | | |
| **Operations** | | | | | | | |
| **Line Item Description** | **Year 1** | **Year 2** | **Year 3** | **Opt 1** | **Opt 2** | **Opt 3** | **Total** |
| **6.2.1 Surveillance and Utilization Review Services** | | | | | | | |
| Salaries and Benefits | $ | $ | $ | $ | $ | $ | $ |
| Administrative Overhead | $ | $ | $ | $ | $ | $ | $ |
| Other Costs (itemized in the following rows) | $ | $ | $ | $ | $ | $ | $ |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| **6.2.2 Data Analytics** | | | | | | | |
| Salaries and Benefits | $ | $ | $ | $ | $ | $ | $ |
| Administrative Overhead | $ | $ | $ | $ | $ | $ | $ |
| Other Costs (itemized in the following rows) | $ | $ | $ | $ | $ | $ | $ |
| | | | | | | | |
| | | | | | | | |
| **6.2.3 Medical Necessity Reviews** | | | | | | | |
| Salaries and Benefits | $ | $ | $ | $ | $ | $ | $ |
| Administrative Overhead | $ | $ | $ | $ | $ | $ | $ |
| Other Costs (itemized in the following rows) | $ | $ | $ | $ | $ | $ | $ |
| | | | | | | | |
| | | | | | | | |
| **6.2.4 Medicaid Value Management Program** | | | | | | | |
| Salaries and Benefits | $ | $ | $ | $ | $ | $ | $ |
| Administrative Overhead | $ | $ | $ | $ | $ | $ | $ |
| Other Costs (itemized in the following rows) | $ | $ | $ | $ | $ | $ | $ |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| **6.2.5 Investigation** | | | | | | | |
| Salaries and Benefits | $ | $ | $ | $ | $ | $ | $ |
| Administrative Overhead | $ | $ | $ | $ | $ | $ | $ |
| Other Costs (itemized in the following rows) | $ | $ | $ | $ | $ | $ | $ |
| | | | | | | | |
| | | | | | | | |
| **Grand Total** | $ | $ | $ | $ | $ | $ | $ |

# Attachment O: Sample Contract

The following pages provide a sample of the actual contract that the Department will use with the successful bidders.