

State of Iowa  
Department of Human Services

Technical Proposal – SANITIZED COPY



Iowa Medicaid Enterprise  
Professional Services

Provider Cost Audits and  
Rate Setting Component

RFP MED-10-001

Federal Identification Number  
48-1164042



December 10, 2009 • Bid Submission

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# Myers and Stauffer<sup>LC</sup>

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Certified Public Accountants

December 10, 2009

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

To The Evaluation Committee:

Myers and Stauffer is pleased to present this proposal in response to RFP MED-10-001, IME Professional Services, released September 17, 2009. We acknowledge receipt of the proposal, amendments 1 through 5, and answers to questions.

As the current contractor, Myers and Stauffer has the staff and experience to continue serving the Iowa Medicaid Enterprise with the knowledge and expertise needed to complete all requirements listed in the RFP. We enjoy working with the IME and look forward to building upon our current relationship.

As requested in Section 7.2.2, we are providing the following information:

- a. The bidder's mailing address:  
Myers and Stauffer LC  
100 Army Post Road  
Des Moines, IA 50315
  
- b. Electronic mail address, fax number and telephone number for both the authorized signer and the point of contact:  
Amy C. Perry (both authorized signer and point of contact)  
E-mail: [aperry@mmlc.com](mailto:aperry@mmlc.com)  
Fax number: (515) 725-1010  
Telephone number: 515-725-1258
  
- c. Myers and Stauffer is a limited liability company organized in the state of Kansas and licensed to do business in the state of Iowa.
  1. No subcontractors will be used for completion of this contract. Myers and Stauffer will perform 100 percent of the work required to complete the contract.
  2. The technical proposal does not include actual price information.

- d. Myers and Stauffer is registered to do business in the state of Iowa. Our corporate charter number is 240079. No subcontractors will be used.
- e. Myers and Stauffer's Federal Tax Identification Number is 48-1164042.
- f. Myers and Stauffer will comply with all contract terms and conditions as indicated in the RFP.
- g. No attempt has been made or will be made by Myers and Stauffer to induce any other person or firm to submit or not to submit a proposal.
- h. Myers and Stauffer is an equal opportunity employer and 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. No cost or pricing information has been included in this letter or the technical proposal.
- j. We acknowledge receipt of Amendments 1, 2, 3, 4 and 5, bidders' questions and responses, and updated bidders' questions and responses.
- k. Myers and Stauffer certifies:
  - 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 purposes of restricting competition; and
  - 2. Unless otherwise required by law, the prices quoted have not been knowingly disclosed by Myers and Stauffer prior to award, directly or indirectly, to any other bidder or to any competitor.
- l. This is to certify that I, Amy C. Perry, member, am an officer within our organization who is authorized to contractually obligate the firm and negotiate a contract on behalf of Myers and Stauffer LC. I am responsible for, or authorized to make, decisions regarding the prices quoted and I have not participated and will not participate, in any action contrary to item k above.
- m. No subcontractors will be used for this contract.

- n. The following proposal materials are considered proprietary; therefore, we request that they be treated as confidential in accordance with Iowa Code Chapter 22.7, confidential records. These materials contain trade secrets, privileged information, and proprietary commercial information that, if released, would give an advantage to competitors. We have marked these as confidential:
- |  |                   |
|--|-------------------|
| 1. Company Financial Content                           | Separately Sealed |
| 2. Sample NF and ICF/MR Desk Review Program            | Appendix          |
| 3. Sample CAH Cost Settlement Program                  | Appendix          |
| 4. Sample FQHC Cost Settlement Program                 | Appendix          |
| 5. Sample CMHC Desk Review and Cost Settlement Program | Appendix          |
| 6. Sample NF/ICF/MR Audit Program                      | Appendix          |
| 7. Sample Audit Questionnaire                          | Appendix          |
| 8. Sample SMAC Reports                                 | Appendix          |
| 9. Sample DRG and APC Rebase and Recalibration Reports | Appendix          |
- o. I, Amy C. Perry, am the authorized person within our organization to respond to any inquires by DHS concerning the confidential status of the listed material.
- Amy C. Perry  
Myers and Stauffer LC  
100 Army Post Road  
Des Moines, IA 50315  
(515) 725-1258
- p. The submitted bid proposal security shall guarantee the availability of the services as described throughout the bid proposal.
- q. Myers and Stauffer acknowledges the acceptance of all term and conditions stated in the RFP.

We look forward to continue working with the Iowa Department of Human Services on this important project. I am available to make an oral presentation of the bid proposal upon request of the evaluation committee. If you have any questions or need any clarification, please contact me at (515) 725-1258.

Sincerely,



Amy C. Perry  
Member

### 3. Checklist and Cross References

The following checklist and cross reference tables are included in this section.

3.1 Bid Proposal Mandatory Requirements Checklist

3.2 General Requirements Cross-Reference

3.3 Professional Services Requirements Cross-Reference

# 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
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	2. Does each bid proposal consist of three distinct parts?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. Technical Proposal	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. Cost Proposal	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	c. Company Financial Information	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	5. Are all boxes containing bids labeled with the following information?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. Bidder's name and address	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. Issuing officer and department's address as identified by RFP Section 7.1.d.2	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	c. RFP title (Iowa Medicaid Enterprise Professional Services Procurement) and RFP reference number (MED-10-001)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	d. RFP component for which the bid proposal is being submitted for consideration (such as Medical Services or Provider Services)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Bidder Check	Requirement	Confirmed by DHS
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6. Are separate boxes utilized for each bid proposal if submitting bid proposals for more than one of the individual contract awards?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	7. Are all bid proposal materials printed on 8.5" x 11" paper (two-sided)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	8. Is Technical Proposal presented in a spiral, comb, or pasteboard binder separate from the sealed Cost Proposal and Company Financial Information volumes? (Note: Technical Proposals in 3-ring binders will not be accepted.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	9. Is each Cost Proposal in a spiral, comb, or pasteboard binder separate from the sealed Technical Proposal and Company Financial Information volumes? (Note: This status will be determined when Cost Proposals are opened after Technical Proposals have been evaluated. 3-ring binders will not be accepted )	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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? (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 )	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	11. Is one sanitized copy of the proposal volumes and Company Financial Information included if any bid proposal information is designated as confidential? (Note: Bidders cannot designate their entire proposal as confidential or proprietary.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	12. Does each Technical Proposal package include:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. One original	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. Eight copies	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	c. One sanitized copy (if applicable) in a separate binder (or set of binders)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	d. Are the original, copies, and sanitized copy correctly marked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	13. Does each Cost Proposal package include:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. One original	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. Eight copies	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	c. One sanitized copy of Cost Proposal in separate, sealed envelope	<input type="checkbox"/> Yes <input type="checkbox"/> No

Bidder Check	Requirement	Confirmed by DHS
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	d. Are the original, copies and sanitized copy correctly marked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	14. Does each Company Financial Information package contain one original of Company Financial Information (in a separate sealed envelope)? (Note: This status will be determined when Company Financial Information volumes are opened for the financial viability screening.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	15. Are all bid proposals also submitted on CD-ROM copies per bid proposal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	17. Are all electronic files in read-only PDF format?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	18. Are all electronic files individually identified by:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. Component name	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. Bid proposal part (technical, cost, or company financial information)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	c. Status (original, copy or sanitized)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Technical Proposal Content</b>		
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	19. Does each Technical Proposal consist of the following sections separated by tabs with associated documents and responses presented in the following order?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. Table of Contents (Tab 1)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. Transmittal Letter (Tab 2)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	c. Checklists and Cross-References (Tab 3)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	d. Executive Summary (Tab 4)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	e. General Requirements (Tab 5)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	f. Professional Services Requirements (Tab 6)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	g. Project Plan (Tab 7)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Bidder Check	Requirement	Confirmed by DHS
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	h. Project Organization (Tab 8)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	i. Corporate Qualifications (Tab 9)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	20. Does the Table of Contents in Tab 1 of the Technical Proposal identify all sections, subsections, and corresponding page numbers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	21. Does the Transmittal Letter in Tab 2 include the following?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. The bidder's mailing address	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. Electronic mail address, fax number, and telephone number for both the authorized signer and the point of contact designated by the bidder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	c. A statement indicating that the bidder is a corporation or other legal entity	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	e. No actual price information	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	g. A statement identifying the bidder's federal tax identification number	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	h. A statement that the bidder will comply with all contract terms and conditions as indicated in this RFP	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	k. A statement that no cost or pricing information has been included in this letter or the Technical Proposal	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	m. A statement that the bidder certifies in connection with this procurement that:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Bidder Check	Requirement	Confirmed by DHS
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	o. Unless other wise 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	q. A statement that the submitted Bid Proposal Security shall guarantee the availability of the services as described throughout the bid proposal.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	r. A statement that the bidder acknowledges the acceptance of all terms and conditions stated in the RFP.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. The general scope of work to be performed by the subcontractor	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. The subcontractor's willingness to perform the work indicated; and	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	24. The name, address and telephone number of the individual authorized to respond to the Department about the confidential nature of the information (if applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	25. Is a completed copy of the Checklist and Cross-References included in Tab 3?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. Mandatory Requirements Checklist	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. General Requirements Cross-Reference	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	c. Professional Services Requirements Cross-Reference	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Bidder Check	Requirement	Confirmed by DHS
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	27. Is a Professional Services Requirements Cross-Reference in Tab 3 included for each Technical Proposal under consideration based upon the sample provided in RFP Section 9?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	28. Are requirements numbers listed above the paragraph or set of paragraphs for all addressed requirements in?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	29. Does information in Tab 9 (Contractor Qualifications) include the following?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. Description of the Contractor Organization (Section 7.2.9.1)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. Description of the Contractor Experience (Section 7.2.9.2)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	c. Contractor References (Section 7.2.9.3)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	d. A signed copy of each of Attachments B through J inclusive with signature from an individual authorized to bind the company.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Cost Proposal Content</b>		
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	30. Does the Cost Proposal include the following sections:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. Table of Contents (Tab 1)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. Bid Proposal Security (Tab 2)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	c. Pricing Schedules (Tab 3)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	31. Does Tab 1 include a Table of Contents of the Cost Proposal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	32. Does the Table of Contents identify all sections, subsections, and corresponding page numbers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	35. If a bond is used, is it issued by a surety licensed to do business in Iowa?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Bidder Check	Requirement	Confirmed by DHS
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	36. Are pricing schedules as specified in the RFP included in Tab 3?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>COMPANY FINANCIAL INFORMATION</b>		
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	37. Does the Company Financial Information include audited financial statements (annual reports) for the last 3 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	39. Does the Company Financial Information include a description of other contracts or projects currently undertaken by the bidder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## 3.2 General Requirements Cross-Reference

RFP Requirement	Location of Response in Bid Proposal
6.1	Section 5, pg. 31-45
6.1.1	Section 5.1, pg. 31-34
6.1.1.1	Section 5.1 A, pg. 31-32
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## 4. Executive Summary

Myers and Stauffer appreciates the opportunity to respond to the Provider Cost Audits and Rate Setting (Section 6.7) Component of the Iowa Medicaid Enterprise Professional Services Request for Procurement, RFP MED-10-001; and we are pleased to offer a proposal that is both comprehensive and unique in its approach to meet the State's Medicaid program goals and objectives, as well as fully compliant with all project requirements and deliverables.

Over the last eight years, we have developed a strong relationship with the Iowa Department of Human Services (DHS). During that time, we successfully helped the Department to work through many important benefit changes, political situations, significant modifications to procedure and process, and perhaps the most important change ever - implementation of the Iowa Medicaid Enterprise.

Throughout our tenure with the Department, we have worked hard to serve as a complete resource for Medicaid auditing and rate-setting services. This is because our firm has more than 30 years of experience in working with state and Federal healthcare programs. We have worked with more than 25 state Medicaid agencies in developing,

implementing, and evaluating Medicaid program policies, performing critical financial and data-driven analyses, and delivering superior services, all of which have well-positioned our clients to successfully and timely respond to the numerous challenges inherent to Medicaid. And finally, we are able to offer to this project and to all of our Medicaid engagements a knowledgeable and experienced project team that is unmatched in their professionalism, dedication and quality, and who has available immediate access to the staffing resources and knowledgebase of our 13 offices nationwide.

For all of our engagements, we employ a multi-state approach, which means that we are able to offer DHS and other state clients an excellent team of project staff, supported further with the resources available throughout our entire firm. We understand well the challenges facing our state Medicaid agency clients, and we therefore believe that when we are selected to provide services, it is our responsibility to do everything possible to perform with excellence so that our state agency clients are able to concentrate on the challenges of managing other aspects of the Medicaid program.

This proposal not only offers the Department a continuation of the excellent project team and service delivery that we have worked so hard to achieve in the past, but also an uninterrupted delivery of services that contains no start-up or transition costs. For all of these reasons, we strongly believe that Myers and Stauffer is the “best of breed” and ideal candidate to be awarded the services included in this procurement.

#### Summary of Proposal

Our proposal responds to all RFP requirements for this service component and is outlined in the manner specified by RFP, Section 7 – Proposal Format and Content. Following the Table of Contents, Transmittal Letter, Requirements Checklists and Cross-References, and Executive Summary, our Technical Proposal contains a description of our understanding of the general requirements, professional services requirements, project plan, project organization, corporate qualifications, applicable certifications and guarantees, and appendices. In addition, the Cost Proposal and Company Financial Information are contained in separate sealed packages as required by the RFP. Each of these sections is logically organized, and easy to follow.

#### ***General Requirements***

We know that quality work products and services are essential to the overall performance and reputation of the Iowa Medicaid Program. For this reason, we propose to offer to this

contract the continued services of proven management staff who have worked closely with the Department, have unmatched technical experience as well as familiarity with the health care environment in Iowa, and who will ensure that we meet all of our contractual responsibilities and adhere to rigorous quality standards. These management staff and others will be available throughout all contract phases.

We will continue to operate from the IME facility, co-located with Department staff as well as the other partnering contractors to the IME. We agree to all general requirements as stated in the RFP, including such items as record keeping, audits, confidentiality, HIPAA compliance, and quality assurance. It is important to note that we have no conflicts of interest, as our firm has never and will never accept health care providers as clients, nor do we have any other potentially conflicting relationships.

#### ***Operational Requirements***

There are numerous operational requirements associated with the rate-setting, cost settlements and cost audits, and other consulting activities of the RFP. We are familiar with all aspects of the scope of work required based on our previous experience with DHS and other state Medicaid agencies.

#### **Rate Setting, Cost Settlements, and Cost Audits for Designated Providers**

Myers and Stauffer accepts full responsibility to perform rate setting,

desk reviews, audits and cost settlements involving various Iowa Medicaid providers, including nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR), hospitals (acute care, psychiatric, rehabilitation), federally qualified health centers (FQHC) and rural health clinics (RHC), and many other institutional and non-institutional providers of health services.

While performing these duties, we agree to continue to apply a variety of cost report auditing/settlement techniques to the reimbursement methodologies specific to each provider type with the full understanding that errors can have serious financial consequences and/or result in decreased confidence in the program.

Our proposal takes all of these responsibilities into account and offers DHS the following:

- A team that is expert across the entire spectrum of audit, desk review, cost settlement, data management and consulting issues addressed in this RFP.
- A demonstrated multi-state performance in the management and execution of the duties required of the audit, desk review and cost settlement contractor.
- An innovative risk-based cost report audit methodology that is designed to yield maximum information for DHS, while minimizing the burdens placed

upon Medicaid providers during the audit and desk review processes.

- A rate setting and cost settlement approach that incorporates computerized rate/cost settlement templates into the development of all project deliverables.
- A unique mix of qualifications in institutional and non-institutional provider reimbursement, analysis of health care costs and utilization, and investigation of fraud and abuse in cost-reimbursed programs.
- A comprehensive array of support services that include detailed reporting, data-driven analysis, provider/employee training, and development of written communications, correspondence, and more.

#### **State Maximum Allowable Cost (SMAC) Program Rate Setting**

Myers and Stauffer offers a SMAC Program that is based on actual acquisition cost data obtained directly from Iowa pharmacies and then applied to a pricing formula that ensures both reasonable and fair cost coverage and predictable expenses. Ours is a superior pricing program that promotes development of a large SMAC drug list with frequent market-related updates and informative reporting.

Myers and Stauffer began our Medicaid pharmacy consulting practice in 1973 with a dispensing cost study for the State of Kansas.

Since then we have performed numerous pharmacy dispensing and drug acquisition cost studies in 17 states, as well as, several other pharmaceutical consulting engagements for state agencies and CMS. Currently, Myers and Stauffer sets SMAC rates for the states of Indiana, Idaho and Iowa.

One of the most significant challenges to Medicaid agencies is to establish reasonable pharmacy reimbursement levels while considering cost and pricing of pharmaceuticals. We have successfully addressed this challenge in Iowa by implementing an innovative SMAC program that establishes reimbursement proportionate to actual pharmacy cost. Rather than depending on unreliable published pricing for drugs, actual acquisition costs for multi-source products are determined by surveying invoices from local pharmacies that participate in the Iowa Medicaid program. SMAC rates are derived from this basic cost data by using a “SMAC multiplier,” a customized factor designed to ensure that pharmacies’ costs are covered, in addition to providing a reasonable profit margin. The use of this customized SMAC multiplier allows DHS to retain significant control over cost savings realized by the SMAC program.

Myers and Stauffer will continue to use an experienced team of pharmacists, consultants and analysts to monitor the pharmaceutical marketplace and to use that information to provide timely updates

to the SMAC rate schedule. In addition, we will continue to operate a user-friendly pharmacy provider Help Desk and a SMAC web site, both with 24 hour/7 day per week access, for Iowa pharmacists to communicate concerns regarding product pricing and availability.

### **Rebasing and DRG and APC Recalibration**

Iowa Medicaid currently utilizes prospective payment systems to reimburse general medical/surgical hospitals for both inpatient and outpatient services. Inpatient services are reimbursed under a diagnosis related group (DRG) system while outpatient services are reimbursed using the ambulatory patient classification (APC) system. Iowa administrative code (IAC) requires that system parameters be rebased and recalculated every three years. These parameters include hospital base, capital cost, disproportionate share, and direct and indirect medical education rates. The DRG system requires the weights used for payment determination to be recalibrated on this same schedule. The APC weights are updated annually based on the Medicare APC weight table published every January 1<sup>st</sup>.

Myers and Stauffer is excited at the opportunity to provide these services to the DHS beginning July 1, 2010. Since 1992, we have provided DRG rate setting and related consulting services to seven states: Alaska, Colorado, North Carolina, Kansas, Indiana, New Mexico and Oregon. The firm has provided each state with

reimbursement system options to address issues related to neonatal, psychiatric, and rehabilitation services. We have developed and refined specialized computer software tools that allow us to conduct the routine portions of the rate setting and modeling processes with superior efficiency. As a result, project team members are able to spend more time on analyses.

Myers and Stauffer also provides reimbursement system recommendations and assists with implementation and on-going operational issues. Our services include:

- Efficiently handling large databases.
- Calculating DRG/APC weights and related statistics.
- Recalibrating payment weights and rebasing base rates.
- Preparing base year Case Mix Indexes and other statistics for rebasing.
- Providing reimbursement system recommendations, including outlier payment, GME/IME, transfers and other payment additions.
- Assisting with implementation issues.
- Analyzing Medicaid cost coverage.
- On-going maintenance and system evaluations.

Myers and Stauffer has the expertise needed to properly perform the

DRG/APC project activities.

Shortcomings in any of these three areas: grouper software; utilization of paid claims data; and linking payment systems to cost data can severely limit the Medicaid program's ability to pursue sound public policy goals. We not only understand the mechanics involved with DRG/APC classification software products, but we also understand hospital cost reporting and cost apportionment issues. These skills combined with our ability to work with Medicaid paid claims data make us uniquely qualified to perform the DRG/APC services under this procurement.

#### **Reimbursement Technical Assistance and Support**

The Medicaid program has many diverse and potentially competing objectives, all of which must be successfully managed with accurate and reliable information. It also requires the commitment of a strong team that is able to respond rapidly to a changing environment and that can be depended upon to provide assistance and support to meet program objectives. Myers and Stauffer is committed to providing DHS with this value added service.

While rate setting and cost audits of various provider types is a major element of this procurement, we believe that a solid understanding of the environment and the ability to provide competent advice on many complex issues are also vital.

Moreover, the successful contractor must quickly interpret vast amounts of data generated by different

participants in health care reimbursement arena, as well as navigate an uncertain future and a myriad of obstacles to assist DHS achieve its goals.

The following is a summary of the services that we propose to meet all of those criteria.

*Provide qualified and experienced personnel necessary to offer technical consultation and advice on reimbursement and related accounting matters*

The complexity of the health care system in general and the Medicaid program in particular, has grown dramatically over the last several years. This is due to additional federal mandates, state fiscal issues, provider litigation, and greater competition for limited resources. As a result, Myers and Stauffer has invested in qualified, expert, and professional staff from a wide variety of disciplines to provide technical services related to the fields of accounting, financial analyses, clinical expertise, computer application and forecast model design. Proposed project staff are highly skilled and have available staff throughout the firm to provide additional expertise and to participate in meetings and discussions with DHS and other state government agencies involving Medicaid policy formulation.

*Conduct studies and analyses of provider information*

Myers and Stauffer will continue to provide DHS with studies and analyses of data to assist with

arriving at reasonable and defensible conclusions. This is a very important aspect of our service and includes meetings with DHS staff, provider and advocate representatives, and other affected parties. We will also continue to prepare written reports and comment statements outlining recommendations or other relevant thoughts and observations relating to these financial and statistical analyses.

*Establish and maintain the Long Term Care Information System (LTCIS) and MDS Information System*

Myers and Stauffer will continue to maintain and enhance the LTCIS, which is a database of statistical, financial and rate information designed specifically to monitor the Medicaid long term care system and provide the time series and cross-sectional data necessary to construct conditional expectation models. This system will be updated regularly to incorporate regulation changes and potential enhancements, and monitored for completeness and accuracy.

The LTCIS provides for quick, efficient compilation and summarization of financial and statistical data to develop fiscal estimates. Reports from LTCIS will continue to be generated quarterly and forwarded to DHS and other parties upon request. In addition, we will analyze information from the LTCIS and MDS system for common applications such as assessing compliance with legislative requirements, evaluating case mix

increases, assessing profitability, providing fiscal estimates of anticipated or proposed regulation changes, and responding to legislative inquiries.

We understand the need for quick and efficient retrieval of information related to the Medicaid program and will continue to work with DHS to determine needs and to establish electronic access to that information.

*Prepare upper payment limit tests and provide consulting on policies designed to maximize federal participation*

The successful contractor will be required to develop and accurately perform upper payment limit methodologies for inpatient and outpatient hospital and nursing facility services. Myers and Stauffer is aware of the high public visibility given to the upper payment limits. We will assist the state throughout this engagement without the need for substantial administrative support.

Myers and Stauffer has assisted numerous states, including Iowa, with Medicare upper payment limit calculations. Our work has encompassed preparing detailed analyses, developing alternative findings methodologies, assisting with the development of payment policies and administrative procedures, preparing public notices and State Plan amendments, and assisting our clients address issues or questions raised by CMS.

Myers and Stauffer will conduct research, analysis, and develop

various models to determine optimal approaches and methodologies to maximize the upper payment limits for inpatient and outpatient hospital and nursing facility services. States have considerable flexibility in determining the upper limit methodologies used and we have assisted many clients in selecting the most appropriate methodology to support their specific objectives. Our goal for this engagement is to develop a defensible upper limit that maximizes the Medicare and Medicaid rate differential for the state of Iowa.

There are many stakeholders involved: Medicaid beneficiaries, DHS management, legislators, and citizens of the state of Iowa. It is critical that contractors have an understanding of the issues affecting all stakeholders. We understand and support the objectives and can successfully and efficiently serve your needs. We are committed to continuing to provide DHS with the high quality services you expect and deserve.

We are fully attuned to developments at CMS through established networks of other practitioners and government officials. Our knowledge, experience and understanding of Medicaid and Medicare reimbursement issues (both technical and political) enable us to meet DHS needs in these turbulent areas.

### **IowaCare**

Myers and Stauffer worked hand in hand with the State of Iowa to negotiate the original terms and conditions of the Iowa Care

demonstration project with CMS. We understand the goals of the program and what we need in order to meet the guidelines of the demonstration project.

We have worked closely with Iowa policy staff on the current IowaCare renewal effective July 1, 2010. We look forward to continuing this relationship for the on-going performance of the IowaCare program. Myers and Stauffer will continue to provide DHS with monthly expenditure analyses and annual reconciliation report.

Strengths of Myers and Stauffer LC  
As the incumbent Provider Cost Audits and Rate Setting Contractor, selection of Myers and Stauffer for the new contract term presents several important advantages to DHS. These include:

- Many years of extensive experience with *all* RFP service requirements in Iowa and numerous states.
- A dedicated, knowledgeable project team that has successfully partnered with the DHS through implementation of numerous program enhancements, policy changes, and other significant program events.
- A proven commitment from all levels within the firm to achieve the highest levels of client satisfaction.

Myers and Stauffer was founded more than 30 years ago with the

mission of serving the needs of state Medicaid and other health care related government agencies. With government health care and reimbursement as our only major business line, we are committed to staying current on all pertinent health care reimbursement issues, and providing options, recommendations and solutions needed by our government agency clients to address the myriad of challenges they face. Our project team has developed unmatched knowledge and expertise through many years of assisting DHS and other state Medicaid agencies with rate setting, auditing, and reimbursement consulting for virtually every Medicaid provider category, development of sophisticated computer systems that provide essential tools for effective program monitoring and reporting, and all aspects of revenue maximization strategy development and defense.

We propose a project team that consists of members, principals, managers and other senior staff for the IME project that are dedicated to its success, have extensive experience working with Iowa and other state Medicaid programs, and who are very knowledgeable about all relevant issues and potential obstacles likely to be faced during this significant period of economic downturn. Our project management team has more than 75 years of combined experience delivering rate setting, auditing and related consulting services in the majority of state Medicaid programs. All members of our management team

have dedicated virtually their entire careers to serving the needs of state Medicaid agencies and have repeatedly proven themselves to be committed to the success of the IME initiative.

We strongly believe that the hallmark of the firm's success is our commitment to client satisfaction. We frequently receive feedback from clients and others that our service delivery level distinguishes us from other contractors, probably because we pride ourselves on meeting and often exceeding our client's expectations. By administering health care programs for the most vulnerable citizens, our state Medicaid agency clients operate in an environment that is extremely challenging in many respects. Medicaid administrators regularly face challenges for which there generally is no solution without negative consequence, where service demands and priorities cannot be met with available resources, and with the responsibility to manage the Medicaid program within state and federal government bureaucracies and under considerable political pressures. Perhaps more than most or all of our competitors, we understand and appreciate this environment and are committed at every level within the firm to ensuring complete satisfaction with our services. We strive to anticipate the needs of our clients based on expertise developed from other states, and we take a proactive approach to client service. We will continue to provide this high level of service to DHS as the new

#### Provider Cost Audits and Rate Setting Contractor.

##### Key Features of Proposed Approach

The key features of our proposed approach builds on many of our strengths enumerated above. Successfully meeting or exceeding DHS goals and objectives for the IME requires a competent and strong management team, as well as senior manager and technical staff resources with considerable subject matter expertise. Our team will approach this project by continuing to foster the collaborative partnership that we have already developed with DHS and other IME contractors. In addition, we will continue to utilize technology to its highest potential to deliver accurate products and services in the most efficient manner possible.

#### ***Myers and Stauffer LC is "the Best of Breed"***

By selecting contractors with specialized skill sets to assist with the management, operations and oversight of the Iowa Medicaid program, DHS was determined to bring substantial change to the concept of Medicaid fiscal agent services. We applaud this innovative approach to Medicaid program administration and fully support these goals. This approach seeks to identify and engage multiple contractors who are best qualified to address interrelated yet different requirements. A firm that has developed high competencies with claims processing, may not have developed similar competencies performing audits of financial

statements or conducting utilization review functions. In recognition of this marketplace reality, and instead of accepting a single firm who performs some functions more effectively than others, DHS has determined to seek the “best of breed” contractor for *all* RFP service functions, and will likely continue to engage multiple firms through this procurement. Over the past five years, this innovative approach to fiscal agent service delivery has provided substantial benefits to the Iowa Medicaid program beneficiaries, taxpayers, and other stakeholders.

Based on our experience, our understanding of the RFP requirements, and our appreciation of the IME concept, we believe we are the “Best of Breed” for the provider cost audits and rate setting component of this RFP. We have performed our responsibilities successfully throughout the current contract term, met all requirements and timelines, provided countless reports and other policy documents, worked proactively and positively with Iowa Medicaid providers, and have developed solid relationships with all other IME contractors. We have worked hard to go above and beyond general contractual obligations, and want very much the opportunity to continue this partnership with the Department.

***Experienced and Proven Management Team***

We are pleased to offer a continuation of strong, experienced leadership to this project. Our

management plan for the Provider Cost Audits and Rate Setting project under the new contract term proposes Ms. Amy Perry as the returning Account Manager. In this capacity, Ms. Perry will provide overall leadership and direction to this project. Not only does she have years of experience successfully meeting DHS’ needs in performing auditing, rate setting and consulting services prescribed by the RFP, but she has also worked closely with all levels of DHS staff, contractors and other stakeholders of the Iowa Medicaid program on complex reimbursement projects and policy issues. Her proven expertise and communication skills combined with an engaging personality have made her a much sought-after colleague with the DHS and within our firm.

***Sufficient Levels of Qualified Staff Dedicated to the IME***

The RFP requires the successful contractor to provide a significant volume of auditing and rate setting activity. In addition to our strong management team, we will continue to provide sufficient senior and other technical staff to meet all service delivery requirements. We are proposing 34 full time equivalent (FTE) staff positions to continue to meet the high performance expectations for delivery of provider audit and cost reporting services within the IME.

***Develop a Collaborative Partnership Relationship***

As has been our practice with DHS for many years, we will continue to work closely with the DHS and other

IME contractors to achieve the common IME goals, and to find solutions to the many issues that we expect to face in the near future. Myers and Stauffer is exceptionally responsive and sensitive to public scrutiny, performance expectations, and the high levels of accountability and integrity that are expected of government agencies and policymakers. It is for this reason that, unlike our competitors, *our firm has always limited its practice exclusively to partnering opportunities with state and federal Medicaid agencies.* As a result of this business decision, we have never experienced any conflict of interest in providing services to private sector or not-for-profit companies or health care suppliers or providers.

Moreover, we have never had any conflict of interest relating to any work that we have performed, and we are careful to avoid any behavior or action that will give the appearance of impropriety or otherwise impede in any way a fair decision on any of the procurement processes in which we participate.

***Provide Technology-Driven Solutions***

Our proposed approach relies heavily on a variety of computer technology tools to help us deliver timely and accurate products and solutions. These tools are effective in minimizing professional and other staff spent on immaterial or potentially irrelevant items in order to devote more quality time to perform analysis and problem resolution that goes beyond mere

“number crunching”. We strongly believe that the Provider Cost Audits and Rate Setting Contractor must promptly identify, and remain focused on the relevant and material issues throughout this project, in order to avoid overlooking key risk areas within each program category. Through our commitment to design and develop technology solutions that improve existing processes, we are fully prepared to meet the demands of this project.

Project Management Plans for Operations Phase

Through our staffing plans, we will continue to dedicate sufficient management and owner resources to the IME provider cost audits and rate setting project to ensure on-going successful operations. Our account and operations managers and dedicated staff will continue to be onsite to provide day-to-day direction and coordination for all contractor functions. We highly value our work with the IME, and we remain committed to the Department to provide superior audit and rate-setting services as cost-effectively as possible.

Project Management Plans for Turnover Phase

In the event DHS contractually transfers operational responsibility for the Provider Cost Audits and Rate Setting Contractor functions to another entity, then our project team under the leadership of our project directors and managers will commit to fully cooperate during the turnover phase with DHS and the transferee entity. We agree to prepare and

provide a turnover plan upon request of DHS.

Our detailed responses to the RFP requirements are presented on the following pages. We are truly committed to the Department and to being an essential component of the IME. We believe that offer superior services that are unmatched throughout the industry. Moreover, Myers and Stauffer may be the only one in our field that has deliberately limited its practice to state and federal governmental healthcare agencies only, making us wholly and demonstrably committed to the interests of our Medicaid clients without any real or perceived conflicts of interest.

## 5. General Requirements

The objective of this procurement is to continue a contract environment where the Iowa Medicaid program is supported by a cohesive enterprise of the best contractors co-located with state staff in a single facility, known as the Iowa Medicaid Enterprise.

The IME consolidates all major functions and services under a single entity and therefore, places a premium on the coordination of efforts. Myers and Stauffer has a long history of working collaboratively and cooperatively with state personnel and other contractors to solve complex problems and issues. We understand that the best results come when all participants provide contributions and the group as a whole is responsible for finding solutions.

We also understand the importance of maintaining high levels of customer service throughout all contract responsibilities of the IME and incorporating such principles in all our contracts and business relationships. Quality and customer service are the foundation of Myers and Stauffer. During the past five years as the Provider Cost Audit and Rate Setting contractor for the Department, our project staff has demonstrated a “solution-oriented” mindset that is reasonable, objective and effective. They have shown

flexibility in their operations and a teamwork attitude that maintains focus on serving and meeting DHS goals and objectives.

Based on our current role within the IME we appreciate the need for all component contractors to exhibit good communication skills and to work cooperatively. As the incumbent Provider Cost Audits and Rate Setting Contractor, we will continue our proven ability to work cooperatively with other contractors to access the MMIS, POS and data warehouse for the purpose of updating provider rate files, reviewing claims history to settle cost reports and identifying, evaluating and reporting on trends and other provider reimbursement activities.

### 5.1 Staffing

(RFP Section 6.1.1)

#### A. Named Key Personnel

(RFP Section 6.1.1.1)

Myers and Stauffer acknowledges the need for experienced and dedicated leadership for this project. Our approach to project staffing is straightforward. By dedicating experienced and proven management talent along with qualified and competent professional and support personnel, we can ensure success.

Amy Perry, our proposed (and current) account manager, has been employed with the firm since 1991 and has held numerous positions of increasing responsibility.

In 2004, Ms. Perry relocated to the IME and served as the account and implementation manager. She was fully dedicated to the IME and managed Myers and Stauffer's provider cost audits and rate setting services. In 2006, she became a member (partner) of the firm. Ms. Perry directed and coordinated the implementation efforts for the State of Iowa's 1115c waiver known as IowaCare as well other new programs such as Remedial Services and Habilitation Services.

Ms. Perry managed and was actively involved in assisting IME with the transition from an APG reimbursement methodology to APC methodology for outpatient hospital services.

Jeff Marston, operations manager, has been employed with the firm since 2004. Mr. Marston has more than 14 years of health care experience. In 2004, Mr. Marston relocated to the IME and served as operation manager. He was fully dedicated to the IME and supervised the desk review and cost settlement functions. He was instrumental in the implementation of the 100 percent cost-based reimbursement methodology for CMHCs.

Key Personnel Requirements, Resumes and References (RFP Sections 6.1.1.1.1, 6.1.1.1.2 and 6.1.1.1.3)

Contained in Tab 8 – Project Organization is our proposed account and operations managers' resumes. Ms. Perry's resume includes relevant employment history for more than ten years, along with three professional client references. For each client reference, we have provided the full name, street address, telephone number and e-mail address of the client's project administrator.

All named key personnel above meet and or exceed all education, experience and other qualifications required by the RFP and will be 100 percent dedicated to the IME project. None will be reassigned or replaced, except as allowed for in the RFP during the first six months of the project. This candidate will be 100 percent dedicated to the IME project.

A project team of experienced professional staff will support Ms. Perry and Mr. Marston. This professional team will include our most senior managers, accountants, programmers, registered nurse consultants, pharmacy consultants and general support personnel. A complete job description for each of these positions is included in Tab 8.

Department Approval of Key  
Personnel  
(RFP Section 6.1.1.1.4)

We understand the unique and sensitive role each key position plays in the overall success of the IME. We are confident that DHS will find the education, qualifications, and experience of our proposed key personnel acceptable and capable of continuing to meet all DHS objectives in a timely and professional manner. All are available immediately to interview with DHS staff.

Changes to Contractor's Key  
Personnel  
(RFP Section 6.1.1.1.5)

The IME project requires the coordination of activities between all IME contractors and DHS staff. The impact that changes made by one contractor may have on the processes of another contractor cannot be overlooked or diminished. Equally important is the continuity of key staff resources assigned to the various responsibilities and activities. We will not replace or alter the number and distribution of proposed key personnel without the written approval of the DHS contract manager. If necessary, we will provide the project director notice 15 days prior to any proposed transfer or replacement of key personnel, including the resumes and references of proposed replacement staff. We will only propose staff that have comparable training, experience and ability. Any replacement staff will be available to interview with the

project director at his/her convenience. Original key staff will remain on the project and be responsible for the performance of duties under the contract until such time as the replacement staff are approved and successfully performing the key functions of the position.

B. Special Staffing Needs  
(RFP Section 6.1.1.2)

Professional Staff Requirements  
(RFP Section 6.1.1.2 a)

Medical staff assisting with this project include James Shin, Pharm.D. and Patrice Padula, RN. Dr. Shin will be involved with the analysis, review and processes necessary to establish rates for multi-source prescription drugs as part of the state maximum allowable cost (SMAC) program. Ms. Padula will assist with the review and analysis of nursing facility minimum data set (MDS) information that is necessary to establish each facility's acuity level for case mix reimbursement.

Both Dr. Shin and Ms. Padula are registered or licensed to practice medicine and are in good standing with their respective examining boards. Dr. Shin has specialized training in managed care and pharmacoeconomics research. He is a graduate of the University of Illinois College of Pharmacy, and worked with the Maryland Medicaid program through his post-doctoral fellowship at the University of Maryland School of Pharmacy. He is currently licensed in the State of Illinois and has

expertise in pharmacy reimbursement methodologies, formulary management, and has experience working in community and outpatient pharmacy settings. Ms. Padula is a registered nurse, and holds a multi-state license that permits her to practice in the State of Iowa. Professional medical staff will carry malpractice insurance as necessary.

Job Rotation and Coverage during Vacations for Sensitive Positions (RFP Section 6.1.1.2 c and d)

A plan to ensure that all contract services are adequately performed during staff vacations or other absences is critical to every successful operation. We utilize several approaches to ensure adequate coverage and service delivery during staff absences. First, for all sensitive positions, we designate a staff member who will serve as a backup for that position. Staff holding sensitive positions meet regularly with their assigned backup to provide training and to keep them apprised of the status of projects and other activities. In order to ensure coverage when key staff are absent, we require backup staff to routinely attend meetings with the key staff. They will then be familiar with department personnel, any current or pending issues, and the status of current projects. For each non-critical position, we identify critical tasks within the position and cross-train other staff on those responsibilities. For scheduled absences, such as vacations, requests are approved in advance of the requested time off. We are able to coordinate staff

schedules to make certain that adequate coverage is maintained during absences.

5.2 Facilities  
(RFP Section 6.1.2)

A. Permanent Facilities  
(RFP Section 6.1.2.1)

The State will provide office space, desks, chairs, cubicles, network infrastructure and connections, personal computers, software licenses for commercially available packages, phones and fax machines, photocopiers, network printers, licenses for other non-Microsoft Office software and office supplies necessary to perform our responsibilities. In addition, the State will provide conference rooms at the IME offices for meetings.

Discussion of our proposed staffing is included in Section 5.1 of this proposal. The total number of staffing to be located at the IME is 32. A total of eight key personnel dedicated 100 percent to the IME include: Amy Perry, Jeff Marston, Lesley Beerends, Jhonna DeMarcky, Andy Johnson, Laura Parker, Melinda Peirce and Chris Urwin.

Many of the functions performed by the Provider Cost Audits and Rate Setting Contractor are interrelated or dependent on other functions. For this reason, we request that our staff continue to be located in contiguous space within the IME. Additionally, since many of the services required in this component require our staff to access financial and statistical cost

reports and accompanying schedules daily, storage of these files should be located in close proximity to our staff to ensure maximum efficiency. We request that this file storage area have controlled access.

The Provider Cost Audits and Rate Setting Contractor's responsibilities for providing equipment and software are limited to proprietary or non-commercially available software and personal workstation printers.

All of the services contemplated by this RFP are services that we currently provide to Iowa and to other state Medicaid agencies. Through the course of our work we have developed proprietary software programs to assist us with our contracting activities. We will adapt these programs for use by our staff located at the IME.

#### B. Courier Service (RFP Section 6.1.2.2)

Since all contractors and state staff will be co-located at the IME facility, the RFP envisions only the Core MMIS contractor having the requirement to contract with and coordinate courier services. When the services of a courier are needed for a pick-up or delivery of IME provider cost audits and rate setting materials, we will coordinate these activities with the Core MMIS contractor.

#### 5.3 Contract Management (RFP Section 6.1.3)

The RFP places primary responsibility for contract

management on the contractor, which we view as entirely appropriate. DHS (like most government agencies) does not have sufficient staff and other resources to manage contractor functions, nor should they, since that is exactly what the contractor is compensated to do. We agree to accept all the attendant responsibilities. We accept all state and contractor management responsibilities identified in the RFP, and will provide whatever assistance and information or reporting needed to discharge those responsibilities.

#### A. Performance Reporting and Quality Assurance (RFP Section 6.1.3.1)

We acknowledge and accept that any contract resulting from this RFP will be a performance-based contract, and that payments to a contractor will be tied to meeting identified performance standards. We also acknowledge and accept that any contract resulting from this RFP will include provisions for actual and liquidated damages assessed to the contractor in the event of failure to meet performance standards.

Project staff will work closely with DHS to develop the specific performance reporting and measurements as identified in Section 6.1.3.1.a of the RFP.

Our many years of multi-state Medicaid reimbursement experience has enabled us to anticipate Medicaid agency client needs. We understand that for IME to succeed, the contractor must remain forward-

looking in all aspects of its responsibilities, both in its ability to assure high quality of services and deliverables and improving processes. Waiting for a system or process to “break,” and then attempting to find a solution is not an acceptable alternative. Many times such a retrospective approach to project management leads to avoidable delays, embarrassment to the program, or unnecessary costs.

It is the policy of Myers and Stauffer that all engagements are properly planned, performed, supervised, reviewed, documented and communicated in accordance with professional standards, regulatory authorities, contractual requirements and firm standards. We continually strive to produce quality deliverables and outcomes. In this regard, we have adopted the following general financial review and audit engagement performance quality control steps.

- Obtain a signed contract or written engagement letter.
- Prepare engagement-specific work program and reference materials.
- Obtain state’s approval of work program and staff assignments.
- Plan the work and obtain background information about the engagement.
- Gain an understanding of internal control.
- Perform analytical procedures.
- Evaluate materiality and risk.

- Develop time budgets.
- Supervise work.
- Document material or complex consultations.
- Evaluate the propriety of a step down to a lower level of service.
- Resolve any professional disputes.
- Prepare required deliverables and draft the report.
- Perform analytical procedures.
- Obtain a management representation letter, if necessary.
- Review the work papers.
- Determine that we have substantially fulfilled all contract requirements.
- Prepare required client communications.
- Determine all review points and open items have been cleared.
- Have appropriate person sign the report or transmittal letter.
- File work papers

In consultation with DHS staff, we anticipate that these steps will be tailored to the different aspects of the contractor’s responsibilities in order to ensure that the objectives of this project are achieved.

These standard operating procedures will continue to be monitored during this engagement by Kris Knerr, a member with Myers and Stauffer, who will oversee the quality control reviews and processes, and provides

high-level strategic input to the project team.

As a standard operating procedure, the account manager and operations manager will regularly discuss all major aspects of the project with Mr. Knerr. They will conduct the operations of the project in an objective and professional manner. There will be prompt and effective response to requests from DHS.

The account manager will review each deliverable and measure its progress against the project time schedule. Control mechanisms designed for this project will ensure that goals are met. Internal status reports will routinely apprise the project director of progress on the project. If problems arise, the account manager will contact DHS to discuss the problem or delay and suggest options for resolution.

#### B. Contractor Responsibilities (RFP Section 6.1.3.3)

We will develop, maintain and provide access to all records required by DHS, state and federal auditors.

We will provide all reports necessary to show compliance with all performance standards and other contract requirements.

We will continue to provide reports to DHS regarding the components of our activities, as well as negotiate with DHS the content and format of these reports. The reports should provide DHS and the components contractors with information for

management of the contractor's activities and the Medicaid program. Draft formats will be prepared for consideration during this process.

We will prepare and submit to DHS requests for system changes and notices of system problems and issues related to our operational responsibilities.

We will prepare and submit for DHS approval suggestions for changes in operational procedures and implement the changes upon approval by DHS.

We will maintain operational procedure manuals and update the manuals when changes are made.

We will ensure that effective and efficient communication protocols are established and maintained both internally and with DHS staff. No action will be taken which reduces open communication or association between DHS and contractor staff or gives the appearance of such a reduction.

We will meet regularly with the IME to review account performance and resolve issues between contractors and the State.

We will provide progress reports to DHS on component contractor's activity as requested by the Department.

We will meet all security requirements within the contractor's operation as required under HIPAA

or in effect under state regulations, whichever is more stringent.

We will work closely with DHS to implement a quality assurance plan that is based on proactive improvements rather than retroactive responses.

We will develop and submit to DHS for approval, a Quality Assurance Plan establishing quality assurance procedures.

We will designate a quality assurance coordinator who will be responsible for monitoring the accuracy of our work and providing a liaison between us and DHS regarding our performance.

We will submit quarterly reports of the quality assurance coordinator's activities, findings and corrective actions to DHS.

We will perform continuous workflow analysis to improve performance of contractor functions and report the results of the analysis to DHS. Such analysis will be communicated and coordinated with DHS on an on-going basis so as to minimize the incidence of surprises.

We will provide DHS with a description of any changes to the workflow and obtain approval prior to implementation.

For any performance falling below a state-specified level, we will provide an explanation of any problems or issues, and identify the corrective action to improve the rating. If

situations arise, we are prepared to work collaboratively with DHS staff and other contractors to seek reasonable and workable solutions, and are committed to meeting and exceeding all DHS expectations.

We will implement a state-approved corrective action plan within the time frame negotiated with the State.

We will provide documentation to DHS demonstrating that the corrective action is complete and meets state requirements.

We will provide a response/resolution to DHS project management team within two business days of receipt to requests on routine issues or questions.

We will provide a response within one business day to DHS project management team on emergency requests, as defined by the State.

We will maintain documentation approved by the Department that describes the methodology used to measure and report the completion of all requirements and attainment of all performance standards.

#### C. Performance Standards (RFP Section 6.1.3.4)

We will provide the monthly performance monitoring report card within ten business days of the end of the reporting period.

We will provide an annual performance report no later than October 15 of each contract base.

Project staff will work with DHS to develop an approved format and content for the annual performance report. The annual performance report will include a demonstration of the state savings requirements as outlined in RFP Section 6.1.3.4.3.7.

We will update operational procedure manuals within two weeks of the implementation of a change and provide the necessary training on operational procedure changes as a result of upgrades or other changes.

Through the course of our project management and quality assurance and oversight, we will identify any deficiencies in a timely manner. Promptly following discovery of an issue, we will communicate this discovery to DHS, and will provide a corrective action plan within 10 business days. We will provide quality control and assurance reports, including tracking and reporting of quality control activities and tracking of corrective action plans.

We will maintain documentation approved by the Department that describes the methodology used to measure and report the completion of all requirements and attainment of all performance standards.

#### 5.4 Training (RFP Section 6.1.4)

Staff training is the foundation of high quality work. Our firm requires personnel to participate in general and industry-specific continuing professional education and development activities. These

activities enable staff to satisfy assigned responsibilities and to fulfill applicable continuing professional education requirements. In addition to formal staff training, we utilize structured and supervised training in the performance of specific project tasks. We have implemented firm-wide professional development policies that include:

- Encouraging participation in professional development programs, as well as considering requirements of the AICPA, state boards of accountancy, and regulatory agencies in establishing the firm's CPE requirements.
- Providing orientation and training on professional responsibilities and established policies for new employees.
- Developing in-house staff training programs that focus on general and industry-specific subject matter.

We understand that the state and federal health care environment is constantly changing in response to numerous external factors, so staff training is of the utmost importance. In order to be successful in this environment, it is critical to stay informed of the many changes that occur at the state and federal level.

Myers and Stauffer sponsors periodic in-house training workshops for professional staff from all office locations. Topics at these workshops generally include Medicaid health care reimbursement and issues from a wide array of provider categories and

disciplines presented by speakers from state agencies, CMS and other practitioners and professionals in health care and related fields who provide valuable insight into evolving issues in health care. In addition, our professional staff typically make presentations in their resource responsibility areas.

In addition to firm-wide Medicaid and health care training, we will continue to provide project staff with initial and on-going training that is specific to the IME project. This training will address system and operational procedures that are required to perform all rate setting, audit and consulting functions required by the RFP. We will designate a trainer who will be responsible for preparing and presenting staff training sessions and also provide similar training to DHS staff and other IME contractors as needed. Staff training will include the preparation of training manuals and all visual aides as necessary.

#### 5.5 Operational Procedures Documentation (RFP Section 6.1.5)

As the current Provider Cost Audit and Rate Setting contractor we have prepared documentation manuals for all major service functions of the Provider Cost Audits and Rate Setting Contractor components. Prior to the new contract period, we propose to review the current operational procedures documentation with DHS in order to identify strengths and weaknesses of current systems and to determine if

enhancements to the rate setting and auditing processes continue to be consistent with DHS objectives. Following these discussions, we will update manual documentation for review and approval by DHS.

We will also update operational procedure manuals within two weeks of the implementation of a change. All documentation will be provided in electronic form and made available online.

#### 5.6 Security and Confidentiality (RFP Section 6.1.6)

As a CPA firm, we have in place standard operating procedures to safeguard the confidentiality of all data. These procedures limit access to confidential files and data to those individuals assigned to the project, and then only on a “need-to-know” basis. We will comply with the Federal Information Processing Standards (FIPS). We will safeguard all data and records that are entrusted to us and within our control from alteration, loss, theft, destruction, or breach of confidentiality in accordance with both state and federal statutes and regulations. We will need to access confidential MDS data, which is obtained through the federal Data Use Agreement (DUA). As DHS’ current contractor, we have an approved DUA currently on file with DHS.

Compliance with the Health Insurance Portability and Accountability Act (HIPAA)  
We have implemented all confidentiality policies and procedures required by law, including without limitation those policies and procedures required under the Administrative Simplification section of HIPAA and the accompanying regulations. HIPAA training and policy manuals have been provided to Myers and Stauffer staff.

The confidentiality, integrity and security of client data are of paramount importance to us. As such we have implemented operating procedures to safeguard the confidentiality of all data, including visitor logs, identification badges, computer and worksite security, and confidential disposal of any documents that might contain Protected Health Information (PHI). All information relating to rate setting, auditing and other consulting and analysis activities under the IME project will be treated as confidential. Information will not be disclosed to any party without the consent and direction of DHS. All staff have on file signed confidentiality agreements to further protect potentially sensitive information.

We will take no action that adversely affects Iowa's compliance with HIPAA. Our policies will ensure compliance with the privacy and security of PHI throughout the life of the contract for all activities required to fulfill all requirements. Policies and procedures relating to the use and

disclosure of PHI are reviewed and updated at least annually, or as the law requires, and available for review upon request.

As a business associate of the State, we agree for all PHI obtained under this contract to:

- Not use or further disclose PHI other than as permitted by our contract or as required by law.
- Use appropriate safeguards to prevent unauthorized use or disclosure of PHI.
- Report any unauthorized use or disclosure of which we become aware and mitigate to the extent practical any harmful effect of that disclosure.
- Ensure that any agents or subcontractors to whom we should provide PHI agree to the same restrictions and conditions.
- Provide the policies and procedures, books and records related to the use or disclosure of PHI received from or created on behalf of DHS to the Secretary of the United States Department of Health and Human Services for the purposes of determining compliance with the law. DHS will be notified immediately of any such request and furnished copies of any materials provided.

On termination of the contract, we will return or destroy all PHI in our possession or where not possible, extend the protections of the contract for as long as the information is retained.

### 5.7 Accounting (RFP Section 6.1.7)

We agree to maintain all accounting and financial records (e.g., books, records and documents reflecting costs and expenses) associated with this contract 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), and will be maintained separate and independent of other accounting records of the contractor. All financial records will be maintained for seven years following the end of the federal fiscal year during which the contract is terminated or until final resolution of any pending state or federal audit, whichever is later. Records involving matters of litigation will be maintained for one year following the termination of such litigation if the litigation has not been terminated within the seven-year period.

### 5.8 Banking Policies (RFP Section 6.1.8)

Myers and Stauffer understands that during the course of our work we may receive checks or money orders on behalf on the Department. Upon receipt of a check or money order, project staff will immediately transfer the check to the Revenue Collections contractor's designated point of contact for placing in the safe. This will allow the check to be deposited

on the day of receipt and to be entered into OnBase for indexing.

Project staff will be available to assist in the maintenance and updating of the existing check classification code schematic, as necessary. In addition, staff will provide assistance to the Division of Fiscal management in the reconciliation of the monthly Title XIX Recovery bank account, we requested.

### 5.9 Payment Error Rate Measurement (PERM) Project (RFP Section 6.1.9)

Myers and Stauffer has extensive experience with Payment Error Rate Measurement (PERM) studies, including eligibility and data processing review.

We have assisted state Medicaid agency clients with payment error rate measurement projects since the beginning of the payment accuracy measurement (PAM) program in 2001.

Myers and Stauffer staff is familiar with, and able to apply, the concepts included in the CMS PERM guidance. We have assisted various states in testing the accuracy of claim payments for both Medicaid and Medicaid Managed Care. In addition, Myers and Stauffer has collected case and error information to help states identify error trends and areas where policy change may be needed.

### 5.10 Subcontractors (RFP Section 6.1.10)

Myers and Stauffer does not propose any subcontractors for this project. The personnel, facilities and equipment included in this proposal will perform the tasks in this project. However we acknowledge and accept that all subcontractors must comply with all requirements of this RFP for all work related to the performance of the contract.

### 5.11 Regulatory Compliance (RFP Section 6.1.11)

Like all other contracts Myers and Stauffer has with state Medicaid programs, we will adhere to all Health Insurance Portability and Accountability Act (HIPAA) Final Rules and Standards related to the electronic transactions of data for this project. Transmission of data for these programs is protected using various types of approved encryption methods such as Secure Socket Layer (SSL).

The following overview of the policies and procedures related to Protected Health Information (PHI) applies to associates and subcontractors (referred to collectively as “associates”) of Myers and Stauffer. Associates must report all violations to their supervisor immediately. Associates not following these requirements are subject to disciplinary actions, including termination.

### Protected Use Requirements

1. Associates must always use the minimum necessary PHI that can accomplish project objectives.
2. Associates agree to not discuss, disclose, or release to others, any data and practice or client information obtained before, during and after the term of their assignment without consent from Myers and Stauffer.
3. Associates agree to not access data files, paper files, or any other information maintained by Myers and Stauffer for any reason incongruent with their assignments and/or responsibilities.
4. Associates agree to not access, review, print, or photocopy data files, paper files, or any other forms or documents maintained by Myers and Stauffer unless specifically authorized to do so.
5. Associates agree to not leave personal and confidential client information in conspicuous areas, such as on print stations, desks or tabletops.
6. Associates agree to not discard client information in waste containers or other areas where unauthorized parties could obtain discarded materials. All confidential client information to be discarded must be placed in a sealed disposal container.

7. Associates must not share passwords, must lock computer work stations before walking away from their computer, and angle their computer screen such that it is not viewable by other associates or passers-by.
8. Associates must use sealed intra-office mail envelopes when transferring materials among staff.
9. Associates receive HIPAA updates and attend routine training sessions.

**Physical Security Requirements**

1. Myers and Stauffer's office suite is a secured area with restricted access. The suite access is locked during and after normal business hours with the exception of the main entrance. The main entrance is locked after hours. Visitors must enter through the main entrance and must sign in and display a visitor badge at all times.
2. Off hours building access is restricted to associates. For any associate entering the building after hours, the time and date of his/her entry is recorded.
3. All PHI is maintained within the office suite and stored in file cabinets, file folders, or other non-conspicuous compendia.
4. Historical hard copy PHI is stored in a secure off-site

location or shredded according to the terms of client contracts.

5. All discarded hard copy information is placed in a secure waste disposal.

5.12 Audit Support  
(RFP Section 6.1.12)

Since 2005, Myers and Stauffer has assisted the Department on several occasions with federal audits and certifications. This is a standard responsibility within most of our state Medicaid engagements, so we not only understand compliance issues, but also the oversight authority and responsibilities of other agencies with respect to the Medicaid Program.

We are accustomed to working through these issues with our clients, assisting in the evaluation of findings, preparing responses to those findings, assisting in drafting corrective action plans (and documenting results) when necessary.

We agree to continue to provide these supports under the new contract and to assist in any way necessary to respond to issues as they arise.

5.13 No Legislative Conflicts of Interest  
(RFP Section 6.1.13)

Myers and Stauffer is not directly involved and does not independently (i.e. as a firm) support legislation that impacts the Medicaid program.

Since our firm's inception, our responsibilities are separately defined by each state Medicaid engagement; therefore, any legislative assistance that we provide is done at the direction of and on behalf of the state Medicaid agency. We do not lobby for any state program, and we do not advocate for any legislation that will impact our firm or the services that we provide.

As a consultant and service partner to state and Federal governmental agencies for over 30 years, we believe that it is important to point out that we are exceptionally responsive and sensitive to public scrutiny, performance expectations, and the high levels of accountability and integrity that are expected of government agencies and policymakers. It is for this reason that, unlike our competitors, *our firm has always limited its practice exclusively to partnering opportunities with state and federal Medicaid agencies*. As a result of this business decision, we have never experienced any conflict of interest in providing services to private sector or not-for-profit companies or health care suppliers or providers.

Moreover, we have never had any conflict of interest relating to any work that we have performed, and we are careful to avoid any behavior or action that will give the appearance of impropriety or otherwise impede in any way a fair decision on any of the procurement processes in which we participate.

#### 5.14 No Provider Conflicts of Interest (RFP Section 6.1.14)

Myers and Stauffer has *always limited our practice exclusively to partnering opportunities with state and federal Medicaid agencies*. As a result of this business decision, we have never experienced any conflict of interest in providing services to private sector or not-for-profit companies or health care suppliers or providers.

As stated in the previous section, our more than 30 years of governmental experience has made us exceptionally sensitive to public scrutiny, performance expectations, and the high levels of accountability and integrity that are expected of government agencies and their contractors. As a result, we are acutely aware of issues, behaviors, and relationships that are not acceptable for any entity entrusted with delivery of services on behalf of the Medicaid Program (or any other publicly-funded program), and we have defined our firm's practices accordingly. We are proud of our work in supporting the Iowa Medicaid Program and will do nothing to blemish our reputation or the reputation of the Department.

## 6. Professional Services Requirements

### 6.1 Rate Setting, Cost Settlements, and Cost Audits (RFP Section 6.7.1)

#### A. Contractor Responsibilities (RFP Section 6.7.1.2)

Meet Objectives, Review Cost and Statistical Information to use in Rate-Setting Calculation, and Perform Cost Audits (desk reviews or field audits) of Provider Records (RFP Section 6.7.1.2 a, b, and c)

We look forward to continuing our relationship with the State of Iowa and further building upon our substantial experience providing the requested services to Medicaid agencies across the nation. We take pride in developing work products designed to meet the specific needs of our clients.

Myers and Stauffer processes nearly 5,000 health care provider cost reports each year, which involves our full spectrum of services, from rate and settlement calculations, to desk reviews and full scope audits. Our experience includes audits and desk reviews of hospitals, nursing facilities, federally qualified health centers, rural health clinics, home health agencies, and intermediate care facilities for the mentally retarded. Using sophisticated analytical and testing methods, Myers and Stauffer can identify

erroneous and/or abusive cost reporting practices.

We understand the issues that are unique to the health care environment and the impact that the desk review and audit process has on provider reimbursement. As the IME Provider Cost Audit and Rate Setting Unit contractor for the past four years, we are well-familiar with the cost report and provider reimbursement issues that are of greatest interest and focus to DHS.

The Medicaid program is complex with diverse and potentially competing objectives. Successful management of this complex program requires combining accurate and reliable information with a competent project team that is driven to meet program objectives. Myers and Stauffer is committed to continuing to provide this high level of support to DHS.

Although audit and rate setting are critical components of this project, this engagement is clearly about more than just financial and statistical report responsibilities. It is also about understanding the health care environment within the State (and outside), providing competent advice, and interpreting the vast amount of data generated by the many participants in the health care reimbursement arena. Myers and

Stauffer has the experience and knowledge to fulfill this need.

Given the limited resources available to the Medicaid program, we understand the importance of developing accurate cost report audit and desk review procedures. An important objective for our Medicaid agency clients is to direct as much of the available program funding toward the care of Medicaid clients. Since the results of these engagements directly impact Medicaid program expenditures, our project activities will be well-managed, disciplined, and contribute to the efficient operation of the Medicaid program. Our field audit, desk review and rate calculations will be designed to verify that financial and statistical reports adhere to Iowa Medicaid policy and that our work products are delivered timely.

While our primary functions are to verify financial and statistical reports and calculate reimbursement rates and cost settlements, the resulting databases linked with our knowledge of the Medicaid and Medicare programs often prove to be as important to our clients. Assessing the impact of alternative reimbursement approaches, sharing new developments within the provider community, program budgeting, and consulting on changes at the federal level are but a few of the areas where knowledge gained through the performance of our primary duties can assist our state agency clients.

Our team's expertise across the spectrum of audit and reimbursement issues is unmatched allowing us to focus our audit effort on issues relevant to provider reimbursement and program management. It also allows us to refine our audit efforts as the reimbursement systems continue to evolve. This, in turn, will ensure that DHS objectives for provider reimbursement continue to be realized in the complex and ever-changing health care environment.

We propose a project team that has the necessary experience to exceed the performance standards for the provider rate setting, cost settlement and cost audit functions. We will complete all duties in an accurate, timely, and professional manner. We understand our reports will be used to distribute significant Medicaid program expenditures.

Complete All Audits in Accordance with Generally Acceptable Auditing Standards  
(RFP Section 6.7.1.2 d)

The focus of Myers and Stauffer's audit work will be sufficient in scope to express an opinion in accordance with Generally Accepted Auditing Standards. The focus of the audits will be to determine that only allowable and reasonable costs were utilized in determining a provider's Medicaid reimbursement.

Myers and Stauffer will execute each audit program step that is applicable. If a step is determined not to be applicable, we will document the reason for this determination in our

work papers in sufficient detail to allow DHS to reach the same conclusion. The project manager will perform a review of each audit that is issued.

Maintain Interfaces  
(RFP Section 6.7.1.2 e)

During the course of this contract, Myers and Stauffer will work closely with other IME contractors and external entities exchanging the necessary information to successfully complete all the requirements of this RFP. We have established strong working relationships with all involved parties to ensure the success of the project. During the course of our current contract with DHS, Myers and Stauffer staff has demonstrated its ability to work with other DHS contractors and providers.

Develop and Maintain Desk Review Program  
(RFP Section 6.7.1.2 f)

Cost report audits and desk reviews can be powerful tools for addressing Medicaid program goals and objectives. Cost report verification processes can be used not only to verify that reimbursement rates and cost settlements are accurate, but also to develop databases of reliable cost and statistical information from which sound health care reimbursement policies are formulated. Myers and Stauffer has experience and ongoing contracts with numerous state Medicaid agencies for performing cost report verification as well as providing them

with valuable database management, analysis, and consulting functions.

We train our professional staff with a detailed understanding of the Medicare and Medicaid definitions of allowable cost along with the underlying reimbursement processes. It is essential for our audit staff to understand not only the cost report and allowable cost definitions, but also how the reports are used in reimbursing health care providers. There can be no substitute for this in-depth knowledge. It allows us to accurately assess the risk of reimbursement misstatements and to focus our efforts where the risk is greatest. This in turn, allows us to efficiently protect program funds and minimize disruptions of provider operations.

Myers and Stauffer has earned a reputation for being able to see the big picture while efficiently applying auditing procedures to each engagement. As certified public accountants, we adhere to rigorous quality control procedures and comply with professional standards as set forth by the American Institute of Certified Public Accountants.

Nationally, there is a trend toward using more sophisticated cost finding methodologies for institutional health care providers. The Medicaid and Medicare programs represent a significant payer for most health care providers. To assure that costs are not double-counted or go unrecognized by either program, it is important for each program to understand and

consider how the other is paying for its services.

Myers and Stauffer recognizes the changing needs of our Medicaid agency clients. Cost report audit and desk review procedures must evolve to address the changing reimbursement environments. We believe that our firm's broad experience in health care reimbursement provides us with the insight and understanding to assure that the audit functions are properly focused on the reimbursement system needs of our clients.

Our approach to audits and desk reviews recognizes that the purpose of provider audits and desk reviews is to promote adherence to state Medicaid program policies and to provide our clients with accurate cost and statistical information for use in settlement calculations, rate setting and analyses. The audit process encourages a sense of discipline among cost report preparers and provides integrity to data on which program policies, analyses and reimbursement rates are based.

Medicaid cost report desk review and auditing is in many ways quite different from more traditional financial statement audits. In traditional financial statement audits, the client is the auditee, and the auditee is typically eager to cooperate with the auditor, since they are paying for the service and want to have their financial statements completed.

In contrast, Medicaid cost report desk reviews and audits are performed under contract for a state Medicaid agency, and the auditees (providers of health care services) are often less willing to cooperate in the audit process since the audit frequently results in a reduction in facilities' Medicaid reimbursement rates. Traditional audit procedures, while effective at verifying that costs were incurred, are less effective at verifying the allowability and proper classification of costs. These audit functions are unique to the health care environment.

Our risk-based approach is designed to provide the most efficient and effective allocation of audit effort by optimizing the use of historical and current collateral evidence. This technique also recognizes that the audit environment makes it extremely important to focus our efforts on situations in which material audit findings are more likely to occur. By focusing on the areas, based upon an evaluation of inherent and control risk, the audits will provide the greatest probability of detecting material misstatements, while not unnecessarily burdening the provider community with audit processes that are unlikely to generate material findings.

High-risk areas include:

- Home office activities.
- Other related party transactions.
- Management fees.
- Multi-tiered capital or ownership structures.

- Joint use of facilities and personnel with other entities.
- Significant reporting changes from the prior period.
- Complex cost allocation issues.

The risk-based approach requires a thorough understanding of the “big picture” of the provider’s environment. To develop a complete understanding, we need to know:

- Ownership and control structures.
- Services the facility provides.
- Other businesses/organizations part of the ownership structures.
- Involvement of a management company.
- History of aggressive cost reporting.

We also focus on the impact that cost report misstatements can have on Medicaid reimbursement. As reimbursement risk increases, increased levels of audit resources will be devoted to examining each issue. By focusing on the big picture and following our risk-based audit and desk review approach, we will complete our cost report audits and desk reviews in a short period of time and obtain results that provide the maximum benefit to the program.

Myers and Stauffer has utilized a risk-based approach to auditing and desk reviewing cost reports for many years. It is interesting to note that in March 2006, the AICPA issued a “suite” of standards (SAS 104-111)

that relate to the assessment of risk in an audit. The AICPA’s primary objective in these standards was to enhance auditor application of the audit risk model. To accomplish this, they specified, among other things, that auditors should:

- Have a more in-depth understanding of the entity and its environment.
- Conduct a more rigorous assessment of the risks of material misstatement of the financial statements based on that understanding.
- Improve the linkage between the assessed risks and the nature, timing and extent of audit procedures performed in response to those risks.

While recent audit failures have lead the AICPA to refocus auditor attention on risk assessment, Myers and Stauffer has been utilizing a risk-based approach in all of its audit and desk review engagements. Risk based procedures are applied to each audit or desk review module to ensure that an appropriate amount of auditing/desk reviewing and corroborating information is obtained. We have performed risk-based desk review and auditing on Medicaid cost reports for many years and for a wide variety of Medicaid providers. This technique is extremely effective in accomplishing our clients’ objectives for the audit process.

Our desk review program will accomplish four primary objectives:

1. Verify the mathematical accuracy of the cost report.
2. Ensure the cost report adheres to Medicaid and Medicare requirements for the allowance of costs.
3. Verify that Medicaid statistical data (Medicaid days, visits, encounters, Medicaid charges and interim payments, if applicable) are accurate and properly reflected on the cost report.
4. Review by management and issue report.

Appendix A contains a sample desk review program developed in response to our current contract with Iowa Medicaid. It demonstrates the thoroughness of our desk review procedures. We will review our current desk review programs to ensure that they address the specific requirements of the Iowa cost reports.

*Mathematical accuracy of cost report:* We verify the mathematical accuracy of the cost reports as part of our data input and reconciliation processes. The first step is to enter cost report information into a database where computer routines verify the cost report foots and cross foots. Mathematical inconsistencies in the as-filed cost report are detected during this data input process. When appropriate, we reconcile the cost report to the facilities working trial balance (WTB). Account balances are traced to amounts reported on cost report lines both on aggregate amounts such as total revenues and expenses and on line item details.

These data input checks, reconciliations, and line item tracings result in a thorough check of the mathematical accuracy of the Medicaid cost report. Any exceptions detected are marked for potential adjustment and communicated to the assigned accountant.

*Professional Review of the Adherence to Allowance of Cost Requirements:* After verifying mathematical accuracy, we perform an initial risk evaluation. The risk of cost report misstatements are assessed during the review of analytical profiles, prior audit or desk review findings, the WTB reconciliation and line item tracings, and any other information available. We then use available information or request additional information to investigate each risk area.

Analytical procedures are efficient tools for use in identifying potential cost report errors. Using facility profiles of cost report information, staff can quickly compare amounts reported on current cost reports with previously audited or desk reviewed information. Unusual relationships such as an increase in the interest expense without an increase in facility debt, or an increase in depreciation without an increase in total assets are easily identified. During our performance of analytical procedures, and depending on the risk of misstated reimbursement, we mark these risk areas for further review.

We review the previously audited or desk reviewed report for each

facility. Emphasis is placed on verifying that prior year adjustment areas are either correctly reported in the current year or are adjusted, by us, in the current period as necessary. The WTB is scanned to verify that non-allowable expenses are offset, revenue was used to reduce cost where required, and expenses and revenues were reported on the correct lines of the cost report. We also look for indicators of risk through the identification of related party transactions, home office cost, and management fees.

Each identified risk area is resolved using information made available from the cost report, through telephone inquiries with the provider or through written requests for additional information. The resolution of these items is documented and any cost report adjustments calculated.

*Verify Medicaid Statistical Information:* We understand that the rate setting, audit and desk review contractor will receive finalized Medicare cost reports from the Medicare intermediary for providers that also participate in Medicare. It has been our experience that these reports are reliable with respect to total facility costs and statistical information (patient days, visits, total charges, etc.). However, we frequently find that the Medicaid statistics are not properly stated in the finalized Medicare cost reports.

It is extremely important that the Medicaid program is able to identify the costs providers incur caring for

Medicaid clients. This will only happen if Medicaid statistics are accurate and properly stated in the cost reports. To resolve this problem, Myers and Stauffer will work with the CORE unit and data warehouse to obtain Medicaid provider statistics and reimbursement reports and ensure that this paid claims data is properly reflected in the cost reports during our desk reviews and audits. The DHS can then base rates and cost settlements on Medicaid program costs and help ensure the overall integrity of the Medicaid program.

*Management Review and Report Issuance:* Once the accountant has completed the desk review, a management review is performed. This is a two-step process. The initial review is a detailed review of each work paper that ensures that the desk review program steps were properly performed and quality control procedures were followed. Any exceptions detected during this review are marked for correction by our staff. Once the initial review is completed, we will perform a final review, which ensures that the initial review was thorough and properly documented within our file.

We will communicate our findings to the provider and DHS. Many of our existing Medicaid audit projects contain provisions for issuing drafts of our reports. This is a valuable step in finalizing the desk review report. It provides both our client and the health care provider a formalized process for review and comment on our findings. It allows us to receive input and address any concerns DHS

or the provider may have before the report is finalized.

information requested by the state.

We use this process to develop and maintain a good professional working relationship with the provider community. We strive to explain our position on desk review findings (adjustments), and provide an opportunity for providers to express their position. These interactions are important in producing accurate, defensible reports, and in resolving differences in factual interpretations most efficiently.

Develop Arrangements with all Medicare Intermediaries to Obtain Form CMS 2552  
(RFP Section 6.7.1.2 g)

The final Medicare cost report will be used in reconciling Medicaid costs. We will accept responsibility for making arrangements with all the Medicare intermediaries to obtain Form CMS 2552 or other relevant cost reports. Both a contact person and backup staff have been designated to coordinate all activities and communication with the Medicare intermediaries. This staff person has worked with the FI to develop procedures for pick up and delivery of Medicare cost reports and related information. This process is vital to meet all project deadlines.

A draft and final report will be prepared and issued for each desk review. Contingent on further guidance and discussions with the Department, these reports will include:

Myers and Stauffer has worked with Medicare intermediaries during the performance of our current contract with Iowa and for many other state Medicaid agency engagements. Project staff are experienced in building positive working relationships with Medicare intermediaries across the nation. We have acquired the software needed to import electronic Medicare cost report (ECR) files and have trained our staff in the use of these software products.

- *An accountant's report* that includes a statement of the purpose, scope and standards used to complete the desk review.
- *A schedule of adjustments* to the historical cost report necessary to bring the report into compliance with cost allowance requirements. These schedules will reflect the dollar amount of our adjustments, provide a brief narrative explaining the nature of each adjustment, and provide a regulation cite supporting our rationale for each adjustment.
- *A report appendix* that includes a copy of the re-stated (corrected) cost report, any rate setting computations and any additional

Gather Necessary Information to Perform Desk Review (RFP Section 6.7.1.2 h)

Upon receipt of a cost report packet from the Medicaid provider, Department or Medicare intermediary, project staff will input the cost report into the database and evaluate its mathematical accuracy. Analytical profiles will be generated and used by the accountant to perform a risk assessment. A list of additional data required to perform the desk review procedures will be developed and information requests will be made.

In addition to the provider's cost report, the data necessary to complete a desk review includes supporting documents from the provider or Medicare intermediary such as Medicare audit adjustment report and copies of selected Medicare audit work papers, trial balance or general ledger, audited financial statements, CMS-339 (formerly HCFA 339) and provider statistical and reimbursement (PS&R) report from the MMIS or data warehouse depending on the provider type being desk reviewed.

While we believe placing some reliance on a Medicare intermediary's desk review or audit is reasonable, we have learned through experience that they often do not focus on getting the Medicaid statistical information correct. This includes Medicaid patient days (by level of care), Medicaid charges (particularly ancillary charges) and, where appropriate, Medicaid interim

payments. It is, however, vital that this information is accurate to ensure that the cost of caring for Medicaid clients is accurately identified from the cost reporting mechanics.

Medicaid cost can be significantly different from Medicare client cost and from other third party payor expenses. The cost report forms only show these differences when the Medicaid statistical information is accurate.

Assist Providers in Understanding Medicaid Regulations (RFP Section 6.7.1.2 i)

Myers and Stauffer's management and technical staff will continue to provide training to state and provider personnel. We will respond to provider inquiries regarding issues such as rate setting criteria provisions, claims payment, reimbursement methodologies and cost report filing guidelines, as well as monitor for frequently asked questions, which will be evaluated for cause and resolution.

Recommendations will be formulated and presented to DHS for review, including additional training or adjustment to the process. We have provided training sessions on such topics as:

- Cost report completion for both established and new programs.
- Changes in allowable cost definitions.
- Case mix reimbursement.

As training opportunities arise, we will work with the Department to

develop materials and programs to meet the needs of the target audience.

Send Blank Cost Reporting Forms to Providers and Ensure Timely Receipt of Cost Reports  
(RFP Section 6.7.1.2 j and k)

The Iowa Medicaid Cost and Rate Setting (IMCARS) software developed during our current contract with Iowa is designed to track not only the timely submission of cost reports, but also the progress of each cost report through the desk review, audit and settlement process. A report listing all active providers approaching fiscal year-end will be used to generate and distribute the required cost reporting forms and instructions. The database will track extension requests and revised due dates. A report identifying providers who are delinquent in filing cost reports will be generated from the database. Those providers will then be notified and DHS regulations will be enforced. A monthly tracking report will be provided to DHS.

Perform Provider Audit or Desk Review Annual Cost Settlement, and Rate Determination  
(RFP Section 6.7.1.2 l)

Specifications outlined in the RFP include audit or desk review, cost settlement and rate determination responsibilities for a wide variety of provider types. We have provided a discussion of our general approach to completing desk reviews and audits in other sections of this proposal and anticipate following these procedures to accomplish the provider audit requirements.

### ***Critical Access Hospitals***

The Critical Access Hospital (CAH) Program was included in the Balanced Budget Act of 1997. It is included within the Medicare Rural Hospital Flexibility Program, which is a permanent Medicare program and requires federal legislation in order to make any program changes.

Iowa was approved by CMS to participate in the Medicare Rural Hospital Flexibility Program on February 18, 1999. The CAH program receives Medicare reimbursement at 101 percent of cost for inpatient, outpatient and swing bed care. In addition, if the 35-mile distance requirement is met, then cost-based reimbursement for a CAH ambulance service is allowed.

Iowa Medicaid reimburses CAH based on 100 percent of reasonable cost achieved through retrospectively adjusted prospective rates. CAH interim reimbursement is based on the facility-specific DRG base rate for inpatient care and a percentage of charges for outpatient care.

Retrospective adjustments are based on the annual cost report submitted by the hospital at the end of the hospital's fiscal year. Once a hospital begins receiving reimbursement as a CAH, the facility-specific DRG and outpatient cost-to-charge ratio are adjusted annually during the cost settlement process and are not subject to the statewide rebasing or recalibration processes.

Both tentative and final settlements are performed. The primary difference between the two is the

status of the cost report. The provider filed cost report is utilized to perform the tentative settlement, while the final settlement is calculated based upon the adjusted cost report.

To perform the cost settlements we obtain the provider's cost report, trial balance or general ledger, audited financial statements, CMS-339 (formerly HCFA 339) and provider statistical and reimbursement (PS&R) report from the fiscal intermediary.

Once a cost report or finalized cost report has been received, the paid claims history will be requested from the CORE MMIS contractor. A work paper notebook will be assembled and the cost report data will be input into an electronic database.

The settlement process includes identification of allowable Medicaid costs of providing covered services to eligible fee-for-service Medicaid recipients determined in accordance with Medicare cost principles as derived from the Medicare costs report. Allowable costs are then compared to the interim Medicaid fee-for-service reimbursement based on the DRG and percentage of charges to determine the settlement amount.

Additional procedures may be part of the cost settlement process to ensure the completeness and mathematical accuracy of the cost report and reconciliation of the cost report to the trial balance and financial statements. Upon contract award, project staff will meet with the Department to

review current settlement procedures, discuss the varying levels of verification and analysis that could be performed, and revise the current settlement program, if necessary, to ensure it meets Department goals. The CAH inpatient and outpatient cost settlement programs will incorporate decisions made during this meeting, after review and approval by the Department.

Once the adjustment report and final settlement have been completed, the provider's facility-specific DRG base rate and outpatient cost-to-charge ratio will be reviewed based on the final settlement. If the provider's current DRG base rate and outpatient cost to charge ratio appear to be significantly over- or under-stated, the DRG base rate and outpatient cost-to-charge ratio will be adjusted to reflect the reasonable anticipated level of costs of providing covered services to eligible fee-for-service Medicaid recipients for the coming year.

Draft copies will be sent to the provider for review and comment. Once communication with the provider is complete, the work papers and final report will be sent to the project manager for final review. Upon manager approval, the final settlement documents along with the Notice of Program Reimbursement (NPR) will be forwarded to the Department for approval.

Appendix B contains the CAH cost settlement program currently used for the State of Iowa.

***Psychiatric Medical Institutions for Children (PMIC)***

Payment to PMIC is based on a daily prospective rate up to a maximum payment per diem established from cost report data submitted annually within three months of the facility's fiscal year end. Myers and Stauffer will annually mail instructions to each PMIC for downloading the cost report template. A desk review will be conducted to test mathematical accuracy, evaluate if the cost report was completed and filed in accordance with DHS rules and calculate the prospective payment rate. Myers and Stauffer will calculate payment rates annually or when a provider requests a rate review based on an interim cost report. The notice of provider reimbursement will be sent providers upon completion of the desk review. An audit will be conducted as requested by DHS. Myers and Stauffer has the expertise needed to analyze alternative reimbursement methodologies and the impact of anticipated program changes.

***Home Health Agencies***

Myers and Stauffer has provided various services pertaining to home health agencies such as cost report verification, rate setting and analysis of alternative reimbursement methodologies on behalf of Iowa Medicaid and our other state Medicaid agency clients. It is our understanding that the successful contractor will be required to provide rate setting and cost verification services to DHS. These procedures will mirror those

discussed throughout this section of our proposal.

Iowa reimburses home health agencies (HHA) on a retrospective cost related basis for skilled nursing, physical therapy, occupational therapy, home health aide, medical social services and home health care for maternity patients and children. This is the lesser of the provider submitted costs, Medicaid limit and Medicare limit in effect for the cost report period. EPSDT receives an interim fee schedule with retrospective cost settlement and is paid the lesser of provider submitted costs or the Medicaid limit in effect for the cost report period. Interim payments are made based on the cost to charge ratio. Annually during the tentative settlement the interim rate is reviewed and updated as necessary. Similar to CAH, both a tentative and final settlement will be performed.

The purpose of the cost settlement is to ensure that payments made to Medicaid providers are in accordance with federal and state requirements. Our review steps will be performed in accordance with the state's reimbursement plans, the Title XVIII Principles of Reimbursement, all applicable federal regulations, and DHS rules.

We will obtain the necessary data including the provider's cost report, trial balance or general ledger, audited financial statements, CMS-339 (formerly HCFA 339) and provider statistical and

reimbursement (PS&R) report from the CORE MIMIS contractor.

During the settlement process we review a detailed listing of all paid claims from the MMIS system to ensure that units stated on the PS&R are actually reported. If errors are found adjustments are made to correct the number of units used to complete the settlement.

Adjustments will be made to the MMIS system if necessary and we will work with other contractors to ensure HHA's are billing in accordance with IAC 441 Ch 78, (249A).

Organization of the data follows the same procedures detailed under the Critical Access Hospital discussion including the request for paid claims history, assembly of a work paper notebook, and input of cost report data into an electronic database.

The settlement process includes identification of allowable Medicaid operating costs as derived from the Medicare costs report. Allowable costs are then compared to the interim payments made to determine the settlement amount. If an underpayment is identified Myers and Stauffer will prepare a Gross Adjustment through the MMIS system to pay the provider the amount due. If an overpayment is identified we will log the accounts receivable and monitor until payment is received. If payment is not received we will prepare a Gross Adjustment through the MMIS system to withhold future payments from the provider until their

obligation to the Department is satisfied.

***Federally Qualified Health Centers and Rural Health Clinics***

Iowa reimburses federally qualified health centers and rural health clinics based on 100 percent of the costs that are reasonable (based on the provider's cost report) and related to the cost of furnishing services.

Interim payments are made based on a budgeted or projected average cost per visit subject to reconciliation after a cost report has been received. Annually during the settlement calculation process the interim rate for each facility is reviewed and updated if necessary. Similar to CAH, both a tentative and final settlement will be performed.

The purpose of the cost settlement is to ensure that payments made to Medicaid providers are in accordance with federal and state requirements. Our review steps will be performed in accordance with the State's reimbursement plans, the Title XVIII Principles of Reimbursement, all applicable federal regulations, including Title 42 CFR Part 405 (Medicare) and Title 42 CFR Subchapter C (Medicaid), DHS rules, and generally accepted auditing standards.

We will obtain the necessary data including the provider's cost report, trial balance or general ledger, audited financial statements, CMS-339 (formerly HCFA 339) and provider statistical and reimbursement (PS&R) report from the CORE MIMIS contractor.

Organization of the data follows the same procedures detailed under the Critical Access Hospital discussion, including the request for paid claims history, assembly of a work paper notebook, and input of cost report data into an electronic database.

The settlement process includes identification of allowable Medicaid operating costs as derived from the Medicare costs report. Allowable costs are then compared to the interim payments made to determine the settlement amount.

Once the adjustment report and final settlement are completed, the provider's interim reimbursement rate will be reviewed based on the final settlement. If the provider's current interim rate appears to be significantly over- or under-stated, the rate will be adjusted to more accurately reflect the provider's current operations, as reported in the final settlement.

As with CAH, draft copies are sent to the provider for review and comment. Once communication with the provider is complete, the working papers and final report are sent to the project manager for final review.

Appendix C contains the FQHC cost settlement program currently used for the State of Iowa.

### ***Community Mental Health Centers***

Iowa reimburses community mental health centers based on 100 percent of actual and allowable costs. Actual and allowable costs are based on the provider's cost report submitted on

an annual basis. Interim payments are made based on a fee schedule amount for each procedure code that was provided. Interim payments are reconciled on an annual basis to the actual and allowable cost to determine if an overpayment or underpayment of cost has occurred during the reporting period. Overpayment occurs when the interim payments exceed the actual and allowable cost of services. Underpayment occurs when the actual and allowable cost of services exceeds interim payments received during the reporting period.

Our review steps will be performed in accordance with the state's reimbursement plans, the Title XVIII Principles of Reimbursement, all applicable federal regulations, including Title 42 CFR Part 405 (Medicare) and Title 42 CFR Subchapter C (Medicaid), OMB Circular A-87, and DHS rules. We will obtain the necessary data including the provider's cost report, trial balance or general ledger, audited financial statements, and utilization data from the Core data warehouse and the Medicaid Managed Care contractor. Once the adjustment report and settlement are completed, we will forward the actual and allowable cost information to the Medicaid Managed Care contractor so they can transact their settlement calculation.

If an underpayment is identified Myers and Stauffer will prepare a Gross Adjustment through the MMIS system to pay the provider the amount due. If an overpayment is

identified we will log the accounts receivable and monitor until payment is received. If payment is not received we will prepare a Gross Adjustment through the MMIS system to withhold future payments from the provider until their obligation to the Department is satisfied.

Appendix D contains the CMHC desk review and cost settlement program currently used for the State of Iowa.

### ***Targeted Case Management Providers***

Iowa Medicaid provides reimbursement for case management services based on a monthly payment per enrollee. Case management is a service developed to assist MR/CMI/DD Medicaid recipients gain access to appropriate and needed medical and interrelated social and educational services to help manage their care. The monthly payment is established by the projected cost report filed at the beginning of the state fiscal year. At the end of the fiscal year end, providers are required to submit a cost report detailing actual cost expenditure for final cost settlement.

Effective July 1, 2010 Iowa Medicaid will begin paying case management providers based on 15-minute units of service. As the current contractor, Myers and Stauffer will continue to work with DHS to coordinate this transition.

Myers and Stauffer will prepare annual rates for each case

management provider using the submitted projected cost reports. Cost report data will be entered into the database to test the mathematical accuracy and to evaluate if the cost report was completed and filed in accordance with DHS rules. Effective July 1, 2010, a 15-minute unit rate will be calculated for each case management provider. Rate notification letters will be sent to all case management providers.

At the end of the fiscal year, Myers and Stauffer will conduct a cost settlement using the final (actual) cost report submitted by the provider. These cost reports will be “as filed,” therefore it is possible that additional verification procedures may be required prior to preparing the final cost settlement amount. Final rate letters will be sent to all case management providers. As the cost settlement process is retrospective, mass adjustments of claims will be completed to determine the settlement amount for each provider. We will submit mass claim adjustments to the Core MMIS contractor for adjudication. These adjustments will be reviewed and released by the Provider Cost Audit and Rate Setting Unit. Under and overpayments will be processed through the MMIS claims processing system.

### ***Home and Community Based Waiver Service (HCBS) Providers***

The Iowa Medicaid program currently has seven HCBS waivers approved by CMS. These waivers cover service delivery to the following beneficiary categories:

HIV/AIDS (AH), Brain Injury (BI), Elderly (E), Ill and Handicapped (IH), Intellectual Disability (ID), Childrens Mental Health, and Physical Disability (PD). Reimbursement methodologies for these waiver services vary among the different service categories, and are based on either fee schedules or retrospectively limited prospective rates with an upper payment limit.

We have worked with several state Medicaid agency clients providing various forms of rate setting and other technical assistance with Medicaid HCBS waiver issues. We are familiar with the unique challenges that waiver rate setting can present. State clients have shared with us their frustrations capturing actual service costs from waiver providers who are either too small, too few in number, or otherwise unwilling to track the needed information. Knowledge of these issues, combined with our considerable experience with rate setting principles, policy issues, and state payment methodologies, places us in a unique position to respond to Iowa's waiver rate setting needs. We can assist DHS with setting waiver rates according to existing rate setting requirements, and in exploring other approaches that may better serve the Department's needs.

***Habilitation Home and Community Based Waiver Services***

Payment to Habilitation Services providers is based on a unit rate up to a maximum established from cost report data submitted annually within three months of the facility's fiscal

year end. Myers and Stauffer will annually mail instructions to each Habilitation Services provider for downloading the cost report template. Myers and Stauffer will conduct a desk review to test mathematical accuracy, evaluate if the cost report was completed and filed in accordance with State and Federal requirements, calculate the retrospective payment rate and determine the cost settlement amount. Payment rates will be calculated annually or when a provider requests a rate review based on an interim cost report. The finalized rates will be transmitted to MMIS and ISIS. Myers and Stauffer will verify that the transmittals were accurately processed. Mass adjustments will be entered into MMIS to adjust individual claim payment to the finalized payment rate. The notice of provider reimbursement will be sent to providers upon completion of the desk review. An audit will be conducted as requested by DHS.

Myers and Stauffer has worked with several state Medicaid agency clients providing various forms of rate setting and other technical assistance with similar Medicaid HCBS programs. We are familiar with the unique challenges that rate setting of non-traditional provider types can present. These providers often have unique organization structure, limited accounting records and few dedicated accounting staff. Our knowledge of these provider types and specific issues prepare us to effectively address Iowa Medicaid's unique needs.

***Remedial Services Program (RSP)***

Payment to Remedial Services providers is based on a unit rate up to a maximum established from cost report data submitted annually within three months of the facility's fiscal year end. Myers and Stauffer will annually mail instructions to each Remedial Services provider for downloading the cost report template. A desk review will be conducted to test mathematical accuracy, evaluate if the cost report was completed and filed in accordance with State and Federal requirements, calculate the retrospective payment rate and determine the cost settlement amount. Myers and Stauffer will calculate payment rates annually or when a provider requests a rate review based on an interim cost report. The finalized rates will be transmitted to MMIS and ISIS. Myers and Stauffer will verify that the transmittals were accurately processed. Mass adjustments will be entered into MMIS to adjust individual claim payment to the finalized payment rate. The notice of provider reimbursement will be sent providers upon completion of the desk review. An audit will be conducted as requested by DHS.

Myers and Stauffer will annually collect historic Remedial Services cost data. The cost data will be inflated using the appropriate methods and economic index to calculate rate maximums for prospective periods. Myers and Stauffer has the expertise needed to analyze alternative reimbursement methodologies and the impact of anticipated program changes.

***School-Based Direct Medical Services***

Iowa Medicaid currently reimburses for school-based services under the Title XIX program for services provided by a Local Education Agency (LEA), Area Education Agency (AEA), or Early Access Service Coordinator (Infant and Toddler). The current reimbursement methodology is a prospective cost-based rate established by cost submitted electronically to the Department of Education. For example, cost submitted for state fiscal year (SFY) 2009, establish cost based rates for SFY 2011.

School-based service cost is composed of direct and indirect costs. Direct cost is generally limited to personnel and identifiable medical supplies used to deliver services. The direct services cost may include only those practitioners to whom a service would normally be attributed through fee-for-service billing in a community setting. Supervisors, coordinators, and administrative staff, for example, may not be included. Providers must identify salary and benefit cost of individual practitioners that meet the criteria for inclusion as direct service cost.

Our review steps will be performed in accordance with the state's reimbursement plans, all applicable federal regulations, including Title 42 CFR Subchapter C (Medicaid), OMB Circular A-87, DHS rules, and generally accepted auditing standards. We will obtain the necessary data including the provider's cost report and

unrestricted indirect cost rate from the Department of Education, trial balance or general ledger, audited financial statements, and provider statistical and reimbursement (PS&R) report from the CORE MMIS contractor.

Upon completion of the cost-based rate calculations we will forward to the Department of Education for their review and approval.

### ***Nursing Facilities***

We have provided a detailed discussion of our approach to accomplishing the desk review and rate setting requirements in our response to RFP Section 6.7.1.2 m. A detailed discussion of our on-site audit procedures is included in our response to RFP Section 6.7.1.2 n of this proposal.

### ***Intermediate Care Facilities for Persons with Mental Retardation***

Medicaid reimburses ICF/MR under a cost-based facility specific per diem rate established according to cost data submitted on the Financial and Statistical Report, Form 470-0030. It is our understanding that the following services for ICF/MR are being requested of the contractor:

- Mail blank cost report forms to providers and track receipt of completed cost reports.
- Perform a desk review of each Financial and Statistical Report submitted.
- Perform rate determination function.

The following section will describe processes utilized to accomplish the desk review and rate determination functions.

ICF/MR are required to submit an annual Financial and Statistical Report, or cost report, with a reporting period of July 1 to June 30. For new facilities entering the Medicaid program, either three six-month cost reports or four six-month cost reports are submitted to transition the facility to a reporting period of July 1 to June 30. It is our understanding that an on-site audit is required to be completed, by regulation, on the second submitted six-month cost report.

During the desk review process, project staff will evaluate each cost report based on the risk assessed during the initial review process by reviewing historical reliability of the provider's records, the size of the facility, and changes in cost. Rates will be established effective the first day of the month in which the cost report is received for each provider based on the desk reviewed cost report. The payment rate will be calculated as the lower of the actual allowable per diem rate, the maximum allowable base rate or the maximum allowable cost ceiling.

Annually effective July 1, a rate for each facility will be established using the most current desk-reviewed cost report and the updated inflation and maximum allowable cost ceiling. The maximum allowable cost ceiling will be calculated annually as the 80<sup>th</sup> percentile of allowable cost and

submitted to the Department no later than January 15th.

A rate worksheet will be prepared for each facility. A rate notification will be sent to each provider and the Core MMIS contractor. In addition, rate calculations will be performed on an as needed basis as new facilities enter the Medicaid program, as rates need updating due to cost report adjustments made during the audit process, and as needed when an exception to policy is granted.

Perform Annual Desk Review for NFs and Calculate Quarterly "Rate Sheet" (RFP Section 6.7.1.2 m)

As a leader in this industry, we have completed thousands of desk reviews and on-site audits of health care facilities. The purpose of provider audits and desk reviews is to promote adherence to state Medicaid program policies and requirements and to provide the Department with accurate cost and statistical information for use in rate setting, settlement calculation (if required) and analyses. The audit process encourages a sense of discipline among providers and adds a degree of integrity to data, upon which program policies, analyses and reimbursement levels are based. Our approach to conducting desk reviews and audits is both thorough and cost effective.

It is imperative that cost reports are evaluated for risk, and that these risk evaluations determine the amount and nature of testing procedures employed. Professional reviews of cost reports will be performed to

assess the risk of material reimbursement misstatement. This is, perhaps, the most important phase for each cost report review. It is crucial to perform this function thoroughly. Our assessment of the risk of cost report misstatements and the potential impact on Medicaid reimbursement will include the following features:

- Reconciling the cost report to supporting financial information (working trial balances (WTB) or audited financial statements), if available.
- Tracing revenues and cost from the WTB, if available, to the cost report and scanning for non-allowable or misclassified costs.
- Reviewing analytical profiles and investigating unusual relationships or large changes from prior periods.
- Checking for inconsistencies in the application of GAAP, or Medicare and Medicaid regulations, policies and procedures.
- Ascertaining if related party transactions, management fees or complex capital transactions are present.
- Determining if there has been a change of ownership or control of the facility.
- Ascertaining when the facility was last audited.
- Reviewing past desk reviews or audits to determine if prior period reporting errors appear to

- be present in the current period cost report.
- Preparing and reviewing preliminary per diem summaries to assess relationships to reimbursement limitation and Medicaid program dollars at risk.
  - Discussing the results of the previous steps with a manager or supervisor and finalizing our review procedures.

We believe the goals of all participants (Myers and Stauffer LC, DHS and the provider) in Medicaid cost report desk reviews and audits are similar. All want Medicaid reimbursement rates to be accurate and generated timely with minimal appeals or disruptions. With these goals in mind, we will evaluate and revise the desk review programs as issues arise. Any changes to the desk review programs will be provided to the Department for review and approval.

Project staff will complete an annual desk review of each financial and statistical report or Medicare cost report received from each nursing facility.

Upon receipt of each complete cost report, a clerical review process will be performed. During this process, the cost report will be reviewed for completeness and internal consistency. Following the initial clerical review, the cost report is assigned to an accountant to perform the professional portion of the desk review.

Once the professional review has been completed, we will prepare a summary of our findings, including any cost report adjustments we have found. We will also prepare a recommendation as to the necessity for the cost report to be audited, either full-scope or limited scope.

The findings and draft report from the professional review will then be reviewed by senior management of the firm. Upon completion of the review process, the accountant's report and supporting schedules will be prepared, finalized, and sent to the provider.

As reimbursement methodologies change, providers' behavior in response will change, some of these changes may be expected and advantageous, while others may be less so. For example, there is always incentive to shift costs between the direct patient care and the non-direct patient care rate components to maximize reimbursement. This becomes more important under the case mix system as separate rate setting parameters are established for each component. The desk review and field audit processes should focus on questionable cost areas. Appropriate procedures should be implemented to ensure that financial reports are prepared in a manner consistent with DHS policy. Generally Accepted Accounting Principles require consistency in financial reporting.

We anticipate working closely with DHS to identify any financial reporting incentives that may have

arisen under the new system. These issues will be discussed with DHS and incorporated in the desk review and onsite audit programs as directed.

### ***Calculate Nursing Facility Rates***

There are two separate components in the Medicaid rate –direct patient care and non-direct patient care. A facility’s costs are subject to several expense limitations that have been part of the Department’s prior cost based rate setting system (e.g., non-reimbursable expenses, advertising, owners and management compensation). The reimbursement methodology also provides adjustments for inflation, a utilization incentive and cost normalization. The direct patient care portion of the rate is further adjusted on a quarterly basis by the Medicaid case mix index. Each rate component can be no greater than the established rate ceiling each of which is stated as a percent of the median of provider costs. Nursing facilities may also receive additional reimbursement under the pay-for-performance program.

We have organized our discussion of the nursing facility rate setting requirements into three components:

- Bi-annual rebasing.
- Quarterly case mix rate sheets.
- Annual rate calculations.

The nursing facility case mix reimbursement system includes a provision to rebase the Medicaid rates using more current cost data every other year. The next rebase will occur for Medicaid rates effective

July 1, 2011, using the latest completed and reviewed cost report with a fiscal year end of December 31, 2010, or earlier.

Medicaid costs will be divided into two components for purposes of determining a facility’s rate. The first component is comprised of direct patient care costs that are case mix adjusted; these include salaries, wages and benefits for nurses. The second component is comprised of all other non-direct patient care costs including administration, support care, environmental and property. A utilization incentive will be applied when determining a facility’s allowable administrative, environmental and property cost. The utilization standard does not apply to hospital-based nursing facilities.

The historical costs will then be adjusted for inflation using the Skilled Nursing Facility Market Basket (SNFMB) index published by Global Insight which measures price level changes occurring in Medicare skilled nursing facilities. It is the most widely used measure of nursing facility cost inflation for Medicaid reimbursement systems. Facility costs will be inflated from the mid-point of the historical cost report period to the first day of the following state fiscal year (i.e., July 1, 2011). Quarterly , a projected nursing facility budget, based on estimates developed in cooperation with DHS, will be prepared and adjustments to the inflation will be made to ensure that estimated expenditures do not exceed the legislative cap.

Prior to determining the median costs, each provider's average nursing costs will be reviewed so that, to the extent possible, cost variations caused by different levels of case mix are removed from the cost comparison. This process, referred to as cost normalization, produces average nursing costs that are more comparable for all providers.

Cost normalization is accomplished simply by dividing a facility's average allowable direct patient care costs by the facility's average case mix index (CMI) score. An average CMI for all residents will be calculated each calendar quarter, with the simple average of the four quarters covering the time period of a facility's Medicaid cost report used to normalize the direct patient care costs.

For each nursing facility, average per diem allowable costs by component will be calculated using actual costs submitted by the nursing facilities. These costs will be subject to several expense limitations that exist within the current rule (e.g., non-reimbursable expenses, advertising, owners and management compensation), as well as adjustments for inflation, the utilization incentive, and cost normalization. The per diem costs are arrayed from lowest to highest and weighted based on each facility's total patient days. The per diem cost of the nursing facility that falls at the median of all patient days (i.e., the weighted median) becomes the basis for determining the rate and profit

rate setting parameters. To determine the Medicaid rate applicable to hospital-based facilities, a separate peer group of hospital-based facilities will be used to calculate the weighted median.

Each facility's Medicaid rate will be calculated as the sum of the direct patient care component and non-direct patient care component. Facilities also have the opportunity to receive additional reimbursement through the pay-for-performance program. Please refer to our response to RFP Section 6.7.1.2 dd, for a more detailed discussion of the pay-for-performance program and corresponding tasks.

As mentioned previously, direct patient care costs are adjusted for differences in resident acuity, or case mix. Extensive research by CMS has shown a strong correlation between nurse staff resource consumption and resident case mix. The case mix system adjusts Medicaid payment rates based on predicted resource use as measured by the Resource Utilization Groups, Version III (RUG-III), 34 group classification system. Standard CMIs developed by CMS will be used for calculating the average CMI, or score, for each nursing facility.

As CMS implements the MDS 3.0 and changes to the RUGs logic, we will work with the Department to determine the best methodologies and timing for implementation into the nursing facility Medicaid reimbursement methodology.

A facility's average CMI, or score, will be calculated four times per year for non-discharged residents on the last day of each calendar quarter. Separate calculations will be made to determine the average CMI for all residents and for those who are Medicaid only. In order to provide adequate time for submission and processing of information, the quarterly CMI for Medicaid residents will be used to adjust Medicaid rates beginning the second quarter following the assessment quarter. The table below illustrates the CMI calculation timing, and the underlying MDS assessments used.

The quarterly CMI calculations will be developed by the Medical Services contractor. Project staff will work with the Medical Services contractor to develop a routine schedule for obtaining the quarterly CMI calculations and supporting MDS data. Once data is received, staff will review the quarterly CMI calculations and communicate any identified issues to the Medical Services contractor.

Upon finalization of the CMI calculations, we will prepare and send each nursing facility accurate rate sheets each calendar quarter that reflect the adjustment in Medicaid case mix index. For a new facility the rate sheet will not reflect the

facility's actual Medicaid acuity until the calculation includes a full quarter of assessment data.

Every July 1, we will calculate each nursing facility's Medicaid rate and provide a rate sheet to the facility. During non-rebase years, this process is identical to generating the quarterly case mix rate sheets for facilities that have been in existence since the prior July 1. As new facilities come into the Medicaid program, they are required to submit a financial and statistical report that reflects cost from the first day of operation to the facility's fiscal year end. Until the provider files the financial and statistical report, the Medicaid rate will not reflect the facility's actual cost. If a financial and statistical report is available and has been desk reviewed, the Medicaid rate calculated on on the Medicaid enrollment date will be updated to reflect the providers' reported allowable cost, subject to the rate ceilings described above.

During rebase years, each facility's allowable cost and rate and profit ceilings will be recalculated using the procedures discussed above and incorporated during the July 1 annual rate process. The Medicaid rate will also reflect the quarterly adjustment in Medicaid case mix index.

Calendar Quarter	Latest Resident Assessment Used as of	Calculation of CMI completed by	CMI Applied to Medicaid Rate Effective
1/1 – 3/31	3/31	6/30	7/1
4/1 – 6/30	6/30	9/30	10/1
7/1 – 9/30	9/30	12/31	1/1
10/1 – 12/31	12/31	3/31	4/1

There are several Iowa long-term care facilities that provide services to atypical Medicaid residents, such as children, individuals with mental disorders, and veterans. These facilities are not subject to the case mix system. For these providers, rates will be updated on an annual basis and notification of rate changes will be sent.

Perform On-Site Audits  
(RFP Section 6.7.1.2 n)

Myers and Stauffer audits begin with development of an overall strategy to determine the scope of the review. Audit planning activities help to form a preliminary assessment of the nature, timing and extent of auditing procedures considered necessary to formulate an opinion on the fair presentation of the cost report (in accordance with generally accepted accounting principles and the appropriate regulatory authorities, including federal and state guidelines).

Our firm obtains an initial understanding of the provider's internal control system through questionnaires and review of correspondence/prior year files to make a preliminary assessment of control risk. This assessment is then used to ensure that the audit is adequately planned and to develop an audit program that is tailored specifically to the provider.

Fieldwork begins with a determination of whether provider representations on the cost report are in agreement with provider records.

Preliminary procedures assist in obtaining an understanding of the provider's control environment, accounting system, and control procedures. We utilize our assessment of control risk to determine the nature, timing and extent of testing to be performed.

We will develop an audit selection process that maximizes benefits realized from the field audits. Like the desk review process, our audits are performed using risk analysis, issue investigation, report preparation and review. The primary difference between our desk reviews and audits is the amount of evidence examined, as well as the documentation needed to support cost report amounts.

Our cost report audits are designed to accomplish two primary functions:

1. Examine each identified risk area to ensure that the risk of cost report misstatements is reduced to an acceptable level.
2. Develop sufficient competent evidential matter to provide a basis for expressing an auditor's opinion on the Medicaid cost report in accordance with the Iowa Administrative Code.

We will work closely with DHS to develop the audit program, questionnaire and standard work papers required for the audit. A separate audit program will be developed for each of the provider types to address differences in risk areas and cost reporting

requirements. Please refer to appendix E for an example of an audit program that we have developed for nursing facilities in a similar engagement.

This program was developed in accordance with Myers and Stauffer's risk-based approach to auditing. It contains "Inquiry and Standard Testing" and "Additional Testing" for each audit area. The inquiry and standard testing steps have been developed to assist the auditor in quickly assessing the reasonableness (material correctness) of the provider's cost report. This testing is generally performed using only the information provided with the cost report or produced as part of a standard accounting package. Yet this testing allows us to assess the risk that the cost report could be materially incorrect in each audit area. If the results of the standard testing indicate that material cost report misstatements may be present, we will perform additional testing to ensure that these risk areas are thoroughly examined. The additional testing steps provide the auditor with guidance for this examination. When necessary, we will request additional information from the providers to resolve material issues. We emphasize our goal of limiting additional information requests to those cases that are truly justified.

By following this risk-based cost report review process, we are able to provide our state Medicaid agency clients with a high level of confidence that material cost reporting errors have been detected

and corrected, while minimizing interruptions and information requests to the health care providers.

Our discussion of the processes we will utilize in completing each field audit engagement is organized into three components:

- Prefield (audit planning) activities.
- Field site visit activities.
- Post field/report preparation activities.

***Prefield "Audit Planning" Activities***

Upon receipt of an audit assignment, we first contact the provider and establish dates for the site visit. We have a standard scheduling letter that informs the facility of records and personnel that need to be available at the time of our site visit.

Concurrently with the audit scheduling, we assign an in-charge auditor and an appropriate number of additional senior and staff auditors, matching audit assignments with staff expertise to properly perform the engagement.

Prior to the site visit, the audit team assigned to the engagement will obtain and familiarize themselves with relevant documents. These include:

- Medicaid Financial and Statistical Report.
- Medicare Cost Report.
- Provider's or Accountant's Cost Report Preparation Work Papers.

- Prior Year Cost Report and Cost Report Audit Reports.
- Provider's Working Trial Balance (WTB) Used to Prepare the Cost Report.
- Independent audit report – if applicable

Having access to these documents allows our audit teams to become familiar with the provider and to identify risk areas that will require additional audit analysis during our site visit.

The prefield/planning section of our audit includes the following procedures:

- Reconciling the cost report to the working trial balance used to prepare the cost report. This reconciliation is performed on total revenues and expenses. We also trace individual expense and revenue amounts appearing on line items on the cost report back to the supporting WTB accounts. These reconciliations and tracings allow our auditors to assess whether the provider has properly reported cost and revenues on the cost report. It also allows us to identify those costs the provider is claiming as allowable and those costs they have self-disallowed. Our tracings also show which revenues have been used to reduce allowable cost.
- Reviewing analytical profiles to assist our staff in identifying deviations in the cost report from industry norms and past cost

report filings for the provider. We typically produce profiles that assist us in identifying deviations in provider reporting for each cost report line item. We also look at the following expense account groupings as part of our analytical review procedures; Salaries and Wages, Depreciation and Interest, Other Expenses, Patient Days and Revenue, and Allocation Statistics.

- Reconciling revenues and expenses to the WTB and performing analytical review procedures assist us in identifying cost report issues that need to be further analyzed during our field audit.

Our accountants make note in a planning memo, the items or risk areas they have identified during the performance of each of these audit steps.

An in-depth, expert level of understanding of the reimbursement system and rate development is critical to properly performing audit planning. Our staff development protocols include intensive training on reimbursement systems and properly assessing the risk of cost report misstatements and misclassifications on the reimbursement rates generated from our audited cost data. For example, reported per diem costs must be compared to screens or limits to determine where the provider's costs are being limited. This allows the auditor to assess the potential benefits of misclassifying reported

costs to shift them into an area that is not limited by the screen.

The accountant in charge and assigned staff meet with the project manager or supervisor to verify that prefield activities were properly performed and that risk was properly assessed. These meetings allow more senior personnel to develop appropriate audit strategies for complicated and often very technical reimbursement issues.

To thoroughly examine risk areas identified, our audit processes are tailored to each specific audit issue. We frequently add questions to our entrance interview questionnaire to obtain additional representation from facility management.

We may also modify our standard audit program to perform additional or expanded testing to examine unique audit risk issues.

Thoroughly reviewing all available information prior to field visits and risk-adjusting our audit process maximizes the audit benefits for our clients.

#### ***Field Audit (Site Visit) Activities***

Our site visit activities are designed to provide the audit team with a consistent approach to auditing the cost report. Specific procedures have been developed for each segment of the audit. The following discussion addresses typical site visit audit activities. Specific site visit steps will be contained in the audit program approved by DHS.

To assist in evaluating our audit process, we have provided brief discussions of the typical site visit activities for:

- Entrance Interviews
- General Ledger/Trial Balance Testing
- Census and Revenue Testing
- Allocation Statistic Testing
- Home Office/Related Organization Testing
- Payroll (Salary and Wage) Testing
- Non-Salary Expenses
- Exit Conference

#### ***Entrance Interview***

At the start of each field visit, our auditors will conduct an entrance interview. This allows us to:

- Gain additional familiarity with the provider operation, records and internal control environment.
- Ensure the availability of records requested in our scheduling letter.
- Inquire about the issues (risk areas) identified during our prefield procedures.

For other Medicaid cost report audit projects, we have developed Interview Questionnaire forms designed for each provider type. Similar questionnaires will be used on this engagement. Please refer to appendix F for an example of an audit questionnaire. Additional



information agrees with the facility's general ledger and other subsidiary ledgers. We trace the WTB amounts to supporting general ledger information and determine that records requested in our scheduling letter have been produced. Any exceptions detected during this portion of the audit are discussed with the provider.

#### *Census and Revenue Testing*

We typically combine our testing of routine revenues and patient days or visits. There is a direct relationship between the volume of routine services provided and the revenue generated. By combining our testing in these two areas, we are able to leverage our audit effort from this direct relationship. An example of how this works can be seen in the following standard audit worksheet we have developed. Computerized worksheets assist our staff in performing testing procedures and ensuring consistent application of the audit, and mathematical correctness.

By recording residents per month, by payer type, and the rates charged to each group, we are able to quickly recalculate routine revenues and total census days. This worksheet helps our staff identify such issues as discounting to non-Medicaid clients, non-routine revenue being improperly recorded as routine, and incorrect reporting of Medicaid and/or total patient days.

In this section of our audit, we will also perform the following:

- Review non-routine revenues and ensure that revenues have been used to reduce allowable cost when required by regulations.
- Look for revenues associated with non-health care services and then assure that the cost report properly reflects these services. For example, an examination of revenues will help us detect if the facility's dietary department is preparing meals for another entity, and if so, whether the associated costs have been removed.
- Review and test patient census records to ensure that only allowable days of care are recorded and reported on the cost report.

As potentially non-allowable costs or other adjustments are identified during the performance of our testing, these items will be discussed with the provider. This gives the provider an opportunity to investigate the issue on his or her own and be prepared to discuss the issue at the exit conference.

#### *Allocation Statistic Testing*

Through our auditing of nursing facility, hospital and home office cost reports, we have developed auditing techniques for testing allocation methods and the underlying statistics. It is clear that allocation statistics are central elements in apportioning cost between Medicare, Medicaid and other payers. In several of our Medicaid audit engagements, we actually audit the Medicare cost reporting forms. As such, we have

developed procedures for verifying the allocation statistics contained in these reports and for adjusting the statistics to ensure an equitable distribution of cost between Medicare, Medicaid and other payers.

We have also used our familiarity with the Medicare program to assist several of our clients in better measuring the true cost of caring for the Medicaid population. We believe our Medicare program knowledge will continue to be extremely valuable to our Medicaid agency clients in coming years.

*Home Office/Related Organization Testing*

We have also dedicated a specific section of our audit program to addressing home office costs and other related organization issues. We have found that spending the time needed to thoroughly review home office cost reports and other related organization issues is necessary since the result of our testing in these areas has frequently revealed material adjustments.

Our process for reviewing home office cost reports replicates the testing procedures discussed in this portion of our proposal (Census and Revenues, Employee/Owner's Compensation, Property, etc.). Our audit processes are designed to ensure that costs reported on the home office cost report are allowable, and that allocation of these costs to each facility is appropriate.

It has been our experience that home offices frequently include non-reimbursable cost at the home office

level and attempt to allocate this cost to their facilities as allowable facility-level cost.

Another area of concern is with respect to expenses such as interest. We need to verify that the provider is not including facility-related mortgage interest expenses in the home office cost and also reporting them as administrative and general home office-related cost on the facility's cost report. Obviously, this reporting scheme will circumvent the Medicaid capital asset reimbursement process.

*Payroll (Salary and Wage) Testing*

We typically combine our testing of employee payroll expenses with owner's compensation. We have developed standard worksheets to assist our staff in performing the audit testing in these areas. We test **total** payroll using the worksheet on the following page.

In addition to performing the testing addressed in this work sheet, we typically perform the following with respect to employee compensation and owner's compensation:

- Trace payroll cost for a sample of pay periods from the payroll register to the general ledger, verifying that there has been no cost shifting between payroll departments and that rates of pay and deduction to net pay are reasonable.
- Scan W-2s and the payroll registers looking for owner and owner related party compensation.

MYERS AND STAUFFER			WORKPAPER INDEX	900.2			
PROVIDER NUMBER			N/A	PREPARED BY	JMB		
PROVIDER NAME			XYZ, Inc.	REVIEWED BY			
PERIOD ENDED			12/31/99	WORKPAPER DATE	2/24/99		
SOURCE OR ACCOUNT			941's	RUN DATE	03/05/99		
				NAME OF WORKPAPER	RCPR		
Payroll Reconciliation							
Quarter MM/YY	Gross Payroll	Percent of Period	Current Period Payroll Amount	FICA 7.65% Percent	FUTA 0.80% Percent	SUTA 1.50% Percent	Total Payroll Tax
Mar-99	345,275	100.00%	345,275	26,414	2,762	5,179	34,355
Jun-99	366,050	100.00%	366,050	28,003	2,928	5,491	36,422
Sep-99	362,572	100.00%	362,572	27,737	2,901	5,439	36,076
Dec-99	368,278	100.00%	368,278	28,173	2,946	5,524	36,644
			0	0	0	0	0
			0	0	0	0	0
SUBTOTAL	1,442,175		1,442,175	110,326	11,537	21,633	143,496
RECONCILING ITEMS							
Less Beg. Accruals:			(89,725)	(7,112)	(725)	(1,350)	(9,187)
Plus End. Accruals:			92,674	7,268	760	1,390	9,418
Other: (401K, etc.)							
		Total	1,445,124	110,482	11,572	21,673	143,727
		Per C/R	1,443,694	110,850	11,683	21,234	143,767
		Diff.	1,430	-368	-111	439	-40
		% Diff	0.10%	-0.33%	-0.95%	2.07%	-0.03%
<u>Comments:</u>							
Differences appear reasonable. No further testing necessary.							

- Verify that hours worked according to the payroll documents agree with amounts reported on the cost report.

**Non-Salary Expenses**

During our pre-field planning processes and other audit verification procedures, we identify the expense accounts that require additional audit emphasis. Our staff focus their review in this segment of the audit on the examination of these accounts to

determine the source of our concerns and then to ultimately determine if the costs are allowable and properly reported within the Medicaid cost report.

By focusing our examination on these risk areas, we increase the quality and value of the audit effort for our clients. These focused examinations are typically performed using judgmental sampling techniques. In addition to the risk-

adjusted focused sampling, we typically also conduct some random sampling of accounts and expenses. This random sampling of provider cost is performed to confirm our understanding of the control environment and to generate sufficient competent evidential matter for expressing our opinion on the cost report.

***Exit Conference***

Prior to leaving the field, the audit team will conduct a meeting with the provider to discuss the findings and questionable costs identified during the field visit. This step in the audit process is extremely effective in reducing the frequency of challenged findings and appeals. Our audit staff is instructed to allow sufficient time at the end of the field visit to thoroughly discuss the proposed adjustment areas prior to leaving.

The audit team then returns the provider's records and a detailed listing of any additional information needed to complete the audit. The results of the meeting will be documented in the work papers.

***Post Field/Report Preparation Activities***

Upon returning from the field (site) visit, team members meet to discuss any audit issues with the project manager or supervisor to determine if the audit was conducted in accordance with the firm's quality control policies and to ensure that all audit areas and risk issues were properly addressed and documented. The meeting also serves as a planning

session for completing the audit process.

Following the post-field meeting, the audit team completes the audit and prepares the draft report, which is guided by standard work paper filing procedures, tick mark legends, checklists and other tools to ensure consistency between audits and over time.

Once the audit is completed, the team performs a two-step management review. The first review includes an initial detailed review of each work paper to ensure that the audit program steps were properly performed and internal quality control procedures were followed. Any exceptions detected during this step are marked for correction by our staff and then addressed by the audit team before proceeding to the final review.

A final review then ensures the initial review was thorough and properly documented in our file. Upon completion of the review procedures, the draft audit report will be issued in accordance with the procedures discussed in our response to maintain desk review program RFP Section 6.7.1.2 f.

Recognize and Honor Agreements for Exchange of Medicare and Medicaid Information  
(RFP Section 6.7.1.2 o)

Myers and Stauffer agrees to recognize and honor the Agreements for Exchange of Medicare and Medicaid Information. We

understand the importance of completing a desk review or audit in an efficient and cost effective manner and the value in eliminating duplication of tasks. As the incumbent contractor, Myers and Stauffer has worked closely with and built a productive relationship with Iowa Medicare intermediaries. We will bear any cost associated with obtaining Medicare cost report and adjustments since CMS no longer provides this information to states free of charge.

It is critical for our audits and desk reviews to ensure that Medicaid statistical information (Medicaid days, Medicaid charges and, where appropriate, Medicaid interim payments) are properly stated in the cost reports.

While the cost report forms are more than adequate to accomplish this task, they only work when Medicaid statistical information is accurate. Myers and Stauffer audit and desk reviews have been designed to ensure this needed data is properly reflected in the cost reports so that Medicaid program decision makers are able to base their decisions on data that shows the true cost of providing services to Medicaid clients. This, in turn, will improve the fiscal integrity and overall administration of this important program.

Correct Submitted Cost Reports,  
Correct Rate Sheets and Submit to  
CORE MMIS  
(RFP Section 6.7.1.2 p, q and v)

At the conclusion of each desk review, audit or cost settlement, project staff will prepare an adjusted rate sheet that will be sent to the provider with their final rate letter along with an adjusted cost report, as needed. Depending upon the provider type, the final rate letter may include the final settlement amount, revised interim rates, or revised prospective rates. Rate changes will be submitted to the core MMIS contractor and the ISIS contractor for entry. If claims adjustments are needed, adjustments will be submitted to the core MMIS contractor for adjudication. These adjustments will be reviewed and released by the Provider Cost Audit and Rate Setting Unit.

Develop Interim Rates  
(RFP Section 6.7.1.2 r)

The Medicaid program reimburses various provider types using a cost based methodology with a retrospective settlement calculated when the facility's cost report is submitted. Interim payments are paid to the facility as services are provided and then settled to cost at year-end. These interim payments are designed to approximate the costs that will be incurred by the facility to provide services. Interim rates will be reviewed as part of the cost settlement process and as requested by the Department.

The accountant-in-charge will review the provider's interim reimbursement rate in relation to the final settlement or cost statements/work papers received by the provider. If the provider's current interim rate

appears to be significantly over-or under-stated, the rate will be adjusted to more accurately reflect the provider's current operations, as reported in the final settlement. Notification of rate change will be sent to the provider and core MMIS contractor.

Calculate  
Overpayments/Underpayments  
(RFP Section 6.7.1.2 s)

For those providers that are reimbursed under a cost based methodology with either a retrospective or prospective cost settlement, an overpayment or underpayment will be determined during the cost settlement process. We have provided a detailed discussion by provider type on the procedures we propose to complete in determining the overpayment/underpayment in our response to RFP Section 6.7.1.2 l.

Maintain Per Diem Rates for Physical Rehab and Psychiatric Units and Submit Rates to MMIS  
(RFP Section 6.7.1.2 t)

Myers and Stauffer will continue to maintain, update and load per diem rates for hospitals with certified physical rehab units and hospitals with certified psychiatric units in accordance with the reimbursement guidelines established by DHS. The prospective per diem rate for each hospital is determined during the inpatient rebase process completed every three years (2005, 2008, 2011, etc.), with payment to hospitals based

on the lower of the Medicaid cost per diem rate or actual charges.

Rates will be calculated every three years and notification sent to the provider and the core MMIS contractor for upload into the claims system upon approval from DHS.

Provide Notice of Provider  
Reimbursement  
(RFP Section 6.7.1.2 u)

A cost settlement letter, along with the NPR will be sent to cost-based providers and will include a copy of the adjusted cost report and instructions for remitting overpayments to DHS and their right to request an appeal. All underpayments will be processed through the claims payment system. All overpayments will be posted to the monthly accounts receivable report submitted to DHS fiscal management by the Provider Cost Audit and Rate Setting Unit. Providers will be required to submit checks for the overpayment. If a check is not received, overpayments will be processed through the claims payment system as an offset to future payments. If a provider has cancelled its Medicaid contract, project staff will coordinate with the revenue collection contractor to pursue collection of overpayments. Project staff will work with providers to develop a repayment plan and to get approval from DHS, if necessary.

Reopen Cost Report Settlements  
(RFP Section 6.7.1.2 w)

Myers and Stauffer will retain desk review, audit and cost settlement work papers and reports. Additionally electronic versions of the calculations will be maintained on the network and backed up in accordance with our normal disaster recovery procedures. This will allow for quick retrieval if it becomes necessary to reopen a cost report settlement, desk review or audit.

Provide Documentation and Participate in Administrative Appeals or Court hearings  
(RFP Section 6.7.1.2 x)

Myers and Stauffer provides our state agency clients with timely and accurate audit, desk review, Medicaid reimbursement rate and settlement information. Occasionally, providers will take exception to our findings and file an appeal. The nature of their exceptions may include disagreements regarding the allowability of costs, the classification of costs, or the treatment of statistical or other rate and/or settlement variables.

Our audit staff, who has an expert level of understanding of Medicaid reimbursement processes and requirements, as well as particular knowledge of the issues under dispute, will be available to assist in the resolution of each provider appeal.

Our assistance will include preparing additional analyses, performing

additional research of the reimbursement criteria, and preparing proforma reports to evaluate the issue(s) under appeal. When the appeal cannot be resolved in an informal setting, staff will be available to consult with DHS staff and legal representatives. Our staff will be available to provide testimony at administrative or judicial hearings. Our project managers have experience providing expert testimony at appeal hearings.

In addition to providing professional services such as cost report audits, rate setting and settlement appeals, Myers and Stauffer is frequently engaged by Medicaid agencies to assist in large class action appeals. We have served as experts in Boren appeals and in other class action lawsuits. When necessary, we will be able to draw upon the full resources of the firm to assist Iowa in resolving appeals.

Provide Monthly Activity Reports to the Department  
(RFP Section 6.7.1.2 y)

On a monthly basis, we will submit to DHS a project activity report. Our status log database will track the progression of cost reports from receipt of cost report through the desk review and audit process. Key dates will be entered into the system as they occur. Therefore, current status log information will be available on an as needed basis with monthly reports routinely furnished to the Department. At a minimum the monthly report will include:

- Number of cost reports received and in process including status
- Number of desk audits completed
- Number of field audits completed
- Number of cost settlements completed
- Amount of over and under payments

Provide Monthly Field Audit Activity Report to the Department (RFP Section 6.7.1.2 z)

On a monthly basis, we will continue to submit to DHS a schedule of provider cost reports being audited, desk reviewed or cost settled. We expect to maintain separate logs related to each provider type addressed in the RFP. These reports will include detailed summary status reports that identify major milestones of the audit, desk review or settlement.

Our provider audit and related experience suggests that comprehensive and routine status reporting is essential to properly manage large complex engagements such as this one. For this reason, we will review with DHS the specific format for each report for each provider type. At a minimum the following information will be contained in the monthly reports:

- Names of providers audited
- Date of each audit
- Audit findings

It is important for DHS to have current information on the status of each project activity. While many functions and processes remain constant, there will still be the need to continually evaluate the adequacy of routine management reporting. We will work closely with DHS to identify needs and tailor reports to meet those needs.

Upon Request, Release Rates to Other States" Medicaid Programs (RFP Section 6.7.1.2 aa)

Myers and Stauffer agrees to release rates to other states upon receipt of authorization from DHS. The cost report and rate setting databases we have developed allow for quick retrieval of information and creation of ad-hoc reports. We will continue to efficiently respond to requests in a timely manner.

Prepare Annual Compilation Reports (RFP Section 6.7.1.2 bb)

We will maintain and continue to enhance our Iowa Medicaid cost and statistical databases. Annual reports that summarize cost and statistical data assembled from the provider cost reports will be prepared. Financial and statistical data will be available for quick and efficient compilation and summarization for use in developing fiscal estimates.

We will be available on a regular basis to assist DHS in analyzing cost and statistical information. Common applications for such analyses include providing fiscal estimates of anticipated or proposed changes to

regulations affecting reimbursement methodology, or responding to legislative inquiries concerning Medicaid expenditures to NF, hospital-based NF, ICF/MR RCF and HCBS. Reports will be generated upon request and forwarded to the Department and other parties as directed.

Develop Suggestions for Improving Provider Accounting Procedures (RFP Section 6.7.1.2 cc)

We will notify DHS of suggestions for improving inadequate accounting procedures of providers as well as reporting unusual cost discrepancies. Any weaknesses in internal controls and failures to maintain adequate documentation of costs will be addressed in the desk review and audit process. All necessary adjustments and recommendations will be presented to DHS in finalizing the provider desk review and audit reports.

Perform Responsibilities Associated with NF Pay for Performance (RFP Section 6.7.1.2 dd)

The nursing facility accountability measures program was redesigned during the Iowa State Legislative Session for the SFY 2010. This included changing the title of the program to “Nursing Facility Pay for Performance”.

Over the past several years, we have been the State’s partner in modifying the pay-for-performance measures. We have provided DHS with calculations and data analysis

involved with determining the accountability measure add-on. During our involvement, we have also provided trend analysis related to the measures producing desired outcomes.

Myers and Stauffer participated as counsel to DHS in the work group that developed the pay-for-performance program. The workgroup’s recommendations require the collection of data, monitoring of regulatory compliance and calculation of points to be awarded to each nursing facility in one of four domains. After the points have been determined, calculation of additional payment will be made.

We will update our cost and statistical databases to be able to provide the necessary calculations for determining additional Medicaid reimbursement for the pay for performance program. In addition, we will work with other state agencies to develop a process for receiving information required to calculate the pay-for-performance add-on and also to monitor regulatory compliance during the fiscal year for potential reduction in payments.

As part of our databases, we will be able to provide required reports to all stakeholders. We will also provide budget analysis of the program to ensure that expenditures do not exceed appropriations.

Finally, we will also continue to provide support to DHS and make recommendations that further enhance the program.

Provide Annual NF Employee Turnover and Evaluation Report to the Department  
(RFP Section 6.7.1.2 ee)

The NF Employee Turnover and Evaluation report is a compilation and analysis of the data submitted on Schedule I-1 of the cost report. As the incumbent contractor we have assisted DHS in the development and implementation of Schedule I-1, which is used to support the employee turnover measure that is part of the NF pay for performance program. In addition, legislation was passed that requires the Department to submit a report to the General Assembly that includes a summary of the data submitted by providers, a comparison of the individual NF turnover rates with the statewide average and recommended improvements and trends.

Myers and Stauffer will provide to the Department the NF Employee Turnover and Evaluation Report annually based upon the agreed schedule.

Provide Quarterly Resource Utilization Report to the Department  
(RFP Section 6.7.1.2 ff)

Myers and Stauffer will provide to the Department the Resource Utilization Group (RUGs) report each quarter. This report provides a count of the number of individuals in each RUG category on a statewide basis, along with counts broken out by payor source.

As previously discussed, each quarter our project staff will obtain quarterly CMI calculations and supporting MDS data from the Medical Services contractor. Using the MDS data and resulting RUG assignment, the RUG report shall be prepared based upon the format agreed with DHS.

Perform Responsibilities Associated with HF 911 and Track Expenditures  
(RFP Section 6.7.1.2 gg)

For services rendered beginning October 1, 2007 and thereafter, the methods and standards for setting Medicaid payment rates for nursing facility services can include a capital cost per diem instant relief add-on or an enhanced non-direct care rate component limit, either or both of which may be requested by a nursing facility.

The capital cost per diem instant relief add-on provides additional reimbursement to nursing facilities for property costs, such as depreciation and interest expense, associated with a complete replacement, major renovations, or new construction that are not included in the nursing facility's base year cost report. This allows providers to begin receiving reimbursement, ("instant relief") for incurred property costs as soon as the assets are put into place, rather than after the costs are reported on a base year cost report. When the property costs associated with a project are included in a nursing facility's base year cost report, the capital cost per diem instant relief add-on is no longer needed and is terminated.

The enhanced non-direct care rate component limit increases the non-direct care rate component limit to 120 percent of the non-direct care patient-day-weighted median. This allows providers who meet the qualification and reporting requirements to receive a higher limit.

Upon receipt of a capital cost per diem instant relief add-on and/or enhanced non-direct care rate component limit, we evaluate the request to ensure the project qualifies under the provisions of Iowa Acts 2007 House File 911 (HF 911). Depending on the type and reason for the project, we will ensure that the appropriate documentation is submitted and that all requirements are met.

After a determination is made we will notify DHS and the provider of the decision rendered. If either the instant relief or non-direct care limit exception is granted, we will calculate the add-on and revised rate and send to the provider. Any new rate will be submitted to the core MMIS contractor and a mass adjustment will be completed to re-price all claims affected by the new rate.

We will continue to monitor the add-on amount paid to each facility to ensure the amount paid to all facilities does not exceed the amount appropriated in HF 911. Once the amount of the expenditure is met, we will notify DHS and update the rates to remove the add-on.

A provider may also request a preliminary evaluation when a facility is preparing a feasibility projection for a construction or renovation project. When a preliminary request is made we will evaluate it as if it was a formal request and notify the provider of the decision, noting that a preliminary evaluation does not guarantee approval of the capital cost per diem instant relief add-on or enhanced non-direct care rate component limit upon submission of a formal request.

Maintain Sufficient Knowledge on Federal Requirements  
(RFP Section 6.7.1.2 hh)

Myers and Stauffer will monitor any changes that may occur within the state/federal funding of the Medicaid program.

Increasingly Medicaid agencies are exploring new ways to leverage federal funds into the Medicaid program, so that they can find new ways to finance program expenditures. The complexity of the federal funding mechanisms necessitate that Medicaid programs devote the resources needed to ensure that all funding they are entitled to are claimed from the federal government.

Myers and Stauffer has assisted several of our state Medicaid agency clients in evaluating their health care programs and restructuring payment policies to help maximize federal participation in the Medicaid program. Some of these enhancements are simple to

implement and involve relatively small changes to existing policies, while others are complex and require cooperation from multiple program stakeholders.

As incumbent contractor, we have developed an in-depth knowledge of Iowa Medicaid program payment mechanisms, which will assist us in continually evaluating payment systems from both a state/federal funding perspective. We will inform DHS of any opportunities identified where the State may increase federal funding. We will then work with the State to evaluate each opportunity and to develop implementation strategies as opportunities arise.

Myers and Stauffer will also be available to assist DHS in addressing any revisions to current federal funding practices that may necessitate re-evaluation of provider payment systems to ensure that Medicaid program expenditures continue to be eligible for FFP.

Log and Prepare All Payments to be Deposited in State-Owned Title XIX Recovery Bank Account and Record Payments Received in IME Accounts Receivable System  
(RFP Sections 6.7.1.2 ii and ii iv)

The Provider Cost Audit and Rate Setting Unit is responsible for completing cost settlements for those providers reimbursed under a retrospective cost based system. After the settlement is completed, the provider is notified of any over or under payments identified during the settlement process. If an overpayment is identified, the

provider is required to reimburse the Department. When an overpayment is identified, we will record the amount owed in the accounts receivable ledger when the notice of program reimbursement is sent to the provider. As providers make payments to DHS, the checks are received in the mailroom and scanned into Onbase. Our project staff then monitor the check queue in Onbase on a daily basis and index any check received related to the accounts receivable ledger.

Once the check is indexed in Onbase, it is posted to the related invoice number in the Provider Cost Audit and Rate Setting Unit's accounts receivable ledger. Project staff complete a gross history adjustment form and submit to core MMIS contractor to record the payment received. If payment is not received from the provider, project staff will complete a gross adjustment form to withhold future payments until the total amount is collected. We will monitor the MMIS system and record the offsets in our accounts receivable ledger. We will also monitor delinquent accounts and perform any necessary write-offs based on the Department's policies. At the end of each month a supervisor will take the accounts receivable ledger and generate the data warehouse report. The accounts receivable procedures will continue to be monitored and updated as necessary to ensure the proper reporting of adjustments on the federal CMS 64 report.

Produce an Annual Analysis and Report of the Relationship between

Medicaid Payment Rates and Those of Other Third-Party Payers (RFP Section 6.7.1.2 ii iv)

Myers and Stauffer agrees to meet this requirement by undertaking rate/service surveys, drawing upon information that we already have, or by pursuing a combination of these approaches. In addition, we will continue to respond promptly to specific rate information requests and to particular rate/coverage issues as they arise.

As the rate setting contractor for the IME and for more than 20 other state Medicaid agencies, it is essential that we understand well not only Medicaid but all other critical components of the national public health care system, as well as their respective payment methodologies and the distinct role that each plays in the overall delivery of healthcare services.

Myers and Stauffer is often called upon to compare and contrast Medicaid rates with rates for comparable services covered by Medicare, commercial insurance, and other third party payers. Our analyses are carefully prepared and reviewed for accuracy and are depended upon to assist agencies in evaluating service and payment policies in terms of cost coverage, payment limits/ceilings, and the relationships between certain (companion) services.

If Contractor Receives a Revised Cost Report with Extensive Changes within 30 Days of the Contractual Deadline,

Contractor can add 30 Days to the Deadline (RFP Section 6.7.1.2 ii iv)

It is the goal of project staff to perform the initial review of the cost report and send a request for additional information as quickly as possible. However, there are times when the accountant identifies several issues that may prompt the provider to submit a revised cost report. As a result, we acknowledge that if a revised cost report with extensive changes is received within 30 days of the contractual deadline, we will be allowed to add 30 days to the deadline.

Provide Rate Sheet to Each NF on a Quarterly Basis (RFP Section 6.7.1.2 mm)

Myers and Stauffer will continue to prepare and mail the nursing facility rate sheets to each provider on a quarterly basis or as needed. Our response to RFP Section 6.7.1.2 m provides a more detailed description of our approach to the nursing facility desk review and rate setting process including preparing the quarterly NF rate sheets.

Complete Compilation Reports According to Department's Schedule (RFP Section 6.7.1.2 nn)

Myers and Stauffer agrees to complete the compilation reports according to the Department's schedule for each provider type. Upon contract award, project staff will meet with the Department to determine a schedule for submission of the deliverables. Please refer to

RFP Section 6.7.1.2 b for a description of our approach to preparing the compilation reports.

Compile NF Pay for Performance Data and Determine Rate Add-on (RFP Section 6.7.1.2 oo)

The nursing facility accountability measures program was redesigned during the Iowa State Legislative Session for the SFY 2010. The redesign included a change to the title of the program to “Nursing Facility Pay-for-Performance.”

Myers and Stauffer will continue to update our cost and statistical databases to be able to provide the necessary calculations for determining additional Medicaid reimbursement for the pay-for-performance program.

We will work with other state agencies to receive information required to calculate the pay-for-performance and also to monitor regulatory compliance during the fiscal year for potential reduction in payments.

After all the data has been collected and entered into our databases, we will compile the information to be able to determine the add-on amounts for the pay-for-performance. This will also include determining the benchmarks associated with some of the measures, including calculating medians, averages and standard deviations consistent with rules. After the benchmarks are established, we will compare each facility's score to the related benchmark and

determine the points to be awarded for each measure. After the points for each measure is determined, the total number of points awarded will be used to calculate the add-on amount. At this time we will work with other agencies to determine if a reduction is required.

After the final amounts are determined, new rate sheets will be generated and sent to providers. In addition rates will be sent to the core MMIS contractor. Once rates are update in the MMIS a mass adjustment will be completed to reprice claims for the payment fiscal year. The rate add-on and mass adjustment will be completed by August 15 each year to ensure that payments are recorded in the State’s accounting system in the appropriate state fiscal year.

Provide the Department with the Semi-Annual Acuity Analysis and the Annual Pay for Performance Report (RFP Section 6.7.1.2 pp)

Myers and Stauffer will provide to DHS the acuity analysis report for the pay-for-performance measures semiannually of each contract year and the pay-for-performance measures report annually of each contract year based upon the agreed upon schedule. Or response to RFP Section 6.7.1.2 requirements dd and oo includes a comprehensive discussion of our understanding and approach to assisting DHS with administering the pay for performance measure program.

B. Performance Standards  
(RFP Section 6.7.1.3)

Myers and Stauffer fully appreciates the importance of producing high quality work in a timely manner. Our proposal presents a comprehensive approach to accomplishing all services required. We acknowledge and agree to the minimum performance standards listed in the RFP.

6.2 State Maximum  
Allowable Cost Program Rate  
Setting  
(RFP Section 6.7.2)

Myers and Stauffer is pleased to offer a proposal that is both comprehensive and unique in its approach to meet the State's pharmacy project goals and objectives, as well as fully compliant with all project requirements and deliverables.

Since 2002, Myers and Stauffer has assisted the Iowa Department of Human Services (Department) in developing, implementing, and managing a state-of-the-art pricing program for prescription drugs paid through Medicaid. The program that we offer continues to be the only one of its kind; it is based on the collection, analysis, and use of actual, observed drug purchase records obtained directly from Iowa pharmacies through a survey process, and then applied to drug selection and other criteria established specifically for Iowa. This approach not only generates actual cost data for setting accurate rates, but it is also

easy to understand and offers flexibility to readily adjust pricing policies to specifically meet the Department's program objectives and the unique characteristics of Iowa pharmacy providers.

If selected as the SMAC program contractor for the new contract term, we will have no start-up costs, and we will continue to perform all SMAC program functions without interruption, while also immediately and carefully focusing resources on the responsibilities and program refinements new to this procurement. Moreover, since the surveys that we have performed for Iowa since 2002 have included actual acquisition cost information for *all drugs*, we are able to easily and quickly implement a single-source drug expansion should the Department so direct.

Myers and Stauffer has worked diligently from contract award to conclusion of the current contract term to serve the Department in the best possible way and with a high level of quality and integrity. We have met or exceeded our performance deadlines, responded to provider inquiries within 24 hours, and have refined or implemented several additional processes and monitoring reports to help the Department better evaluate rates, drug availability and pricing, marketplace trends, and overall program performance. We value our partnership with the Iowa Medicaid Enterprise (IME) and work hard to assure that we consistently meet our contractual obligations.

A. Contractor Responsibilities  
(RFP Section 6.7.2.2)

General Responsibilities  
(RFP Section 6.7.2.2.1)

***Services to be Provided***  
(RFP Section 6.7.2.2.1 a)

Myers and Stauffer's services to DHS are designed to comprehensively develop, support, update, and maintain the SMAC program for legend drugs. We will assist in the development, evaluation, and implementation of policies or initiatives to support the efficient operation of the SMAC program and the achievement of the Department's fiscal objectives. Myers and Stauffer's goals will be to maintain and update the Iowa SMAC program and achieve the Department's objectives of promoting good health outcomes for Medicaid beneficiaries. We will assist the Department to establish SMAC reimbursement reflective of Iowa pharmaceutical market conditions and quickly respond to stakeholders' questions or concerns about the SMAC program

We propose to provide the following services. A more detailed description of our approach to accomplishing these services is provided in our responses to RFP Sections 6.7.2.2.2 through 6.7.2.2.6.

- Establish state maximum allowable cost program reimbursement rates for legend drugs meeting criteria determined appropriate by the Department.
- Assist the Department, as necessary, with recommendations, research, or other evaluative processes to develop appropriate criteria for adding or removing legend drug products from the SMAC program.
- Update and maintain SMAC program reimbursement rates and reference file changes.
- Periodically examine SMAC reimbursement rates, published pricing information, service providers' acquisition cost information, and other available Iowa pharmaceutical market indicators to determine the adequacy of SMAC reimbursement rates.
- Provide support by telephone, fax, e-mail, mail, Internet, or other means to investigate and respond to pharmacy or other stakeholder questions and concerns regarding the SMAC program.
- Assist the Department in managing its relationship with the Iowa Pharmacy Association and other industry groups.
- Coordinate with other contractors to update and maintain the SMAC rate file for claims processing.
- Monitor important trends in reimbursement, service utilization, and fiscal outcomes.
- Assist the Department in the development, evaluation, and implementation of policies supporting the SMAC program.

***Meet Objectives***

(RFP Section 6.7.2.2.1 b)

Myers and Stauffer agrees to comprehensively support, update, and maintain the SMAC program for multiple source prescription drugs that are reimbursed by the Iowa Medicaid Program.

We believe that an optimal State MAC pharmacy pricing approach is one that is based on the collection, analysis, and use of actual, observed drug purchase records obtained directly from pharmacies, and then applied to drug selection and other criteria established specifically for each state.

For the past seven years, Myers and Stauffer has partnered with the IME to develop and implement a SMAC program that, unlike all other Medicaid pharmacy pricing approaches, incorporates all of these features. Through its unique design, pricing approach, and consistent updating schedule, the program has built-in components that minimize issues and elements that could adversely impact program success and achievement of goals. In addition, by setting Iowa's pharmacy rates according to actual (rather than estimated) costs obtained directly from Iowa pharmacy providers, Medicaid reimbursement is consistent, fair, and transparent, and can be easily maintained within federally-established payment limits.

We understand and appreciate the Department's goals and have developed the Iowa SMAC program

so that it incorporates the full range of supports necessary to enable the Department to easily measure performance in achieving those goals. The supports to which we refer include the following:

- Frequent and accurate rate updates that respond to changes in the marketplace.
- Routine evaluation of SMAC and non-SMAC drug utilization to ensure that access problems (that may impact good health outcomes for beneficiaries) do not develop.
- Timely updates to the SMAC Web site to keep pharmacy providers informed.
- Responsive and effective Help Desk services that manage stakeholder interests; supported by a provider contact tracking feature that allows Department staff unfettered access to monitor inquiries, response times, and resolution.

Furthermore, by using actual acquisition cost data to establish and maintain SMAC rates, the Department has available the range of data needed to fully analyze comments and concerns from the public regarding the adequacy of those rates. Success can be measured by a marked reduction in rate challenges by providers and in achieving savings that meet annual targets within the context of the Medicaid Program's overall objectives.

Obviously, selecting a reasonable level of cost coverage for a provider

group is complicated and often involves numerous policy considerations that are not always motivated by savings. We know this because of our more than 30 years of experience in partnering with state and federal agencies. Within this context, Myers and Stauffer will continue to provide data, analysis, and other information to the Department that is relevant, that takes the “big picture” into account, and that offers more than one alternative whenever possible, so that Department staff can fully evaluate each situation and its impact on pharmacy pricing and the Iowa Medicaid Program as a whole.

SMAC Program success also depends upon timely identification of new opportunities that become available to establish new rates, promote efficiencies, and share in savings opportunities in the pharmaceutical marketplace. To that end, Myers and Stauffer will continue to explore ways to improve the Iowa SMAC pricing methodology and to carefully follow changes at the Federal level that are likely to impact Medicaid pharmacy pricing in the future so that we can assist Iowa in seamlessly adapting to required changes.

***Maintain Interfaces***  
(RFP Section 6.7.2.2.1 c)

We appreciate the value and importance of the pharmacy providers as a key stakeholder group within the Iowa Medicaid Program. We also appreciate their diversity. For this reason, we have worked to develop a SMAC pricing approach

that depends upon regular communications with and input from pharmacies. Our approach incorporates a survey function that is performed with providers annually to collect the actual acquisition cost data needed to set and rebase SMAC rates. Our survey approach is designed to be user friendly and to minimize any administrative burden on the provider community. We have been careful to link the survey process to the production of fair and accurate rates, so that pharmacy providers can be confident that their role in the rate setting process is both valuable and necessary.

Our approach also incorporates several distinct provider relations features (i.e., Help Desk, SMAC Web site, etc.), all of which have added significant benefit, efficiency and effectiveness to the Department and its stakeholders. These services are intended to promote two-way communication, which includes the identification of problems, marketplace issues, and utilization trends that might not be otherwise caught through a standard Medicaid pharmacy pricing methodology.

***Provide Reports***  
(RFP Section 6.7.2.2.1 d)  
Myers and Stauffer agrees to provide to the Department a monthly report on the savings associated with the SMAC program.

We will create and provide a monthly Dashboard report that provides the IME with reports to monitor the performance of the SMAC program along with

additional information relating to the pharmacy marketplace. As always, Myers and Stauffer is happy to make modifications to content and format as needed in order to better respond to the needs of the Department.

Prior to the start of the new contract term, Myers and Stauffer recommends convening a meeting with Department staff to review current and possibly future reporting needs to determine whether existing reports are fully meeting expectations or whether they can be modified to better target desired information.

Myers and Stauffer agrees to provide to the Department recommendations at least every two months on updates to the SMAC.

Myers and Stauffer currently performs an annual rebase of Iowa SMAC rates that is generated by the provider acquisition cost survey, with regular (subsequent) updates that occur periodically throughout the year. As required by this RFP, we will modify the existing schedule to accommodate a two-month reporting period, but will also perform additional, more frequent rate updates when needed. Information contained within this report will include detail on rate increases, rate decreases, new drugs groups added to the program, drug groups removed from the program, and any other information that the Department requests.

Myers and Stauffer agrees to provide to the Department an annual

acquisition cost study summary. Upon notification of contract award, staff will schedule a meeting with Department staff to discuss and define the exact contents of this report. Discussion points might include, for example, whether the summary should include survey findings only, comparison of findings with those of the previous survey, a description of emerging pricing issues/concerns, etc.

The annual cost summary includes the following information:

- Number of pharmacies surveyed.
- Number of pharmacies responding.
- Breakdown of chain/independent status.
- Breakdown of urban/rural location.
- Reporting of any issues with regards to the survey.

Myers and Stauffer agrees to provide a quarterly report on SMAC program operation and utilization trends.

To fully meet the expectations of the Department, we propose to provide a quarterly Market Research and Monitoring Report, which will incorporate several key features that are critical to understanding pharmacy pricing. These include the following:

- Drug Patent Watch List – a list of legend drugs presented according to projected patent expiration dates.
- SMAC Additions Watch List – presents a list of drug groups

- whose patents have recently expired and for which we are tracking purchase experience in order to set a SMAC rate at the earliest opportunity.
- SMAC Program Revisions – a cumulative summary of drug list changes by type and effective date, followed by a table that details each revision.
  - Support Statistics – Provides a summary of the issues that Iowa pharmacies and other stakeholders presented to Myers and Stauffer for resolution. The report provides information on the type of issue reported, notification method (Help Desk, e-mail or Web page posting), and final status of the action taken. We have provided a sample report in appendix G of this proposal.

The content of this report will be carefully reviewed with the Department in order to best match the information presented with performance objectives.

State Maximum Allowable Cost Program and Rate Schedule Maintenance (RFP Section 6.7.2.2.2)

***Be responsible for the operation, support, and maintenance of the Iowa SMAC program and rate schedule.***

(RFP Section 6.7.2.2.2 a)

Currently the Iowa SMAC program consists of approximately 900 SMAC rates. Eligible drug groups are identified by Myers and Stauffer through criteria established by the

Department for a number of product characteristics. These include a minimum number of available manufacturers of generic products, therapeutic equivalency ratings for generic products, and minimum number of drug acquisition cost observations needed to establish a SMAC rate. Rates are updated regularly and accurately, and are rebased once each year through performance of an actual acquisition cost survey of Iowa pharmacies.

As the incumbent SMAC program contractor, Myers and Stauffer is able to offer to the Department a smooth and seamless transition of responsibilities from the current contract term to the new, with no associated start-up costs. We will continue to set and update rates, maintain a current and expansive drug list, perform provider relations functions, and provide all reports and other support needed to maintain a superior pharmacy pricing program for Iowa.

Myers and Stauffer practices a rigorous protocol of quality assurance, which addresses every function that we perform, process that we utilize, and deliverable that we produce. Quality assurance is built into our services and overseen by a quality assurance manager who compares internal standard operating procedures with Iowa's unique RFP requirements and validates the quality of service and product provided.

***Respond to changing circumstances in the drug marketplace that require***

***SMAC fees to be removed,  
suspended or developed.***

(RFP Section 6.7.2.2.2 b)

We believe that an aggressive monitoring and updating protocol is an absolutely essential component of a successful state MAC program.

The high-performing SMAC program that we have developed for the IME is one which takes the dynamic drug marketplace fully into account and successfully *anticipates, identifies and reacts to* changes that will influence Medicaid pharmacy pricing. When this occurs, the Department can be depended upon by its providers to make regular updates to SMAC rates, thereby removing as much responsibility as possible from the pharmacies to initiate administratively burdensome and time-consuming inquiries and solicit rate change requests.

As the incumbent contractor for the Iowa SMAC Program, Myers and Stauffer has worked hard throughout the contract term to optimize response times and actions. Our success in this regard can be measured by the absence of provider complaints and the minimal number of provider requests for rate updates.

***Maintain a Web site approved by  
DHS and available to all providers.***  
(RFP Section 6.7.2.2.2 c)

The Web site must maintain at a minimum: the SMAC list and rates, combined federal upper limit/state maximum allowable cost/over the counter (FUL/SMAC/OTC) list and

rates, informational letters regarding the SMAC program, CMS FUL Releases, a provider inquiry e-mail address, telephone number and other information deemed necessary by the Department.

We will continue to maintain the Iowa SMAC Web site that allows pharmacy providers 24-hour per day/seven days per week access to review current SMAC rates and other required program information and to submit inquiries via forms available electronically.

Currently, the Iowa SMAC Web site offers the following information:

- Up-to-date SMAC rate listings, revisions, and interim ad hoc updates.
- One-step link to FULs.
- An updated list of frequently asked questions (FAQ).
- A communication plan for provider support, which includes a toll-free hotline, electronic mail address, facsimile, and an Internet portal.
- Online communication forms, which identify emerging drug pricing issues that we quickly research through actual invoice records or wholesaler price lists.
- Important links to the Web sites of the Iowa Department of Human Services and the Centers for Medicare and Medicaid Services (CMS).

Providers may access, complete, and submit on-line forms electronically.

Help Desk technicians will review and respond to all inquiries/information requests normally within one business day. We will continue to quickly respond to new issues by reviewing actual invoice records.

Myers and Stauffer will continue to monitor Web site format and contents to assure their applicability to current policies. Additionally, changes that are made to rates and/or program processes and to the provision of services will be communicated timely and effectively according to Department-approved requirements. Updates will be made to the Web site on a regular basis and as frequently as they are issued.

Our systems technicians routinely perform tests on Internet linkages, processes, and functions to assure optimum performance and user-friendliness. Our success is measured in our proven and timely responsiveness to provider communications, as well as minimal and predictable system downtime (e.g., maintenance).

Myers and Stauffer will also continue to offer to the Department through the SMAC Web site access a Help Desk log book, located in an “Administrative Only” section. The log book is regularly updated to allow Department personnel unfettered access to monitor inquiries into the SMAC Help Desk.

***Demonstrate annual savings in total outlays for prescription drugs associated with the SMAC program.***  
(RFP Section 6.7.2.2.2 d)

Since we became the SMAC contractor for the Iowa Medicaid Enterprise, we have assisted in securing more than \$70 million in total pharmacy savings.

Moreover, cost-saving targets have been met each year since implementation. This has been accomplished through a combination of careful cost analysis that has led to accurate pharmacy pricing, as well as frequent rate updates and solid reporting that affords the state a monitoring protocol for every major utilization trend and program feature that influences pricing (and therefore measures progress in meeting savings targets).

In addition, Myers and Stauffer actively monitors developments at both the state and Federal levels to assure that the Iowa pharmacy program is well-positioned to respond to any changes that may arise. Throughout the current contract term and always, we take our partnership with the Department very seriously; we have demonstrated our commitment by initiating numerous program and reporting improvements, writing policy papers, and developing recommendations for consideration by Department staff, most of which were not contractually required.

Program Monitoring, Product and Rate Review and Adjustments (RFP Section 6.7.2.2.3)

It is important to note that a successful State MAC program depends upon a strong monitoring approach. For this reason, we have developed a number of administrative reports that are designed and specifically adapted to review multiple program aspects and to track areas of interest unique to each of our engagements. These include comprehensive listings of established State MAC prices, as well as others that reflect critical information necessary for decision-making and efficient program operation.

A list of the reports that we currently provide to the IME is as follows:

- Quarterly SMAC Savings – Shows estimated costs avoided due to the SMAC program.
- Cost Coverage – Analyzes the ability of Iowa pharmacy providers to purchase drugs at or below the SMAC rate based on costs reported by in-state providers.

Additional reports that can be incorporated into the program include:

- Dashboard Report – Provides the Department with reports to monitor the performance of the SMAC program along with additional information relating to the pharmacy marketplace. Information in the Dashboard Report includes expected drug patent expirations, recent

changes in the SMAC rates, recent provider inquiries to the Help Desk with resolution status, drug shortages, and estimated fiscal savings due to the SMAC program.

- Federal Upper Limit (FUL) Aggregate Payment Comparison – Compares the expenditures for multiple-source legend drugs utilizing the current state reimbursement (EAC and SMAC) to the FULs. This provides the Department assurance that it is compliant with the provision of reimbursing, in aggregate, under the FULs. It also gives the Department an opportunity to evaluate its reimbursement and make any necessary adjustments to fulfill the aggregate payment requirement.

***Monitor product availability at a national level.***

(RFP Section 6.7.2.2.3 a)

Using the criteria approved by the Department, Myers and Stauffer will continue to identify eligible prescription drugs through a comprehensive review of product availability at the national level. Changes in pharmaceutical prices, product availability, the number of manufacturers and/or wholesalers providing drug products, and brand drug loss of patent protection occur on a regular basis. Accordingly, Myers and Stauffer maintains multiple published, academic, electronic, and provider resources for monitoring changes in the drug

marketplace and determining an appropriate response that is consistent with the efficient and successful operation of the IME and each of our other State MAC clients.

***Employ rigorous data analysis; Identify drugs that lose patent protection, test product availability.***  
(RFP Section 6.7.2.2.3 b)

As the SMAC contractor for the new contract term, we will continue to work closely with the Department to maintain reasonable thresholds for drug selection, and to carefully evaluate the drug marketplace to determine which drugs should be recommended for addition to and/or removal from the SMAC program. When drugs become eligible for the SMAC program, they will be reviewed and, if appropriate, quickly added since application of drug pricing to like products offers additional opportunities to produce program savings. We will use a similar process to determine products to be removed from the program and will periodically re-evaluate deleted drugs to identify opportunities to reinstate them to SMAC pricing. Changes in the SMAC list will be regularly and timely posted on the Web site.

To further assure the most timely access to drug pricing information, Myers and Stauffer has established agreements with a number of pharmacies whom we have engaged to provide to us acquisition and wholesaler information on a monthly basis and who are available to respond to our inquiries as often as

needed (even daily) as issues evolve in the marketplace. These agreements serve to augment our already strong internal drug pricing review protocol, thereby minimizing the chance that significant pricing opportunities are missed.

***Perform programmatically driven data analysis to identify changes in drug volume, utilization patterns and other factors.***  
(RFP Section 6.7.2.2.3 c)

SMAC initiatives are not concluded when the rates are established. A program that has objectives to both improve health outcomes and use funds efficiently must monitor not only the fiscal impact of the SMAC rates, but also the utilization behavior of physicians, pharmacies, and beneficiaries. In addition, the POS system and claims processing procedures should be monitored to ensure appropriate claim adjudication, limiting instances where applicable SMAC rates were not applied or where pharmaceutical market trends favorable to the program were not acted upon timely. States implementing SMAC programs must be prepared to identify claims processing, physician, pharmacy, and beneficiary behaviors that may produce outcomes counter to the intentions of the SMAC program. These include use of inappropriately rated products, physician override of the SMAC rate for a brand drug by indicating that the brand drug is medically necessary, altering drug selection and utilization to manipulate SMAC

reimbursement for drugs that do not have a SMAC rate.

We will perform programmatically driven data analysis to identify changes in drug volume, utilization patterns and other factors. Basic algorithms utilized will include techniques for examining distribution patterns of variables to identify highly skewed or non-normal patterns. Multivariate algorithms will include techniques designed to identify patterns in data. Using cluster analysis, linear and non-linear regression, factor analysis, and significance testing, the analyses can:

- Ensure use of SMAC drugs is maximized through utilization review.
- Detect opportunities to recommend therapeutic interchange to physicians. Data should be analyzed to determine opportunities to recommend that physicians switch appropriate patients to comparable, less expensive, therapies without risk to patient outcomes.
- Trend physician patterns for prescribing medically necessary brand drugs. Data should be analyzed to identify physicians who habitually override SMAC pricing on brand drugs by indicating, on the prescription, that the brand drug is medically necessary.
- Detect opportunities to educate providers regarding the SMAC program. Call logs and other records of interactions with pharmacy providers should be

reviewed to detect opportunities to address common questions, comments, or concerns to other affected service providers.

- Perform periodic reviews of the POS system's pricing files to insure valid rate segments. The POS system's pricing file should be reviewed, periodically, for all products affected by the SMAC to confirm correct rates on file, correct rate segment dates, and other relevant information affecting proper claim adjudication.
- Test POS payment procedures for drugs on the SMAC list through periodic claims sampling. A random sample of claims should be tested quarterly to determine if POS system payment processes are appropriately applying SMAC rates and SMAC payment policies.

***Perform an acquisition cost study, at least annually.***

(RFP Section 6.7.2.2.3 d)

We will continue to perform an annual survey to evaluate and update SMAC pricing to reflect prevailing Iowa pharmaceutical market conditions. Not only are Iowa pharmacies already accustomed to our survey process and protocol, but we have also worked hard to streamline the data collection function to ensure that their participation entails minimal administrative burden and time commitment.

The approach depends upon records that pharmacies already have and requires no change in format or “sorting” of information. In addition, the data requested is not excessive in volume and it still captures enough of a pharmacy’s purchase cycle to ensure that all regularly purchased drugs are represented. *Moreover, it is important to note that many pharmacies surveyed as part of our SMAC functions tell us that our information requests require only about 30 minutes of non-pharmacist staff time.*

It is also important to point out that we have developed relationships with the major wholesalers such that a growing number of providers can simply request that their wholesaler compile and email a file of the drug information to Myers and Stauffer, further decreasing the burden on pharmacies.

Drug purchase information received from the annual re-survey of participating Iowa Medicaid pharmacies is added to the database. As we do currently, we will continue to carefully review the information to identify errors and potential discrepancies, such as unrecognized National Drug Codes (NDC) and missing pricing information. We will compute a per unit price for each line of information. Legend and OTC drug products meeting criteria for therapeutic equivalency, product availability, and utilization will be grouped based on similar chemical composition, strength, dosage form, and route of administration. Each common class of drugs will be

identified as a “drug group.” In between the survey and re-survey process, we will update SMAC rates every two months and more often as needed with drugs that come off patent and to reflect major changes (increases or decreases) in drug prices.

***Evaluate the SMAC rate schedule, at a minimum every two (2) months.***  
(RFP Section 6.7.2.2.3 e)

Myers and Stauffer agrees to evaluate the SMAC rate schedule as often as necessary, at a minimum every two months, to determine the need to update the list of drugs affected by the SMAC or adjust the SMAC rate schedule and ensure that the SMAC program meets its goals to reflect prevailing pharmaceutical market conditions and ensure reasonable access by most providers to drugs at or below the applicable SMAC rates.

Myers and Stauffer currently provides the Department with information on how many Iowa pharmacies in the sample are able to purchase each drug at or below the SMAC rate. This is a feature of our unique pricing approach that cannot be performed by other vendors (since they rely on out-of-state data generated by means other than state-specific surveys).

After SMAC rates have been approved by the Department, Myers and Stauffer provides timely updates to the Iowa SMAC rate file to reflect changes in pharmaceutical prices and product availability. To assure that we have the most timely updating

capability possible, we draw upon agreements that we have established with a number of pharmacies to support our state Medicaid engagements; these pharmacies have agreed to provide us acquisition and wholesaler information on a monthly basis and are available to respond to our inquiries more often (even daily) as issues evolve in the marketplace.

***Monitor changes in Average Wholesale Price (AWP).***  
(RFP Section 6.7.2.2.3 f)

Myers and Stauffer agrees to monitor changes monthly in average wholesale price (AWP), wholesale acquisition cost (WAC) and other appropriate national pricing standards for each specific product affected by the SMAC rate schedule to detect indications of potential changes in providers' acquisition costs and assess the need for adjustments to the SMAC rates.

We conduct drug market research based on published drug prices and information obtained from pharmacies participating in the Iowa Medicaid program. In addition, we considered pharmacies' comments and input regarding SMAC prices that may require an update to ensure adequate availability. Changes in Average Wholesale Prices (AWP) for drugs on the SMAC list are examined based on information obtained from First DataBank and from the most current, available, edition of The Red Book and its periodic supplements. We observe published prices for all drug groups included in the SMAC program and

measure the degree to which AWP has changed. Circumstances where AWP changes occurred in excess of a predetermined threshold are noted, and additional research, including the collection of invoices from providers, are undertaken to determine the degree to which actual drug acquisition prices may have changed. A recommendation is then made to DHS regarding any necessary refinements to the SMAC program.

We also closely monitor policy and litigation developments (such as the First DataBank/Medi-Span AWP settlement and implementation of the DRA changes) that have the potential to impact the Medicaid programs. We will provide these updates to the Department along with any ad hoc analyses and modeling that may be needed to facilitate understanding and application of the information. White papers and memos can also be developed to share insight with administrators.

***Identify new drug products, assess the need to add new drug products to the SMAC program and establish reimbursement rates. Identify drug products, and assess the need to remove the drug products from the SMAC program.***

(RFP Section 6.7.2.2.3 g and h)

To capitalize on efficiencies in the drug marketplace promptly, be responsive to market changes potentially affecting providers' ability to purchase drugs, ensure SMAC rates that are reflective of the Iowa drug marketplace, and to

maintain good will with the provider community, Myers and Stauffer proposes to continue our rigorous protocol for reviewing and updating the SMAC program.

Review will include examination of and comparison with published pricing information, current acquisition cost data, prescription drug patent expirations, and other state-specific market indicators. Updates will be made monthly and will include, but not be limited to: cost changes related to high expenditure drugs, investigations initiated by new cost information, circumstances that warrant re-examination of drugs that were previously excluded from SMAC, and as otherwise directed by the Department. This review will also include identification of pharmacoeconomic issues, opportunities to set new SMAC rates, promote efficiencies, and share in market-related savings opportunities.

Myers and Stauffer is prepared to act quickly and efficiently to address issues important to the Department and to its providers. When changes to SMAC rates are needed between regular updates, we will quickly address the issues using our extensive databases of acquisition costs.

Since the addition of drugs to the SMAC program accounts for the majority of costs avoided, it is important that the SMAC contractor is constantly monitoring for these opportunities. We will continue to monitor drug patent expirations for new generics to add to the program.

When the patents for brand drugs, especially blockbuster drugs that can create large costs avoided for the State expire, Myers and Stauffer will collect acquisition cost data and propose SMAC rates as soon as possible to maximize fiscal savings.

In addition to prudent monitoring of drug patent expirations, another vital component in the optimal performance of a SMAC program is to identify instances when a SMAC rate needs to be adjusted upwards or removed due to a drug shortage. The evolving marketplace creates situations where these instances occur. To assure that the program continues to be responsive to provider interests and concerns, Myers and Stauffer will monitor for drug shortages, propose SMAC rate increases when we observe that the cost of the drug has increased, or propose rate discontinuations when the drug has limited availability, and rate reinstatement when the drug shortage is resolved.

***Consult pharmaceutical industry information to identify issues with product availability.***

(RFP Section 6.7.2.2.3 i)

Myers and Stauffer recognizes that changes in pharmaceutical prices and product availability occur on a regular basis. Accordingly, we maintain multiple published, academic, and electronic resources for monitoring changes in the drug marketplace and determining an appropriate response, consistent with the efficient and successful operation of SMAC programs.

Via the Help Desk and the Website, we will also continue to solicit pharmacy provider comments and input regarding SMAC prices that may require an update to ensure adequate availability. We will review the fee schedule, summarize our findings, and then forward the results with recommendations to the Department. Approved changes will be promptly processed. This includes receiving a provider rate review request through the SMAC program Web site or the Help Desk, or through our internal monitoring procedures that identify drugs that should be added, updated, or deleted from the SMAC list.

State Maximum Allowable Cost Program Administrative Support and Assistance to the Department (RFP Section 6.7.2.2.4)

***Receive monthly claims files from the Medicaid POS contractor to support the evaluation and management of the SMAC program.***

(RFP Section 6.7.2.2.4 a)

We have worked extensively with claims processing systems used by all major fiscal agents, as well as other contractors who process claims for state Medicaid programs.

Accordingly, we understand the capabilities and limitations of most systems, as well as the technical capabilities and system functionality needed to develop and operate a SMAC Program. Some examples are as follows:

- Exchange of SMAC rate information.
- Updates and storage of rate information in system reference modules.
- Claims adjudication.
- Disposition of service authorizations.
- Disposition of scripts marked “dispense as written.”
- Linkage of all affected drug products to the assigned SMAC rate.
- Report production.

Our policy and reimbursement work with pharmacy and SMAC programs, payment integrity programs (for both PAM and PERM), long term care, acute care, and other Medicaid service areas has given us the opportunity to work with and exchange data and other information routinely with many other Medicaid vendors. As a result, we are expert in information technology and claims processing and fully knowledgeable in the types and conventions of the most commonly recognized pharmaceutical information sources. In this capacity, we currently exchange SMAC rates, updates, and other information with Goold Health Systems (GHS), Affiliated Computer Services (ACS), and Electronic Data Systems (EDS) to facilitate claims processing that is based on established SMAC rates.

***Provide experienced staff sufficient to work with large sets of Medicaid claims data and identify and***

***analyze trends affecting the SMAC program.***

(RFP Section 6.7.2.2.4 b)

As a consultant to numerous state Medicaid agencies, Myers and Stauffer maintains a technical and management team that has not only the necessary technical systems and telecommunications experience, but also extensive knowledge of Medicaid Program systems *and service delivery* requirements. Our team has successfully established connectivity for secure transfer of information for many of our clients.

Unlike our competitors, Myers and Stauffer has always limited our practice to Medicaid, Medicare, and other governmental programs. We are a well-known certified public accounting firm that performs extensive cost and rate analyses, fiscal modeling, claims data review, and projects expenditures for state Medicaid programs. We expect all of our employees to develop a full understanding of program policies and requirements so that they can more accurately *apply* their experience and expertise to best and most efficiently meet the technology and other needs of each state Medicaid engagement.

***Confidentially maintain all pharmacies' cost or purchase information obtained for SMAC rate setting, rate evaluation, or product availability assessment.***

(RFP Section 6.7.2.2.4 c)

We clearly understand the desire of the Department to keep all Iowa

pharmacy invoice information confidential, and we therefore agree to collect and maintain this information in a manner separate and distinct from the data that we collect for other states.

Myers and Stauffer complies with all federal, state, local, and other laws, regulations, or authorities that govern the terms of our work. We are familiar with the various mandates governing confidentiality of the information utilized on behalf of our clients. We understand the proprietary and competitive nature of drug cost information and the need to maintain the confidentiality of the information made available to us. Our procedures ensure we comply with confidentiality requirements. Staff are trained to maintain information confidentially. Security measures are required at all locations where sensitive information is maintained including physical plant, workstations, and server platform. Work papers and notes that may contain sensitive information are kept in a locked and secure environment with limited personnel access. Items to be discarded are either shredded or otherwise destroyed. We will protect all proprietary information submitted by providers to support SMAC operations.

***Prepare all necessary reports, updates to provider manuals, draft communications and correspondence to pharmacy providers, legislators, and other stakeholders.***

(RFP Section 6.7.2.2.4 d)

Accurate, up-to-date, clear, and concise information, communication, reports, and reference materials are essential for maintaining Medicaid program integrity. We routinely prepare memorandums, arrange meetings, coordinate with other contractors and state agencies, and perform other tasks in the interest of promoting information-exchange and clear directives in the Medicaid program.

The ongoing operation, maintenance, and improvement of the SMAC program will sometimes require our participation in meetings with external stakeholders, as well as development of special reports and correspondence. We are accustomed to providing the full range of support needed to operate Iowa's SMAC program, and we routinely draft revisions of provider manuals, provider correspondence and legislative analyses, and other policy documents for state approval. As with any successful and proactive program, policy updates must be routinely and accurately documented to assure consistency throughout the SMAC program enhancement process. In addition, written communications to key stakeholder groups are often essential in eliminating "surprise" or unwanted reactions that can quickly derail planned enhancements and program objectives.

We are accustomed to performing these functions and stand ready to continue to assist the Department as needed throughout the new contract term.

***Prepare documentation outlining all technical specification changes to POS claims payment systems in support of the SMAC program.***

(RFP Section 6.7.2.2.3 e)

As the current Iowa SMAC contractor, Myers and Stauffer has already developed and maintains an internal working draft of the Iowa SMAC Operations Manual; therefore there will be no time delays associated with delivery.

Immediately following contract award, we will incorporate any new requirements, process changes, and procedures established through this RFP, as well as any refinements identified by the Department directly into the Operations Manual. Once complete, we will submit the revised manual to the Department in draft form for final approval. The final Manual will then be made available to the Department in both hardcopy and electronic format. Ongoing program modifications will be fully and timely documented as they occur and, once approved by the Department, will be incorporated within the Operations Manual.

***Develop all draft documents to promulgate administrative rules necessary to support the SMAC program.***

(RFP Section 6.7.2.2.4.f)

As we have stated previously, we are accustomed to providing the full range of administrative support functions that accompany delivery of Medicaid Program services. As we have in the past, we will continue to

support the Department in developing draft rule language, fiscal modeling, preparing public notices, developing responses to public comments, and providing testimony before legislative and provider committees, advisory bodies, and attendance at hearings.

***Develop all draft documents to promulgate administrative rules necessary to support the SMAC program.***

(RFP Section 6.7.2.2.4 g)

We will continue to support the Department throughout all steps of the Medicaid State Plan Amendment process. This may include performing research, analysis and fiscal modeling, drafting State Plan Amendment text, and developing responses to rule-related write-backs and other inquiries made by CMS.

The staff assigned to this project have assisted several states, including Iowa, in their regulatory process including, formulation of state plan/rule language, reviewing regulations and drafting responses to questions from legislative and other interested parties. We have worked with states in amending their state plans in response to policy changes, litigation and updates required by state and federal legislation or regulation.

We monitor CMS Web sites on a daily basis for revisions, upgrades and publication of new federal requirements relative to the Medicaid and Medicare programs. We update our clients on the impact any changes

may have on the programs they administer. We strive to stay abreast of the new state plan requirements as well as the types of information and documentation requested by CMS regional and central offices. Also, members of our staff attend conferences and training seminars to stay current on national, state and local health care issues.

During the course of this project, various issues pertaining to state and federal laws and regulations may arise. When unanticipated changes occur in any of these areas, Myers and Stauffer responds quickly and efficiently to incorporate any new state and federal requirements and regulations.

Project staff will participate in the formulation of Medicaid policy changes. We will assist in drafting state plan revisions as needed. The new state plan amendments will be developed to comply with federal laws and regulations including drafting justifications and publication notices, now required for federal compliance. Once the state plan has been submitted, the state will work with CMS to ensure its approval.

***Prepare all information requests, required findings and assurances, and respond to all inquiries from CMS related to the SMAC.***

(RFP Section 6.7.2.2.4 h)

As required by CMS, each state must demonstrate that reimbursement for FUL drugs does not exceed the FUL rates in aggregate. To perform this analysis, pharmacy rates set by the

state-specific pricing methodology, which normally includes reimbursement based on the estimated acquisition cost (EAC) and SMAC rates, must be evaluated.

The analysis begins by isolating those drugs with an FUL rate, since reimbursement for drugs without an FUL is by definition excluded from the FUL aggregate test.

The utilization experience for a selected time period for these drugs is obtained from Iowa Medicaid claims data. The total units dispensed for each drug is multiplied by its FUL rate, and the results are summed to determine the drug spend, in aggregate, that would have resulted if only the FUL rates for these drugs had been applied. The same process is performed for the IME's current multiple-source drug reimbursement algorithm (i.e., the lower of EAC, SMAC, or FUL) for these drugs. Finally, a comparison is made between the aggregate drug spend using only the FUL rates and rates paid under the current reimbursement algorithm to determine the extent by which the Department is under the FUL aggregate drug spend.

Currently, the Iowa pharmacy program and most state programs necessarily satisfy the FUL aggregate test since the FUL rate is included as a factor in the multiple-source drug reimbursement algorithm. In other words, Iowa pharmacy pricing cannot by definition exceed the aggregate federal limit since it is based on a "lower of" methodology.

As the Department is aware however, the Deficit Reduction Act of 2005 (DRA) mandates a significant change in the calculation used to determine FULs for Medicaid multi-source drug reimbursement rates. If implemented according to the definitions established in the Final Rule (CMS-2238-FC), these AMP-based FULs present a number of pricing, reporting, and updating challenges. As a result, Myers and Stauffer consistently monitors developments with regard to these changes, and has the background and data and modeling expertise necessary to provide the Department with meaningful fiscal and policy analysis. Early on, we provided the Department with analysis on the effect of these revised FULs compared to the current multiple-source drug reimbursement, and we are ready to provide additional fiscal impact modeling and relevant discussion to frame the changes for their applicability to and impact on the Department once Federal regulations are finally implemented.

In addition, we are tracking Health Reform legislation for AMP and other changes that impact pharmacy pricing for Medicaid. Once a specific policy change appears imminent, we will proactively perform comparison modeling to help our State MAC clients anticipate the full extent of the impact on their Medicaid pharmacy programs.

***Design, develop, and implement protocols to analyze, review, and research utilization and service***

***delivery patterns for brand and generic drugs.***

(RFP Section 6.7.2.2.4 i)

Analysis, review, and research protocols are standard features within the SMAC rate setting and claims analysis services that Myers and Stauffer currently provides to the IME.

We understand the importance of the Iowa SMAC program in implementing specific program policies and then monitoring its performance with respect to meeting specific goals and objectives. For this reason, we will design, develop and implement an aggressive protocol for observing provider behavior and utilization trends, and their relationship to pharmacy pricing (changes) to assure that the Department is fully informed with respect to overall program performance as well as poised to respond quickly and effectively if necessary.

***Analyze, review, and research utilization and service delivery patterns for brand and generic drugs, focusing on the extent to which the SMAC program affected observed trends.***

(RFP Section 6.7.2.2.4 j)

As required by this RFP, we will perform provider payment, recipient drug use, and fiscal impact analyses utilizing the most recent Iowa Medicaid claims data. We will also continue to prepare fiscal impact analyses electronically using database applications to sort,

summarize and review the claims data.

States such as Iowa that implement and operate State MAC programs for Medicaid pharmacy pricing must be prepared to readily and timely identify, trend, and minimize physician, pharmacy, and beneficiary behaviors that may produce outcomes counter to the objectives of the State MAC program. Such behaviors may include the following:

- Use of brand drugs (via brand medically necessary) in lieu of generic drugs, particularly where the pharmacist may be allowed to make therapeutic changes at the point-of-sale.
- Physician override of the State MAC rate for a brand drug by indicating that the brand drug is medically necessary.
- Patient over-utilization of the pharmacy benefit and other ambulatory care.

Myers and Stauffer will develop protocols for examining the impacts the SMAC program has on utilization and service delivery patterns for brand and generic drugs. The following types of trends and perspectives will be examined:

1. Expenditures by drug, drug group, or NDC.
2. Quarterly SMAC drug spending.
3. Change in AWP by drug group.

4. Brand medically necessary overrides.
5. Brand medically necessary overrides by drug.
6. Brand medically necessary overrides by pharmacy.
7. Brand and generic preferences.
8. Strength and dosage interchange.
9. Drug interchange.

***Analyze, review, and research utilization and service delivery patterns for brand and generic drugs to identify inappropriate incentives and examine potential fraud.***

***Prepare and submit to the Department an update on SMAC program operation and utilization trends no less frequent than quarterly.***

***Recommend utilization controls to correct phenomena affecting the efficiency or fiscal objectives of the SMAC.***

(RFP Sections 6.7.2.2.4 k, l and m)

In our more than 30 years of work with state Medicaid agencies, we thoroughly understand Medicaid claims processing systems and therefore know how to minimize claims system opportunities to circumvent desired policies and pricing objectives, as well as how to quickly identify pricing problems and undesirable provider behaviors. The programs and services that we offer

have been carefully developed to minimize provider opportunity for program manipulation through a series of carefully developed system edits, quality assurance features, and through various monitoring and reporting tools that we use internally and offer to our clients. The result is an effective system of monitoring from both the contractor and state agency perspectives.

Myers and Stauffer will recommend policy, utilization, or other program changes that might assist the Department in refining the SMAC program to better meet its health outcome and fiscal goals, as well as the overall integrity of the Medicaid program. A primary tool in determining a need for such changes will be measuring program utilization.

Factors affecting program savings and largely driven by service provider and patient behaviors are termed, utilization factors. Programs that have simultaneous objectives of improved health outcomes and the efficient use of funds must monitor not only the fiscal impact of the SMAC rates themselves, but also the utilization behavior of physicians, pharmacies, and beneficiaries. Utilization factors are not simply the quantification of units of service provided or dollars reimbursed. Utilization factors also encompass deliberate service provider or patient actions that may promote or produce program inefficiencies, abuse, or fraud. Myers and Stauffer will develop a series of mechanisms that we will propose to utilize in assisting

DHS efforts to preserve the integrity of the SMAC program.

As the incumbent contractor, we have carefully developed a series of reports that were created specifically for the Department to track and communicate these and other issues of interest. In addition, we offer flexibility in content and frequency in order to best meet the needs of the Department.

Through the aggressive monitoring protocols incorporated within the Iowa SMAC pricing methodology, we are able to quickly identify isolated and/or unusual issues and patterns that influence (positively or negatively) SMAC program objectives. Once identified, we will quickly develop one or more recommendations to remove, replicate, incorporate, or otherwise respond.

***Provide a staff knowledgeable of the Iowa Medicaid program and with experience implementing, updating, and maintaining a state maximum allowable cost program.***

(RFP Section 6.7.2.2.4 n)

See Section 8 of our proposal for information regarding the project team.

***Employ a pharmacist with sufficient training and certifications to evaluate and maintain the clinical and pharmacological integrity of the SMAC program.***

(RFP Section 6.7.2.2.4 o)

To fully meet this requirement, we propose to continue to offer the services of our staff pharmacist, Dr. Shin, as project manager for this engagement. He is a doctor of pharmacy with specialized training in managed care and pharmacoeconomics research. Dr. Shin will work closely with our consultant pharmacists on drug selection issues and research. We are pleased to bring their combined expertise and credentials to this engagement and envision that they will contribute the following services and assistance to the Department.

- Identifying therapeutically equivalent brand and generic drugs.
- Developing groups of common brand and generic drugs.
- Recommending appropriate drug selection criteria.
- Identifying Narrow Therapeutic Index drugs.
- Identifying other drug issues (shortages, recalls, scientific controversy, etc.).
- Providing pharmacoeconomic observations.
- Serving as professional resource for state pharmaceutical and other clinical staff.
- Participating in meetings with stakeholders or other interested parties.

***Identify medical policy and claims processing enhancements or refinements to ensure SMAC and program integrity.***

(RFP Section 6.7.2.2.4 p)

Since 2002 when Myers and Stauffer first assisted Iowa in developing and implementing its SMAC program, we have significantly expanded our actual acquisition cost database, enhanced our experience in developing and implementing the pharmacy survey protocol, improved our pharmacy provider partnerships and communications, expanded our capabilities in performing sophisticated pharmacy-specific program and fiscal analyses, refined reporting requirements and capabilities, and expanded our knowledge of claims processing systems, pricing, and file updates.

The expertise that we have developed in recent years in performing payment integrity work (PAM and PERM projects) has also contributed significantly to our extensive knowledge of claims payment system loopholes and un-edited data fields. As a result, we have been able to recommend systems enhancements that minimize opportunities for pharmacy provider fraud and drug abuse by Medicaid patients, as well as implement “flags” within our monitoring protocols.

The degree to which our State MAC experience, services, and State Medicaid engagements have expanded over the past few years makes Myers and Stauffer uniquely qualified to identify any new and

realistic opportunities to improve Iowa SMAC program functions and outcomes and to assist in their implementation.

Myers and Stauffer will recommend any policy, claims processing or other program changes that would assist the Department in refining the SMAC program to better meet the health outcome and fiscal goals and maintain overall program integrity.

***Provide all necessary assistance to the Department with the administration of the SMAC program and utilization goals.***

(RFP Section 6.7.2.2.4 q)

We appreciate the value and importance of pharmacy providers as a key stakeholder group within the Medicaid Program. We also appreciate the diversity of pharmacies and pharmacists within the State, as well as the part that they each have in serving the Medicaid population in unique settings. Moreover, it has been our experience that pharmacy providers and their trade organizations, regulators, program beneficiaries, and others appreciate the opportunity to play an active role in the development and ongoing operation of the SMAC program.

For this reason, we have worked to develop a pricing approach that not only draws from, but actually depends upon regular communications with and input from pharmacies. Our approach incorporates several distinct stakeholder relations features (i.e.,

provider Help Desk, SMAC Web site, etc.), all of which have provided significant benefit, efficiency and effectiveness to the IME and its stakeholders. These services are intended to promote two-way communication, which includes the identification of problems, marketplace issues, and utilization trends that might not be otherwise caught through the program.

To further foster this relationship, Myers and Stauffer will continue to assist the Department by monitoring claims payment issues and trends, preparing documentation and correspondence, delivering and/or assisting with presentations, providing technical support, and performing other services necessary to sustain pharmacy program goals and educate stakeholders.

***Provide monthly reports indicating the savings associated with the SMAC program. Provide financial projections with any recommended changes to the SMAC.***

(RFP Section 6.7.2.2.4 r)

We will continue to offer regular savings and expenditure analysis, as well as to deliver effective and timely reporting that meets the ongoing needs of the Department. As the incumbent SMAC contractor for Iowa, we have been careful to successfully meet the requirements of all deliverables and their respective timelines, and we promise to continue to do so throughout the new contract term.

Support for Prescribing Providers and Pharmacies

(RFP Section 6.7.2.2.5)

***Provide a telephone help-desk support “hotline” whereby pharmacies may report problems with SMAC fees, product availability, and utilization.***

(RFP Section 6.7.2.2.5 a)

As the incumbent contractor, Myers and Stauffer maintains a toll-free telephone number to receive such input. This has proven to be an effective tool in responding to service providers’ questions and concerns regarding the SMAC program, and we plan to continue the use of this support mechanism.

Provider contacts will continue to be recorded in the provider log, analysis will be initiated, and the results of the analysis submitted to the Department for review and decision. We will notify the provider of the results once a decision is rendered. In addition, the Iowa SMAC Web site will continue to include a Help Desk log book, located in an “Administrative Only” section to allow Department personnel unfettered access to monitor inquiries into the SMAC Help Desk (and our responses).

***Provide an Internet, Web-based application whereby pharmacies may report problems with SMAC fees, product availability, and utilization.***

(RFP Section 6.7.2.2.5 b)

Myers and Stauffer will continue to maintain and, if desired, modify an

Internet site to support the Iowa SMAC program. The site is available 24 hours per day, seven days a week, with minimal/no downtime. It is designed to be interactive, informative, and *user friendly* and is based on a model that has proven to be successful in facilitating and improving communication and collaboration with pharmacy providers.

Myers and Stauffer is committed to ensuring that provider issues are addressed positively and promptly; therefore, we will review with the Department any opportunities to refine performance of overall services and provider satisfaction throughout the new contract term.

***Assure that pharmacy providers have an active role in discussing SMAC rates, recommending rate adjustments, and apprising DHS of changes in their ability to purchase drugs.***

(RFP Section 6.7.2.2.5 c)

It has been our experience that pharmacy providers and their trade organizations, regulators, program beneficiaries, and others very much appreciate the opportunity to play an active role in the development and ongoing operation of the SMAC program. To foster this relationship, Myers and Stauffer agrees to continue to develop all necessary provider notifications of SMAC changes, and to further assist the Department by preparing documentation and correspondence, delivering and/or assisting with presentations and training, and by

providing technical support and other services necessary to sustain State MAC program goals and educate stakeholders.

As a partnering contractor to the IME, we take seriously our role in performing educational outreach and in assuring and maintaining the integrity of the SMAC program. We also very much understand and appreciate the numerous and competing demands on state staff and are committed to working independently to the extent possible with providers to minimize the Department's role in managing routine provider and contractor inquiries and concerns.

Providers will be encouraged to forward specific concerns about the SMAC rate schedule to Myers and Stauffer. Supporting documentation, such as invoice information may be forwarded to Myers and Stauffer to illustrate specific concerns about SMAC rates, product availability, or other issues.

Providers who wish the Department to consider adjustments to SMAC rates or other concerns about the SMAC program will follow the procedures outlined previously in our proposal.

***Coordinate with the Iowa Pharmacy Association's Medicaid Advisory Committee and the Iowa Drug Utilization Review Commission.***

(RFP Section 6.7.2.2.5 d)

As a DHS contractor for the current SMAC program and other

engagements, we have built successful, on-going relationships with industry groups, DUR boards and other Medicaid contractors with whom it was necessary to coordinate or exchange information. We have often assisted our clients in implementing programmatic changes such as adding SMAC rates. We have also built many relationships with other state agencies and enjoyed successful working relationships. Presently, we work directly with several other contractors on pharmacy-related engagements on behalf of DHS. We will pursue our work in a manner careful to coordinate with industry groups and other contractors and agencies, when necessary, at DHS direction and approval.

***Receive, adjudicate, and respond to written requests from pharmacy providers.***

(RFP Section 6.7.2.2.5 e)

As stated previously, we offer providers access to communicate rate issues and other concerns through our Iowa SMAC Help Desk feature and through the Iowa SMAC Website, both of which we make available to Iowa pharmacy providers on a 24/7 basis.

Where supporting documentation, such as invoice information may be necessary to evaluate specific concerns about SMAC rates, product availability, or other issues, pharmacies will be contacted directly and requested to provide such information.

It is important to note that Iowa pharmacy providers are accustomed to working with Myers and Stauffer Help Desk staff and understand how to most effectively present new issues and concerns to minimize the time involved in generating resolution. Throughout the current SMAC program contract term, we have received no complaints from Iowa providers regarding the qualifications or professionalism of our Help Desk technicians.

Finally, Myers and Stauffer understands and appreciates the numerous and competing demands on state staff and is committed to using Department staff time wisely and reducing to the extent possible its role in managing routine provider inquiries and concerns. To accomplish this goal, we will continue to make every effort to communicate with Iowa pharmacy providers effectively in both oral and written form to assure successful problem resolution at the earliest stages. Similarly, data and other informational requests, as well as technical issues and concerns can be streamlined and often resolved quickly with Department technical staff.

***Notify pharmacy providers of any new drug(s) being added to the SMAC fee schedule, and changes in reimbursement rates and any deletion(s) of drug product(s) from the SMAC fee schedule on a regular basis.***

(RFP Section 6.7.2.2.5 f)

Providers will be notified at least 30 days prior to the effective date of any new drug(s) being added to the SMAC fee schedule. Providers will be notified of any changes in reimbursement rates and any deletion(s) of drug product(s) from the SMAC fee schedule on a regular basis. Changes will be communicated to providers in the most efficient and comprehensive manner, typically through informational notices that are e-mailed to providers and updates rate lists posted to the Web site.

***Provide changes to the POS contractor, in a format determined by DHS, at least 30 days prior to the effective date of any changes to the SMAC fee schedule.***

(RFP Section 6.7.2.2.5 g)

The POS contractor will be notified at least 30 days prior to the effective date of any amendments to the SMAC fee schedule.

As the incumbent SMAC contractor for the IME, a successful interface between Myers and Stauffer and the claims processing/point-of-service (POS) contractor has already been established, so no start-up expenses or development functions are required.

Iowa SMAC rates are currently transferred, added to, and verified in the MMIS through the following process:

- On a bi-weekly basis, Myers and Stauffer transfers SMAC rates electronically in a text file format directly to the State's MMIS/fiscal agent contractor.

- Once transferred, the MMIS contractor sends us notification that they have successfully received the new SMAC rates.
- Myers and Stauffer then loads the file into our database and compares the file with the Medi-Span file to validate all rates that were added, deleted, and updated as required.
- Once all rates have been verified, we notify the MMIS contractor to load the rates into the Production environment.

It may also be useful to note that Myers and Stauffer is also prepared to readily adapt our SMAC rate updating process to accommodate any changes in claims processing, POS, and/or contractors that might arise through this procurement. We have worked with our state Medicaid clients through numerous systems transitions over the years and are able and committed to managing a seamless transition of responsibilities if necessary.

Technical Support, Pharmacological Expertise and Evaluation Services  
(RFP Section 6.7.2.2.6)

***Examine the drugs and drug groups eligible for inclusion in the SMAC rate schedule.***

***Insure that drug products included in the SMAC program are only those brand and generic drugs of similar chemical composition, package size, dose, and form.***

(RFP Sections 6.7.2.2.6 a and c)

Among the more important aspects of a successful SMAC program is the selection of drugs for inclusion in or exclusion from the program and continuous efforts to identify new opportunities to add drugs to the program as the pharmaceutical market evolves. Myers and Stauffer works closely with the Department to establish thresholds for drug selection and evaluates the drug marketplace to determine which drugs should be recommended for the SMAC program. A pharmacist identifies therapeutically equivalent brand and generic drugs and groups them into common drug classes. When drugs become eligible for the SMAC program, it is important that they be reviewed and, if appropriate, added in a timely manner, since SMAC reimbursement's equitable application of drug pricing to like products offers opportunities to produce program savings. To monitor compliance to policies, we subscribe to reference materials and other tools to identify drugs of similar chemical composition, package size, dose, and form. As a secondary review, our pharmacist also reviews and approves proposed SMAC list drug changes.

As the incumbent SMAC program contractor for Iowa and several other states, we have in place a rigorous protocol for reviewing pharmaceuticals both in terms of Medicaid pricing and optimizing patient outcomes. We regularly review utilization of both SMAC drugs and non-SMAC drugs to ensure that patterns and trends are consistent with Medicaid program objectives. Through our

comprehensive monitoring and reporting system, we are able to quickly identify and assess problems and then develop a logical and effective solution, which we then immediately present to the Department for consideration. We believe that this process has been proven effective throughout the current contract term.

***Identify drugs with known clinical issues involving efficacy of substitution and evaluate the appropriateness of their inclusion in the SMAC program.***

(RFP Section 6.7.2.2.6 b)

SMAC programs allow Medicaid programs to more appropriately align reimbursement for drugs to the price pharmacies pay to purchase those products. However, the ultimate goal for Medicaid programs is to protect program recipients and ensure the best health outcomes possible. When developing SMAC programs, we are mindful to incorporate measures to protect Medicaid patient outcomes and ensure that the SMAC rate schedule does not offer perverse incentives in drug selection.

We already have in place a comprehensive review process. Our proposed project manager, Dr. Shin, works with his staff and consultant pharmacist to ensure that drugs are thoroughly and carefully reviewed for their appropriateness (or continued appropriateness) for the Iowa SMAC program. We have worked with the SMAC program long enough to be successful in achieving the proper balance

between program objectives both in terms of patient outcomes and pricing limitations.

***Complete required reports accurately and timely.***

(RFP Section 6.7.2.2.6 d)

Myers and Stauffer agrees to complete required reports accurately and timely.

As the incumbent contract for the Iowa SMAC program, we have worked diligently with the Department to meet all content, quality, and timing expectations for required reports. In addition, it has been our practice to make every effort to improve and modify reports as necessary, or to design additional reports that will further enhance the strong monitoring feature of the program services that we provide.

***Complete all duties in an accurate, complete, timely and professional manner.***

(RFP Section 6.7.2.2.6 e)

Myers and Stauffer agrees to complete all duties in an accurate, complete, timely and professional manner.

Our response to each RFP requirement represents the full range of SMAC program services that we have developed and refined specifically for the IME since 2002. We have made every effort to meet or exceed performance deadlines, respond to provider inquiries within 24 hours, and have refined or implemented several additional

processes and monitoring reports to help the Department better evaluate rates, drug availability and pricing, marketplace trends, and overall program performance. We value our partnership with the State of Iowa and work hard to assure that we consistently meet our contractual obligations.

We believe that the greatest challenge to state Medicaid agencies is to always find the “right” balance between health care service prices and overall expenditures and beneficiary coverage, access and health outcomes; and it is specifically this often-delicate balance that the Myers and Stauffer pricing approach is designed to help achieve.

Our more than 30 years of service experience has given us a level of understanding and expertise that is virtually unmatched. Namely, we understand and appreciate *what is expected and required of us with respect to completing all contractual obligations*, as well as the full range of responsibilities associated with our role in serving as a trusted extension (representative) of the Iowa Medicaid Enterprise.

***Be knowledgeable of and apply all state and federal requirements.***

(RFP Section 6.7.2.2.6 f)

Myers and Stauffer agrees to meet all aspects of this requirement.

Our experience has taught us to be exceptionally responsive and sensitive to public scrutiny, performance expectations, and the

high levels of accountability and integrity that are expected of government agencies and policy makers. Moreover, unlike our competitors, *our firm has limited its practice exclusively to partnering opportunities with state and federal Medicaid, Medicare, and other governmental agencies.*

It is with this extensive expertise and sense of responsibility that we helped the IME and other state Medicaid agencies to develop a Medicaid State MAC pharmacy program that is superior to all other Medicaid pharmacy programs. In order to maintain the highest standards upon which our actual acquisition-based cost approach depends, it is imperative that we are fully knowledgeable regarding all state and Federal requirements pertaining to the program, issues of real or potential legislative and litigative interest, changes in the pharmaceutical marketplace, and virtually all other aspects of the Medicaid Program.

**B. Performance Standards  
(RFP Section 6.7.2.3)**

Provide notification to the POS contractor a minimum of 30 days prior to implementation of changes to the SMAC fee schedule, unless otherwise directed by the Department.  
(RFP Section 6.7.2.3 a)

Myers and Stauffer agrees to provide notification to the POS contractor a minimum of 30 days prior to implementation of changes to the SMAC fee schedule, unless

otherwise directed by the Department.

As the incumbent SMAC program contractor, we have established a good working relationship with the POS contractor and always provide advance notice within the contractually required timelines.

Provide notification to pharmacy providers a minimum of 30 days prior to the effective date of any new drugs being added, change in reimbursement rate and/or deletions of any drug products from the SMAC fee schedule on a regular basis, unless otherwise directed by the Department.  
(RFP Section 6.7.2.3 b)

Myers and Stauffer agrees to provide notification to pharmacy providers a minimum of 30 days prior to the effective date of any new drugs being added, change in reimbursement rate and/or deletions of any drug products from the SMAC fee schedule on a regular basis, unless otherwise directed by the Department.

As the incumbent SMAC program contractor, we have already established a good working relationship with the Iowa pharmacy community. Through the SMAC Web site and Help Desk features of our program, we give them 24/7 access to the latest SMAC drug and rate information. In addition, Iowa providers know and expect that we will proactively monitor and identify changes in the marketplace to facilitate the most up-to-date and accurate SMAC drug list and rates.

6.3 Rebasing and Diagnosis  
Related Group and  
Ambulatory Payment  
Classification Recalibration  
(RFP Section 6.7.3)

A. Contractor Responsibilities  
(RFP Section 6.7.3.2)

Meet Objectives  
(RFP Section 6.7.3.2 a)

Iowa Medicaid currently utilizes prospective payment systems to reimburse general medical/surgical hospitals for both inpatient and outpatient services. Inpatient services are reimbursed under a diagnosis related group (DRG) system while outpatient services are reimbursed using the ambulatory patient classification (APC) system. Iowa administrative code (IAC) requires that system parameters be rebased and recalculated every three years. These parameters include hospital base, capital cost, disproportionate share, and direct and indirect medical education rates. The DRG system requires the weights used for payment determination to be recalibrated on this same schedule. The APC weights are updated annually based on the Medicare APC weight table published every January 1.

Myers and Stauffer will perform the triennial rebasing of hospital base, capitol cost, direct and indirect medical education and disproportionate share rate. In addition project staff will recalibrate the DRG weights every three years

and the update the APC weights annually. The following sections provide a discussion on our approach to accomplishing these tasks.

Maintain Interfaces  
(RFP Section 6.7.3.2 b)

Myers and Stauffer is prepared to provide these services to the Iowa Department of Human Services (DHS). We understand that work will commence effective July 1, 2010. We will continue to work with DHS staff, the core MMIS contractor, and the DW/DS contractor to obtain the necessary reference materials, provider cost information, and claims data including charges. We already have a working relationship with 3M-HIS and employ their 3M Core Grouping software for both DRG and APC grouping of claims. As part of this project, we will continue to work with Medicare intermediaries in the State of Iowa to obtain Form CMS 2552 (Hospital and Healthcare Complex Cost Report) and other information needed to complete the recalibration.

Myers and Stauffer understands that we will follow policies established by the state governing the triennial hospital rebasing and recalibration. Our policy has always been to provide our state clients with the best possible options and the necessary information to make appropriate decisions. State officials are best situated to understand the various ramifications of fiscal changes and we will not implement any changes to the reimbursement systems, including rates, without prior approval.

Perform Calculations, Maintain and Operate DRG-based Prospective Payment System and Maintain and Operate APC-based Prospective Payment System  
(RFP Section 6.7.3.2 c, d and e)

As Myers and Stauffer is the current contractor providing these services to IME, upon contract award, our team members will be able to immediately respond to any new tasks assigned by the Department. We will meet with the Department to review any concerns and/or desired changes with the current DRG and APC reimbursement methodologies. We have vast experience in developing and maintaining DRG reimbursement systems and are currently assisting our state clients with the evaluation and eventual implementation of APC systems. We understand and appreciate that each state has unique requirements that guide us in our approach.

Myers and Stauffer understands that the data sources that will be used for the rebasing and recalibration of the DRG and APC functions include Iowa Medicaid paid claims, hospital cost report (CMS 2552) data, along with DRG/APC grouper software.

Myers and Stauffer has extensive experience across the entire range of data sets needed to complete the recalibration of weights and base rates. We are one of the few firms in the entire country that has extensive experience auditing and cost settling hospital inpatient and outpatient services, as well as extensive experience working with and

analyzing Medicaid paid claims data and DRG/ APC grouper software products. Few, if any other firms can match our knowledge and experience across this spectrum.

Myers and Stauffer offers the Iowa Medicaid program a DRG/APC recalibration contractor that is expert with the current system as well as the spectrum of issues faced by Medicaid programs in these times. We also strive to continue developing better alternatives and to work at refining existing software.

***Base Rates and Related Parameters***

Myers and Stauffer will need to determine both aggregate and facility-specific hospital costs on an inpatient and outpatient basis. Hospital costs will need to be apportioned to Medicaid based on facilities' hospital cost reports (CMS 2552). In the past, we have utilized claims data to apportion costs based on routine per diems and ancillary cost to charge ratios. It is also possible to apportion costs based upon discharges and/or payor days. Ancillary costs will need to be further divided into inpatient and outpatient services.

At this point, capital costs will be isolated. Capital costs are easily identified on the hospital cost report. For purposes of rate setting and following state guidelines, these capital costs will be multiplied by 80 percent and then divided by the number of discharges and the facility's case-mix index.

Medical education (both direct and indirect) expenses will then need to be identified. Direct medical education expenses are usually identified as a post-step-down adjustment. Indirect medical education expenses are not directly identifiable from a hospital cost report. Instead, indirect medical education expenses are usually determined as a percentage of cost using a formula based upon the number of hospital beds and the number of interns and residents.

Since the PPS reimbursement systems will have additional expenditures for transfers, outliers, psychiatric services, and physical rehabilitation services, we will need to make allowances for these payments, determined from calculations using historical claims data, fiscal impact models, and following guidelines from the State Plan.

In the next step, CMI will be determined in aggregate and on a hospital-specific basis using historical claims data and either APC weights or DRG weights for outpatient and inpatient services, respectively. A CMI is simply the total aggregate weight divided by the number of claims and is a relative measure of patient acuity and/or resource utilization. Facilities with more complex cases have a higher case-mix than facilities with less complex cases.

Another important part of this process is the validation and accuracy of the claim set utilized in the

process. Myers and Stauffer's experience with the Iowa claim sets will continue to be of great benefit in reducing the time required to perform this function.

Aggregate and hospital-specific costs will then be divided by their respective Iowa Medicaid discharges and CMIs to determine a case-mix adjusted cost per discharge. This amount is then adjusted to reflect inflation to the upcoming rate year to establish a base rate.

Using this methodology produces initial base rates for operations and capital. There are further refinements and "blending" of rates indicated in the Iowa State Plan that Myers and Stauffer will follow to produce the final DRG and APC rates

#### ***Medical Education and Disproportionate Share Payments***

Hospitals providing medical education programs and/or serving a disproportionate share of low-income patients are eligible for additional payments from Iowa Medicaid. As part of our information gathering task, Myers and Stauffer will determine the eligibility of hospitals in receiving these payments and the appropriate levels of reimbursement under these programs.

Medical education payments fall under two categories, direct and indirect medical education. Indirect medical education payments further break out into two separate categories, payments for all facilities with medical education programs and supplemental indirect medical

education payments for facilities that qualify for the first category and have more than 500 beds and/or eight or more specialty or subspecialty programs. Medical education fund distributions are apportioned from a fund established for these programs based on various parameters that include claims data, facility bed size, and the number of interns and residents.

Disproportionate share hospital (DSH) payments also break into two separate pools of funding. Hospitals qualify for the first fund either by having a low-income utilization rate that exceeds 25 percent or a Medicaid utilization rate that exceeds one standard deviation from the statewide average Medicaid utilization rate (or as a children's hospital meeting certain criteria). Myers and Stauffer will continue to determine the apportionment of this fund based on state guidelines.

A supplemental disproportionate share payment fund, known as the GME and DSH fund, is available for facilities that qualify for both DSH and graduate medical education payments. These facilities must also have more than 500 beds and be owned by the State of Iowa. Myers and Stauffer will continue to determine the apportionment of this fund based on state guidelines.

***Recalibrate DRG and APC Weights***

For the State of Iowa, previous discussions have led to adoption of Medicare weights with the switch from an APG to an APC outpatient system. Therefore, the following

discussion applies mostly to the inpatient DRG system.

Claims are edited to ensure that non-covered and duplicate claims are removed. They are then processed with the latest version of their respective grouper. Any grouping errors are investigated and any systematic coding mistakes are reported to DHS for follow-up action with providers (informational provider bulletins, etc.). Statistical analyses are then run on the data sets to identify potential outlier claims. Outliers are identified based on criteria established under the State Plan. Hospital charges are capped at the outlier threshold and then these "trimmed claims" are added to the non-outlier claims to form the database used to determine DRG weights.

From the resulting database, the geometric mean of the charges for the aggregate claim set and for each DRG is determined. To determine the DRG weight, the geometric mean of each DRG is divided by the geometric mean of the data set. This set of weights is normalized so that the average case has a weight of 1.0000.

Once weight sets are generated (or imported from Medicare for the APC system), Myers and Stauffer will generate fiscal impact models to demonstrate any anticipated changes in reimbursement between the new set of weights and the set of weights currently used for reimbursement.

While this is a simplified explanation of the methodology that Myers and Stauffer employs in recalibrating DRG weights, we will be careful to conform to the methodology as described in the Iowa State Plan and utilized by our firm over the course of the previous contract. Before any changes are made to the process either through improvements in our software or to address state objectives and goals, we will seek the prior approval of state officials.

There are several areas of PPS reimbursement that Myers and Stauffer would like to discuss with state officials based on our experiences in other states. The two issues that always seem to be of interest to our clients are the handling of neonatal claims, especially with respect to premature births, and the systematic determination of weights for low volume cases. Any options that we present will have significant background analyses and be at the complete discretion of state officials.

#### Provide Required Reports (RFP Section 6.7.3.2 f)

In the process of completing updates to the DRG and APC reimbursement systems, Myers and Stauffer will generate various work products including databases, spreadsheets and accompanying memorandum. We have worked with DHS over the last several years to develop a comprehensive package of documents that meet all requirements. These will be provided in draft form to DHS staff on a regular basis during the completion of our tasks.

Upon completion of each task, Myers and Stauffer will generate a comprehensive report that includes the following:

- Hospital-specific and statewide average rate sheets with supporting documentation used to generate base, capital cost, disproportionate share, and indirect and direct medical education rates.
- Revised DRG and APC weight schedules including outlier thresholds and average lengths of stay.
- Hospital-specific and statewide average CMIs based on both the updated and previous DRG and APC weights.
- A summary of projected charges to projected payments and estimated cost based on hospital cost report and claims data for both individual hospitals and on a statewide basis.
- Fiscal impact models that project hospital payments for inpatient (outpatient) services using the updated CMIs, base rates, capital cost rates, direct and indirect medical education payments, and disproportionate share rates. These models will also include the estimated payments under the previous system parameters.

Only after DHS has approved the new rates, weights, and accompanying report will a final report be issued. We have included a package of sample reports in appendix H.

**B. Performance Standards  
(RFP Section 6.7.3.3)**

Myers and Stauffer ensures complete accuracy in our calculations to apportion costs to Medicaid for each hospital submitting Form CMS 2552. We also ensure complete accuracy in calculating hospital CMIs, inpatient base, capital cost, direct and indirect medical education and disproportionate share rates and outpatient base and direct medical education rates. This same level of accuracy will also be obtained in the calculation of DRG/APC weights.

Quality control for this project is broken down into several redundant levels. Our staff has several years of experience in this area and is accustomed to dealing with differences between state reimbursement systems and identifying potential difficulties. We also employ automation whenever possible to remove human errors from the process. Once work products are generated, staff is trained to seek out and evaluate potential areas of concern.

Myers and Stauffer has also developed software applications that track adjustments to data sets and automatically generate validation report, which provides an additional level of product review and transparency.

A complete work product is then presented to our project managers for review and compilation. Their extensive experience allows them to identify common areas prone to

errors and to cross-check results. Once the results have been reviewed and approved, they are presented to the project director who reviews both the results and the methodology employed to generate the results.

As a final check, Myers and Stauffer utilizes a quality control manager that is outside of the project team in order to introduce a fresh viewpoint to question assumptions made by the project team in internal discussions.

**6.4 Reimbursement  
Technical Assistance and  
Support  
(RFP Section 6.7.4)**

**A. Contractor Responsibilities  
(RFP Section 6.7.4.2)**

Myers and Stauffer LC has been providing reimbursement technical assistance and support services to the Iowa Department of Human Services since July 2001. Our relationship with DHS began with the successful development of the case-mix reimbursement methodology for Iowa nursing facilities that was implemented July 1, 2001 and has continued through implementation of the Iowa Medicaid Enterprise. Our project staff has the technical expertise required for these projects and experience working on these and similar projects for Iowa and other states.

General Responsibilities  
(RFP Section 6.7.4.2.1)

***Update or make changes to rate methodologies***

***Conduct analysis and assist the department in development of new reimbursement methodologies***

***Provide on-going technical assistance to the Department in analyzing alternative reimbursement systems; Provide findings related to state plan amendments, and assist with other special projects***

(RFP Section 6.7.4.2.1 a, f and h)

As the incumbent contractor, Myers and Stauffer has developed a comprehensive understanding of the Iowa Medicaid program and stands ready to provide on-going technical assistance to the Department as it analyzes alternative reimbursement systems or to implement changes needed to comply with federal or state law changes.

We recognize the value state Medicaid agencies can realize from having a rate setting and audit contractor who has a broad understanding of the different methods and standards used across the country in setting reimbursement rates and who is available to assist with policy revisions and special projects as well as to advise the Department concerning alternative systems. Myers and Stauffer is that contractor. We have considerable experience assisting Iowa and numerous other states, which enables

us to offer insights into this complex area, and advice on meeting the new standards and completing the justifications process.

Drawing upon this experience, we can assist the Department in identifying strengths and weaknesses of potential reimbursement systems and developing reimbursement systems that meet the programmatic goals of the State of Iowa.

During this contract period we will participate in meetings, discussions, and training with the Department and other state government agencies involving Medicaid policy formulation and alternative reimbursement methodologies. We will be available to assist in documenting the process of establishing the annual upper payment limits and other components of the rate setting methods and standards.

A key element in developing a new reimbursement methodology is thoroughly modeling the alternatives under consideration. We can create dynamic models that allow for easy modification of reimbursement parameters. Fine tuning the models creates a reimbursement system that meets as many Department goals and objectives as possible.

As decisions are made to modify reimbursement methodologies, Myers and Stauffer project staff will participate in the formulation of Medicaid policy changes. An evaluation will be completed to determine if the changes in the

reimbursement system will require modifications to the system component contractors. Meetings will be held with the core MMIS contractor to discuss possible changes to the claims processing and develop a work plan and a timeline for accomplishing changes.

When changes to reimbursement methodologies are needed, we will continue to assist with the drafting of State Plan revisions, developing findings and providing a full range of technical support.

***Maintain monitoring and reporting system for NFs***  
(RFP Section 6.7.4.2.1 b.1)

Myers and Stauffer has developed and maintains extensive databases containing financial and statistical data from cost reports, rate calculation data, and MDS assessment data for Iowa nursing facilities. These databases are organized to promote rapid retrieval of data and flexibility in data queries and analyses. We have assisted DHS in meeting the monitoring and reporting requirements contained in House File 740 regarding the use of any excess payment allowance to nursing facilities. For the direct care excess payment allowance, providers are required to spend the additional reimbursement to increase direct care staff compensation or to increase direct care staff ratios. For the non-direct care excess payment allowance providers are required to spend the additional reimbursement to fund resident “quality of life improvements.” Using cost report

and MDS data, we performed detailed analyses on nursing facility spending patterns that are required by H.F. 740. Based on our analyses, DHS was able to satisfy its monitoring and reporting requirements and conclude that the intent of H.F. 740 had been met.

Currently the reimbursement methodology does not include excess payment allowance payments. However the experience gained from preparing analyses and monitoring payments will be invaluable in the development and monitoring nursing facility spending of the pay for performance and quality assurance payments.

We also utilize these databases in modeling proposed changes in reimbursement methodology, performing analysis on provider costs, statistics and CMIs, cost coverage statistics, financial projections, and monitoring of expenditures. We have developed and currently prepare numerous reports for DHS such as the cumulative rate listing and CMI summary. Myers and Stauffer possesses the technical expertise, experience, infrastructure and ability to provide all necessary technical assistance and monitoring services to DHS.

***Provide technical assistance for NFs***  
(RFP Section 6.7.4.2.1 b.2)

DHS reimburses nursing facilities through a modified price-based case-mix reimbursement system. The

case-mix reimbursement system was implemented effective July 1, 2001, and was phased in over three years. Rates are established on July 1 of each year with quarterly updates for changes in Medicaid CMI. Costs are rebased every other year beginning with July 1, 2001.

Myers and Stauffer provided technical assistance and support services to DHS during the development and implementation of the case-mix reimbursement system and currently provides ongoing technical assistance and support services to DHS. We have developed detailed models to assess the fiscal impact of changes in reimbursement methodology such as the recent change in the minimum occupancy used in the non-direct care component of the rate from 85 to 90 percent. State regulation requires case mix rates to be updated with new cost report data adjusted for inflation every second year. We assist DHS with ensuring the appropriate cost report data has been utilized, the correct inflation applied and the CMIs generated.

We have worked with DHS in the development and monitoring of the pay for performance, which provides additional reimbursement for nursing facilities. As part of the pay for performance monitoring process, we will assist DHS with developing reports for summarizing pay for performance information and review pay for performance summaries for accuracy.

The Iowa Administrative Code allows nursing facilities to request an exception to policy for the geographic wage index. The purpose of this is to allow nursing facilities that are classified as rural to request an exception to their classification when they can demonstrate that their costs, wages and location are similar to that experienced by urban facilities. Nursing facilities receiving a geographic wage index exception are allowed greater recognition of incurred nursing wage costs when the facility has high costs that are influenced by urban populations. The amount of additional reimbursement to be received by nursing facilities classified as urban is determined annually. We will assist DHS in calculating the urban wage index amount applied to urban nursing facility rates in accordance with regulations. We worked with DHS to develop criteria for reviewing and approving the requests for geographic wage index exception requests. We drafted an information release providing guidance to providers on the review process and criteria. We also performed reviews and analyses on all exception requests submitted and made recommendations to DHS on whether the requests satisfied the exception criteria. As part of our review process, we assist with monitoring the status of geographic wage exceptions and drafting responses to providers facilitating compliance with time requirements outlined in the regulations.

We currently monitor and review CMI data, RUG-III calculations, rate

calculations, cost report data, and project expenditures. We have participated in meetings with DHS, legislators, workgroups, and other contractors. Myers and Stauffer has the technical expertise, experience, infrastructure and ability to provide all necessary technical assistance services with the case-mix reimbursement system.

***Crossover claim reimbursement for hospitals and NFs***

(RFP Section 6.7.4.2.1 b.3)

The Medicare fiscal intermediary (FI) processes claims for dually eligible beneficiaries (i.e., eligible for both Medicare and Medicaid benefits). During Medicare's adjudication process, the FI determines any applicable coinsurance and deductible amounts owed by the beneficiary. Because the beneficiary is dually eligible, Medicaid is the financially responsible party for any applicable coinsurance and deductible amounts due for these services. These claims for Medicare coinsurance and deductible amounts are referred to as "crossover claims." After verifying Medicaid eligibility for the provider and recipient, the Medicaid fiscal agent contractor pays the crossover claim amounts as computed in accordance with Medicaid payment policy. Any reduction in Medicaid reimbursement to providers for the crossover claim is allowable as bad debt expense on their Medicare cost report. Medicare policy for hospital-based Medicare certified facilities allows recovery of only 70 percent of bad debts.

Previously, Myers and Stauffer assisted DHS in developing a revised reimbursement methodology for crossover claims for hospitals under which reimbursement for crossover claims would be limited by the Medicaid allowable amount. These changes were, however, never implemented due to resistance from the provider community.

Our services on this project included drafting and amending all documents associated with rule changes, provider manual updates, technical specifications and state plan amendments. We have modeled proposed reimbursement methodologies for crossover claims and provided fiscal impact analyses of the proposed methodologies. We have also been involved in discussions with CMS and provider associations regarding proposed changes in reimbursement methodology for crossover claims for hospitals.

Myers and Stauffer has the technical expertise, experience, and ability to provide all necessary assistance to DHS with ongoing development, monitoring and evaluation of the crossover claim reimbursement methodology for hospitals.

Effective May 1, 2003, DHS amended the Medicaid reimbursement policy for crossover claims for free-standing nursing facilities. Under this policy, DHS now pays up to the Medicaid allowable amount for Medicare Part A nursing facility crossover claims for residents in free-standing nursing

facilities. If the prior Medicare payment for free-standing nursing facilities is greater than the Medicaid allowable (computed as the Medicaid per diem multiplied by the number of days), then DHS will pay zero for the crossover claim. If the Medicaid allowable is greater than the prior Medicare payment, DHS will pay the difference, up to the coinsurance and deductible amount of the crossover claim.

Myers and Stauffer currently provides technical assistance and support services to DHS for the change in reimbursement methodology for crossover claims. Our services on this project have included drafting and amending all documents associated with rule changes, provider manual updates, technical specifications and state plan amendments. We have modeled proposed reimbursement methodologies for crossover claims and provided fiscal impact analyses of the proposed methodologies. In addition, we currently monitor MMIS claims data for compliance with the reimbursement policy for crossover claims. When it was determined that Part B claims were not being paid correctly, we met several times with the Medicaid fiscal agent contractor to assist them in identifying the crossover claims that are subject to the reimbursement policy. We spoke with the Medicare FI and reviewed sample claims to identify the claim fields that should be used by the Medicaid fiscal agent contractor to identify the Part A claims subject to the policy. We have developed reports to assist with monitoring the

fiscal savings resulting from the amendments made to the Medicaid reimbursement policy for crossover claims. We have also worked with Department staff to assist the county IM workers in revising procedures for applying client participation in accordance with the reimbursement policy for crossover claims. Myers and Stauffer possesses the technical expertise, experience and ability to provide all necessary technical assistance and support services to DHS for the ongoing monitoring and evaluation of the crossover claim reimbursement methodology for nursing facilities.

***Provide technical assistance on Medicaid payment policies designed to maximize federal financial participation***  
(RFP Section 6.7.4.2.1 b.4)

Because of the limited focus of our practice (i.e., state and federal government healthcare programs only), all of the Medicaid work that we perform is policy driven and must normally be accomplished within fixed budgetary goals and expenditure limits. We take our responsibilities seriously and are always focused on identifying opportunities to save taxpayer dollars whenever possible and to optimize the use of limited funds so that they can serve more people effectively.

The technical assistance that we provide to all of our state Medicaid engagements consists of general administrative support as well as fiscal modeling, analysis, and consultation. In this capacity, we

routinely calculate federal upper limit assurances, provider tax modeling and auditing, as well as produce other necessary computations that are program data driven. We have in-depth knowledge of federal matching fund requirements and are frequently called upon to help state agencies apply those policies in ways that will produce optimal outcomes.

Similarly, we understand the limits of those policies, and we use that knowledge to help our state clients avoid violations that can result in compliance notices, penalties, and requests for repayment.

***Update rates within 5 business days of request***

(RFP Section 6.7.4.2.1 c)

Myers and Stauffer understands the need to have accurate and timely rates on file to ensure that proper payments are made to providers. We agree to respond within five business days of the request to update rates that are updated as routine maintenance. We will submit rate updates via a system action memo through Onbase to the core MMIS contractor using the agreed upon file structure.

***Update CPT, ICD-9 and HCPCS***

(RFP Section 6.7.4.2.1 d)

Myers and Stauffer has significant expertise in the updating process for CPT, ICD-9, and HCPCS codes. As the current contractor, we have an understanding that timely updates to the Iowa MMIS are critical to the Medicaid reimbursement process.

We will work with the Medical Services contractor and core MMIS contractor to ensure that the codes are updated by October 1 for ICD 9 codes and January 1 for CPT and HCPCS codes. We will also work with DHS policy staff to determine if the current pricing is appropriate for existing CPT and HCPCS codes upon request.

***Conduct analysis and provide data to support assurances and findings***  
(RFP Section 6.7.4.2.1 e)

Unlike many contractors whose cost report audit or rate setting services are just a part of their business, Myers and Stauffer's entire practice is devoted to health care reimbursement issues. We have provided audit, rate setting, and consulting services to numerous states throughout the country. This experience enables us to offer Iowa a unique perspective into the current trends and payment methodologies used by other Medicaid programs

The Department is responsible for developing and maintaining a Medicaid reimbursement system that meets state and federal standards. The repeal of the Boren Amendment in the federal Balanced Budget Act of 1997 (BBA 97) was intended to give states even greater flexibility in designing nursing facility payment systems. BBA '97 added new requirements concerning federal Medicaid payment oversight by instituting a "public process" through which changes to Medicaid institutional reimbursement rates are to be implemented. The "reasonable

and adequate” *payment standard* has now been replaced with a public process *procedural standard*.

The focus of this regulation is a public process requirement that gives interested parties an opportunity for review and comment on the determination of rates. Proposed and final rates should be published by each state, as well as the underlying methodologies and justifications for these rates.

The rate setting process should document the decision making process, beginning with the accumulation of data through the submission of the State Plan Amendment. We constantly monitor proposed and final federal legislation and regulation relative to the Medicaid program in order to update our clients on the impact any changes may have on the programs they administer. We strive to stay current with new State Plan Amendments submitted to CMS as well as the types of information and documentation requested by CMS regional and central offices.

We will assist in drafting State Plan revisions as needed. The new State Plan Amendments will be developed to comply with federal laws and regulations including drafting justifications and publication notices, now required for federal compliance.

The Medicaid State Plan approval process has become more challenging over the past few years, which makes the technical support that Myers and Stauffer provides as a standard

feature through our Medicaid service engagements especially valuable to DHS. In addition, we will continue to evaluate Iowa Medicaid rules and regulations to determine if and where changes are needed.

Prior to the repeal of the Boren Amendment, we performed detailed findings for several clients each year. An element of these findings was an analysis of the state’s compliance with the Medicare upper limit requirement. Since the repeal of Boren, we have worked with many of the same states to develop appropriate public notice including justifications and Medicare upper payment limit calculations to reflect changes in the Medicare reimbursement methodology.

The staff assigned to this project have assisted Iowa and several other states with their regulatory process including, formulation of state plan/rule language, reviewing regulations and drafting responses to questions from legislative and other interested parties. We have worked with states in amending their state plans in response to policy changes, litigation and updates required by state and federal legislation or regulation.

***Attend training, meeting or conferences***

(RFP Section 6.7.4.2.1 g)

Our account manager and operations manager will continue to maintain high levels of communication and coordination of work activities with DHS. Significant amounts of data

will need to be exchanged between DHS and Myers and Stauffer during this contract term. This includes cost report data, paid claims information, audit/desk review/settlement information, work papers and other requested data.

Myers and Stauffer personnel will be available to meet with DHS as requested. We anticipate having a monthly meeting with DHS to report progress on each contract activity and to discuss issues of concern. We have found the routine monthly meeting process to be very effective in coordinating audits, desk reviews and settlement activities.

As part of Myers and Stauffer's staff development practices, project staff are encouraged to attend outside conferences to keep current on federal and state issues. Insight gained at these conferences is shared with our clients.

We are also available to assist the Department with initiatives or inquiries from other governmental agencies and provider groups to address reimbursement issues, such as developing reimbursement cost ceilings and projecting expenses for Department budgets. We will make available experienced and knowledgeable staff to be responsive to and interact with the Department and providers upon the Department's direction, and offer both phone contact support and written communication as needed. Project staff will respond to questions from Department staff within three working days of the request.

***Provide assistance with policy-related items***

(RFP Section 6.7.4.2.1 i)

Myers and Stauffer is accustomed to developing state plan amendments, proposed rule changes, legislative text, provider and operations manual updates, training materials, stakeholder correspondence, and all other documentation that is needed to support the Medicaid Program.

As the incumbent contractor, Myers and Stauffer provides technical assistance, including analysis and modeling whenever requested but always as part of a significant change in policy and/or process. We understand well the full range of laws and policies under which the Iowa Medicaid Program operates, and we work diligently to help evaluate issues as they arise and to provide valuable support in helping the Department respond appropriately (and proactively).

Upper Payment Limit Tests  
(RFP Section 6.7.4.2.2)

***Maintain Interfaces***

(RFP Section 6.7.4.2.2 a)

Myers and Stauffer has significant experience interfacing with DHS and the other units within the IME. We have developed strong working relationship with other contractors to ensure smooth operations.

Myers and Stauffer has also demonstrated that project staff can work with providers and industry associations through our cost report

and desk review functions. In these relationships, we certainly understand the delicate balance of maintaining the Department's interests without creating negative reactions from providers. As such, we have good, professional, working relationships with the associations and look forward to continuing these relationships.

***Review and analyze hospital and nursing facility Medicaid and Medicare reimbursement data.***  
(RFP Section 6.7.4.2.2 b)

Myers and Stauffer has extensive experience auditing Medicaid cost reports, analyzing reimbursement rates, using cost report data to rebase and recalibrate prospective payment systems and developing upper payment limit findings. Medicare principles of reimbursement, cost reporting processes, and administrative guidelines form the foundation upon which many Medicaid systems are built. Myers and Stauffer professionals have developed a detailed understanding of the Medicare program – including cost reporting and allowable cost guidelines, provider reimbursement, rate setting rules and regulations and the specific administrative processes that execute program requirements.

As a current contractor to the Department, we maintain hospital and nursing facility cost report information necessary to review and analyze statistical information used in the computation of UPLs.

Due to the importance of the underlying data, we will continue to perform data quality checks before beginning any analyses and modeling activities. This will involve performing analytical procedures to identify data elements or relationships between data points that appear aberrant.

After analyzing information necessary to compute the UPL findings, we will present options for the Department to consider. Our final recommendation to DHS will rely heavily on the quality of the data used to model Medicare upper limit methodologies.

***Develop an approach or methodology that can be used to perform the upper payment limit tests for all hospital and nursing facility services.***  
(RFP Section 6.7.4.2.2 c)

One of the most important aspects of this engagement is the ability to make good, informed decisions. Myers and Stauffer will prepare models or methodologies for DHS to consider. These models will illustrate the upper payment limit using different variables and/or approaches. Over the years, we have developed numerous models and other computerized tools to support these activities. The development of models and the analysis of relationships between variables and approaches is essential to making good decisions. Our models will provide the highest degree of flexibility possible to achieve these objectives.

While we believe that Medicare payment simulation offers the best UPL options, our studies will consider other approaches. Although states have traditionally had considerable flexibility in determining the upper limit, that flexibility appears to be changing. CMS continues to alter its policies and to define new “Medicare principles of reimbursement.” We will also investigate allowable Medicare costs and payments that have been successfully applied in other state programs to determine their applicability in Iowa. This analysis will enable Myers and Stauffer and DHS to further refine the upper limit methods and identify the recommended approach.

***Accurately perform the upper payment limit tests for all hospital and nursing facility services***  
(RFP Section 6.7.4.2.2 d)

Project staff will prepare the upper payment limit tests for all hospital and nursing facility services based on the CMS approved methodologies. If at anytime the Department decides to modify the methodology in calculating the upper limit tests, project staff will assist with the applicable regulatory and State Plan amendments, and perform the UPL tests for all hospitals, both inpatient and outpatient services, as well as nursing facility services. We will also prepare final versions of “findings” that must remain on file with DHS. We acknowledge and agree that UPL tests will be completed within 30 days after the end of each state fiscal year.

***Update or make changes to comply with change in federal or state law.***  
(RFP Section 6.7.4.2.2 e)

Over the past several years, the Department has endured the changes CMS has implemented in the UPL testing process. Myers and Stauffer was ready to assist the Department with models that had the flexibility to accommodate such changes. If changes continue to occur, we will modify the UPL calculations to comply with federal or state laws, as well as CMS policy changes.

Other Technical Assistance and Monitoring  
(RFP Section 6.7.4.2.3)

***Provide support for the Payment Error Rate Measurement (PERM) project***  
(RFP Section 6.7.4.2.3 a)

Myers and Stauffer will provide on-going support and technical assistance for the PERM project. As the current contractor for DHS, we have worked with the PERM auditors when issues arise regarding the reimbursement of a claim or discuss the Medicaid reimbursement methodology to ensure the auditors have a greater understanding.

***Provide support and technical assistance to the Department for the development, implementation and monitoring of the NF provider tax.***  
(RFP Section 6.7.4.2.3 b)

Senate File (SF) 476 required DHS to implement a nursing facility provider tax. It is our understanding

that DHS has submitted the state plan amendment to implement the additional reimbursement to nursing facilities and also submitted a request for both a broad-based waiver and a waiver of uniformity.

As the incumbent contractor, we have worked side by side with the Department, providing fiscal impact models, assisting with legislative questions and presentations and drafting state plan and regulations.

We look forward to continue or work with the state in the implementation and monitoring of the NF provider tax. Upon notification from CMS, we will work DHS to develop a reporting tool that will nursing facilities will be required complete and submit payment of the tax on a quarterly basis. We will monitor receipt of payments and notify the Department of any delinquent payments and enforce penalties as requested by DHS.

In addition, the Senate File also stipulated how the additional reimbursement must be spent by the nursing facilities. We will work with the Department to develop a form that must be completed and submitted by nursing facilities to demonstrate how the funds were expended. Upon receipt of the data, we will prepare an analysis of the data and submit a formal report to the Department that can be provided to the General Assembly.

Project staff will monitor changes at the federal level to ensure the NF provider tax continues to be

compliant with federal law. We will also assist the state in monitoring the percent of tax to revenue to ensure that the tax amount does not exceed the hold harmless threshold which is currently at 5.5 percent.

***Provide support and technical assistance to the Department for the development, implementation and monitoring of new programs directed by the legislature, at the request of the Department.***

(RFP Section 6.7.4.2.3 c)

As the incumbent contractor for the Department, Myers and Stauffer has provided support and technical assistance to the Department for the development, implementation and monitoring of new programs directed by the legislature, at the request of the Department. Examples include reimbursement methodology changes for psychiatric services provided by community mental health centers and inpatient hospital psychiatric units and the implementation of the IowaCare program. In addition, project staff are accustomed to preparing reports and presenting to legislative subcommittees.

Our proposal anticipates providing the full array of services that are required when developing and implementing new programs. These services include developing alternative options, preparing fiscal impact models, providing the necessary training, assisting with state plan language and regulations and responding to questions from CMS when necessary.

***Provide support and technical assistance for any updates to MDS.***  
(RFP Section 6.7.4.2.3 d)

CMS published in the Final Rule for the Skilled Nursing Facility Prospective Payment System (SNF PPS) in the Federal Register, August 11, 2009. This rule details CMS's plans to implement both a new assessment form and a new classification system. The new assessment, Version 3.0 of the Minimum Data Set (MDS) and the new classification system, Version IV of the Resource Utilization Groups (RUG-IV) are to be implemented October 1, 2010. The SNF PPS RUG-IV grouper will have 66 groups.

The large lead time between publishing the final rule and implementation should allow states, providers, vendors and Medicare fiscal intermediary sufficient time to become familiar with the components of the assessment and the new classification system and to incorporate them into their existing processes. CMS plans to issue the MDS 3.0 final data specifications, the MDS 3.0 RAI User's Manual and the data specifications for the RUG-IV grouper sometime in October 2009. CMS is also planning training sessions for the state resident assessment coordinators and webinars for the providers in early 2010.

The goals for the MDS 3.0 implementation are to introduce advances in assessment measures, increase the clinical relevance of

items, improve the accuracy and validity of the tool and increase the resident's voice by introducing more resident interview items. The MDS 3.0 assessment contains all the items used to calculate the current quality indicators, quality measures and the RUG-III (with some of the MDS 3.0 items cross-walked back to MDS 2.0 items) and RUG-IV classification systems.

In addition, there will be new transmission requirements which will impact how the state obtains the MDS data for rate setting and other purposes. The new transmission requirements are:

- Shortens the required time for transmission of the assessments to within 14 days rather than 31 days.
- Directs submission to a national data repository rather than to the current state sites.
- Necessitates CMS to develop procedures for State Medicaid Agencies to receive MDS data necessary to support current reimbursement systems.

The second change to the SNF PPS is the implementation of RUG-IV. CMS has released the components of the RUG-IV classification system, which contains eight major categories. These were developed based on a time study (STRIVE) conducted by volunteer nursing homes in 15 states. The eight categories are:

- Rehabilitation Plus Extensive Services (nine groups)
- Rehabilitation (14 groups)
- Extensive Services (three groups)
- Special Care High (eight groups)
- Special Care Low (eight groups)
- Clinically Complex (10 groups)
- Behavioral Symptoms and Cognitive Performance (four groups)
- Reduced Physical Functions (10 groups)

The RUG-IV classification is similar to RUG-III with the following changes:

- ADL scores range from 0-16 (RUG-IV) rather than 4-18 (RUG-III).
- Therapy days and minutes remain the same for each of the Rehabilitation groups except individual, concurrent and group therapy are now used in the calculation.
- A Medicare Short Stay Assessment is used instead of Ordered Therapies for calculating admission and readmission therapy categories.
- Special Care has two categories: Special Care High and Special Care Low.
- Behavior Systems and Cognitive Performance have been combined.

Our proposed project staff continually monitor the changes being implemented by CMS and

currently participate in monthly conference calls with CMS. As the incumbent contractor, we have already begun discussions with state regarding the implications of MDS 3.0 and RUG IV for Medicaid case mix reimbursement and identifying decisions that need to be made. These implications and decision points include the following:

- The cross-walked data from the MDS 3.0 assessments to a MDS 2.0 format will support state's current RUG-III based reimbursement systems (both RUG-III 34 or 44).
- States utilizing the current RUG-III classification systems for their Medicaid case mix reimbursement systems do not have to implement RUG-IV.
- States decide if and when they transition to RUG-IV (10/1/10, a later implementation date, or never).

States will want to study the fiscal impact of RUG-IV on their current systems and budgets.

CMS intends to provide the states with RUG-IV scores to be used in the evaluation of the impact.

A Medicaid version of RUG-IV will contain collapsed Rehabilitation categories as in RUG-III (47 group version).

Our proposed account manager was actively involved in the successful development of the case-mix reimbursement methodology for nursing facilities that was

implemented in July 1, 2001. The tasks and analyses that will need to be performed during this project will be very similar to those that will be required in order for the state to make a decision to move to RUG-IV.

Upon contract award, we will schedule a meeting with DHS staff to provide a thorough understanding of the changes and determine if the State wishes to move forward on evaluating the RUG-IV for Medicaid reimbursement. During this meeting, we will provide DHS with the advantages and disadvantages of moving towards RUG-IV. Once a decision has been made, project staff will work with DHS to develop a work plan and timeline for accomplishing the tasks. Our staff's expertise in this area will allow us to prepare interactive models to replicate proposed case mix systems allowing multiple options to be evaluated quickly and efficiently. These models will include fiscal impacts that project nursing facility payments using RUG-IV (66 or 47 group version).

***Provide support and technical assistance to the Department for development and monitoring of the medical assistance budget.***  
(RFP Section 6.7.4.2.3 e)

We will continue to attend the monthly budget meetings with DHS staff and provide support to the monitoring of the budget through informing staff of issues that may affect the medical assistance budget. We will provide requested analysis to help in the monitoring of the

medical assistance budget and maintain levels of communication and coordination with budget staff.

***Consult with Medical Services contractor when medical judgment is needed for manual pricing of claims when no current fee or payment exists for the service.***  
(RFP Section 6.7.4.2.3 f)

We will be available to provide technical assistance to the Medical Services contractor to develop a methodology to calculate reimbursement rates when it currently does not exist. By working with other state Medicaid agencies, Myers and Stauffer is able to offer a wide range of pricing methodology options for developing Medicaid rates.

***Provide draft policy changes related to all work performed under this RFP to meet the timeframes for the filing process required by: 1. CMS for Medicaid State Plan Amendments; and 2. the Department for state administrative rules and provider or employee manuals.***  
(RFP Section 6.7.4.2.3 g)

Myers and Stauffer clearly understands both the functions and the timing required to memorialize all policy changes through the formal CMS approval and rule promulgation processes, and we are committed to always meet and when possible exceed performance and timeliness expectations. Never have we been responsible for causing a state

Medicaid agency to miss a critical CMS deadline.

Reporting  
(RFP Section 6.7.4.2.4)

We will continue to provide all of the required reports contained in the RFP. Myers and Stauffer currently tracks and monitors program expenditures and recommends adjustments to reimbursement based on our findings. We have experience in compiling and performing detailed analyses of cost report and MDS data for DHS and other states. We will provide any other reports as requested by DHS. Myers and Stauffer has the technical expertise, experience, infrastructure and ability to provide all necessary reports to DHS.

**B. Performance Standards**  
(RFP Section 6.7.4.3)

Our objective is to continue to perform at a level that meets and exceeds the expectations of DHS throughout the new contract term. We acknowledge and agree to the minimum performance standards listed below for the technical assistance function.

1. Provide annual reports of upper payment limit test results within 30 days after the beginning of each state fiscal year, applicable (prospectively) for that state fiscal year.
2. Draft all policy changes to the Medicaid State Plan,

state administrative rules, and provider or employee manuals according to the timeframe required by the Department.

**6.5 IowaCare**  
(RFP Section 6.7.5)

**A. Contractor Responsibilities**  
(RFP Section 6.7.5.2)

House File 841 authorized Iowa Medicaid to expand eligibility for the Medicaid population. This expansion was approved as an 1115 Medicaid demonstration project (IowaCare) effective July 1, 2005 through June 30, 2010 by CMS.

The IowaCare program was approved to provide a limited set of Medicaid benefits to adults ages 19 through 64, including parents of Medicaid and SCHIP eligible children, using a limited provider network.

Myers and Stauffer worked hand-in-hand with the State of Iowa to negotiate with CMS the original terms and conditions of the IowaCare demonstration project. We understand the goals of the program and what we need in order to meet the guidelines of the demonstration project.

We have also worked closely with Iowa policy staff on the current IowaCare renewal effective July 1, 2010, and look forward to continuing this relationship throughout the new term.

Assist in Administration of IowaCare Program  
(RFP Section 6.7.5.2 a)

We will continue to participate in monthly IowaCare monitoring conference calls with CMS as requested by the Department and will be available to assist with responses to CMS questions regarding the IowaCare program.

Myers and Stauffer anticipates assisting the Department by our continued participation in monthly meetings with IowaCare providers and providing training as requested by DHS.

We will prepare IowaCare budget projections as requested by DHS, monitor the IowaCare account balance, and monitor the IowaCare budget neutrality cap.

Prepare Monthly Expenditure Analysis  
(RFP Section 6.7.5.2 b)

Myers and Stauffer will continue to complete the monthly IowaCare expenditure analysis using an export of IowaCare claims from the data warehouse. Using a claims database, expenditures are tracked based on category of service (i.e. inpatient, outpatient, physician, etc.) and by month.

We will use a linear regression model to establish projected monthly expenditures. Projections are calculated separately for each category of service. Total IowaCare expenditures will be projected for the year in order to monitor expenditures

compared to the balance in the IowaCare account and to determine if claims are going to exceed each hospital's annual appropriation amount.

Prepare Annual Reconciliation of IowaCare Funding and Reconcile Claims with Prospective Interim Payments  
(RFP Section 6.7.5.2 c and d)

Myers and Stauffer will complete the annual reconciliation of IowaCare funding including a reconciliation of claims with prospective interim payments.

Once the Medicare hospital cost reports (CMS 2552) and disproportionate share surveys are received, we will apportion costs based on routine per diems and ancillary cost-to-charge ratios. Ancillary costs will be further divided into inpatient and outpatient services. Based on this analysis, we will calculate aggregate inpatient and outpatient cost-to-charge ratios.

We will then use annual inpatient and outpatient claims data from the data warehouse to reconcile paid claims with the actual payments made to the IowaCare network providers for the year. The aggregate inpatient and outpatient cost-to-charge ratios from the Medicare cost report will be utilized to cost out each claim. This estimated cost is then used to determine a shortfall or longfall for each Medicaid claim.

This claim set will then be compared to the total amount of prospective

interim payments. If the paid claims amount is less than the total prospective interim payments (i.e. appropriation) an analysis is completed to determine if the provider qualifies for enhanced DSH or enhanced medical education payments. Using information received from the DSH survey along with the total Medicaid shortfall or longfall the hospital-specific DSH limit is calculated for each IowaCare network provider. The DSH limit is calculated to determine the total amount of DSH payments that can be used towards the annual prospective interim payment amount.

A formal reconciliation report of IowaCare funding sources will be prepared and submitted to DHS.

**B. Performance Standards  
(RFP Section 6.7.5.3)**

Myers and Stauffer will complete the monthly expenditure analysis within 20 days after the last day of each month.

We will submit a formal reconciliation report of IowaCare funding sources to DHS within 30 days after receipt of the annual Medicare cost report and disproportionate share survey.

## 7. Project Plan

(RFP Requirement 7.2.7)

### 7.1 Transition Phase (RFP Section 4.3.1)

Planning Task  
(RFP Section 4.3.1.1)

During the planning phase for services required to be operational by July 1, 2010, we will work closely with the DHS contract management team to ensure all tasks are fully evaluated, documented, communicated and approved before taking action. The goal of the planning phase is for the contractor to acquire (or affirm) knowledge of the Iowa Medicaid program and detailed requirements of the IME. In addition, contractors are expected to review their proposed transition plan with DHS and to update the work plan to ensure complete understanding and integration of various transition tasks and activities. As the incumbent contractor, project staff have the necessary underlying knowledge of the Iowa Medicaid program and fully understand the requirements of the IME to ensure continued success.

The following is an overview of the planning tasks outlined by the RFP, followed by a discussion of our proposed approach.

#### ***Planning Task Activities, Contractor Responsibilities, Deliverables***

(RFP Sections 4.3.1.1.1, 4.3.1.1.3,  
4.3.1.1.4)

*Establish DHS approved project team* – We will establish and finalize our project team members, who are subject to DHS approval. As addressed in Tab 10, we have proposed a reporting structure that mirrors the current operations of Myers and Stauffer within the IME. Our project team’s experience with the State of Iowa is unmatched and will be able to provide uninterrupted services to the Department.

*Prepare transition plan* – Following notice of contract award, we will refine and clarify the transition plan for all contractor responsibilities and timelines, taking into account new developments pertinent to this project. This refinement process will involve input from DHS through meetings, other discussions, and exchange of documents as necessary. We will be sensitive during this process to the time constraints of DHS contract management staff, and will consult on an as-needed basis to arrive at a work plan that meets all DHS objectives.

*Review and update operational procedures* – The current operational procedures were developed by

members of our proposed project team. Over the past five years, operational procedures have been reviewed and updated as needed. However, project staff will further review the operational procedures to ensure they align with the requirements of this RFP and the goals of DHS. Revised operational procedures will be submitted to DHS for approval.

*Review the turnover plan from the current contractor* - As the current contractor, reviewing a turnover plan will not be necessary.

We will prepare and submit to DHS for approval the following plans:

- Transition Project Plan
- Transition Staffing Plan
- Operations Staffing Plan
- Operational Procedures Sign-Off

Operational Prereadiness Task  
(RFP Section 4.3.1.2)

As the Provider Cost Audit and Rate Setting Unit contractor for the new term, we will participate in the Operational Prereadiness phase to ensure that all applicable procedures are in place and that all interfaces are working correctly. Our project management and staff will provide DHS with all necessary testing data, procedures and interface documentation in a timely manner. Because this procurement involves all the professional services components of the IME, it will be critical that project staff are able to document and communicate interfaces with any new vendors.

Being the incumbent contractor, we fully understand the interrelationships and operation of the IME and stand ready to provide the assistance and support to DHS to ensure the transition to operations is successful.

As part of the Operational Prereadiness activity, we will provide DHS with comprehensive checklists to facilitate the verification of all applicable operations and procedures, including the interactions with the other IME units including the systems component contractors and others as applicable. We will prepare draft operational checklists and submit them to DHS for review and comment. We will respond promptly to all problem conditions noted during the testing activity and will prepare corrective action plans as needed.

We will participate fully and respond to all issues and problems relevant to the provider cost audits and rate setting component during and after the testing activity. This includes: developing applicable check-off lists of start-up tasks and activities, testing these activities and reporting results to DHS, assuring DHS that all activities have been satisfactorily completed and approved by DHS, providing walkthroughs for DHS as needed, conducting all necessary training of staff, and obtaining written sign-off from DHS to begin implementation.

In order to document compliance with IME standards, we will provide checklist matrices for: operations,

training activities, interface operations, documentation activities, and any outstanding issues or problems (with plans of correction,) and updated operational procedures reflecting revisions and refinements culminating from these checklists. These documents will be used by the Department's contract manager to document successful acceptance testing, and to ensure a smooth and seamless transition to the operations phase.

#### Operational Readiness Task (RFP Section 4.3.1.3)

The goal of the tasks leading up to implementation is to prepare all RFP service components for a smooth and seamless transition to operations. The RFP outlines many of the required goals that contractors must achieve to DHS' satisfaction before full implementation of the IME can occur. It is likely that throughout the implementation process, there will be additional goals identified by DHS. We will remain flexible throughout this process and adapt our approach and work plans to accommodate the changing needs. We fully understand and appreciate the responsibilities associated with meeting these implementation objectives.

Our responsibilities during this process will be documented through the agreed-upon work plans, operations documentation, and interface documentation which will be updated as necessary. We will provide sufficient time for DHS to review our proposed revisions to such plans and provide feedback.

Following the successful completion of all planning and operational pre-readiness activities, including staff training, all IME contractors will begin the implementation tasks. During this phase, all aspects of the IME will begin moving towards the operations phase.

We will prepare and submit to DHS the following to demonstrate our ability to meet our operational responsibilities in order to receive approval to begin operations:

- Completed operational readiness checklist
- Final documentation and operational procedures

#### 7.2 Operations Phase (RFP Section 4.3.2)

As the incumbent contractor we will be able to retain full operational responsibilities for the Provider Cost Audits and Rate Setting functions without interruption, while also immediately and carefully focusing resources on ensuring the continued successful operations of the With as many as nine different service contractors involved, the operations of the IME cannot be successful without full and complete cooperation and coordination of activities among DHS and all contractors. To ensure appropriate and timely resolution of all issues that arise during operations, it is critical that our project management team, DHS staff and other contractors remain updated on progress and obstacles associated with all key elements of the work plan. This will

require frequent and efficient communications between the parties. Assumptions need to be clearly stated and affirmed before acting on them.

Our project management team has demonstrated their ability to manage the complexities and uniqueness of the IME and truly understand that the IME cannot succeed without on-going communication, coordination, and cooperation with DHS and other IME units as well as numerous other Medicaid program stakeholders.

Each service requirement's draft project plan provides a detailed list of tasks and completion dates for the first year of the operations phase. It is anticipated that the tasks and completion dates for years two through contract end would be similar to the first year of the operations phase. We have provided one turnover phase draft project plan that reflects tasks that will be completed for all services.

### 7.3 Turnover Phase (RFP Section 4.3.3)

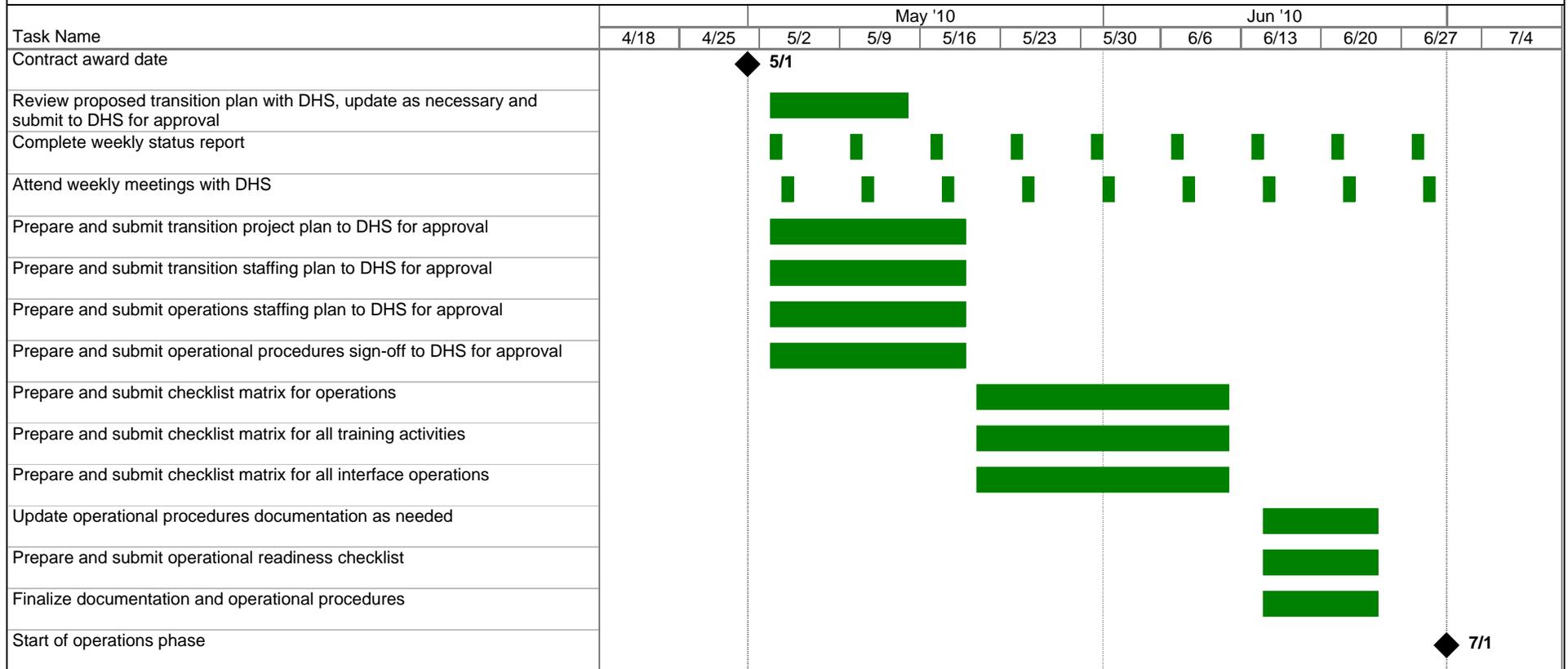
In the event DHS contractually transfers operational responsibility for the Provider Cost Audits and Rate Setting Contractor functions to another entity, then our project team under the leadership of our account manager and operations manager, will commit to fully cooperate during the turnover phase with DHS and the transferee entity. We agree to prepare and provide a turnover plan upon request of DHS.

### 7.4 Project Management Plans (Gantt Charts)

To illustrate the detailed tasks that will be performed in order to successfully complete each service requirement, we have provided a draft project plan below. Tasks have been separately identified for each of the three phases: transition, operations and turnover.

# Provider Cost Audits and Rate Setting Component Draft Project Plan

## Transition Phase: May 1, 2010 - June 30, 2010



Task  Milestone 

Summary 

Provider Cost Audits and Rate Setting Component Draft Project Plan  
 Contract Management (RFP Section 6.1.3)  
 Operations Phase Year 1: July 1, 2010 - June 30, 2011

Task Name	Q3 '10			Q4 '10			Q1 '11			Q2 '11		
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Maintain and update operational procedure manuals when changes are made	[Solid Green Bar]											
Meet with DHS to review account performance and resolve any issues												
Prepare and submit to DHS a report of quality assurance activities, findings and corrective actions (if any)												
Prepare and submit monthly performance report	■	■	■	■	■	■	■	■	■	■	■	■
Prepare and submit annual performance report			■									

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Provider Cost Audits and Rate Setting Component Draft Project Plan  
 Rate Setting, Cost Settlements, and Cost Audits Function (RFP Section 6.7.1)  
 Operations Phase Year 1: July 1, 2010 - June 30, 2011

Task Name	Q3 '10			Q4 '10			Q1 '11			Q2 '11			Q3 '11		
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Attend monthly meetings with DHS															
Prepare semi-annual compilation reports		█						█							
Generate monthly status log report and mail blank cost reports to appropriate providers			█	█	█	█	█	█	█	█	█	█	█	█	█
Process requests for extension of due dates approved by DHS, and submit rate reductions to MMIS and ISIS for delinquent C/R when necessary	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
Generate monthly project activity report and field audit activity report and submit to DHS		█	█	█	█	█	█	█	█	█	█	█	█	█	█
Prepare monthly accounts receivable file and submit to data warehouse	█	█	█	█	█	█	█	█	█	█	█	█	█	█	█
Perform desk reviews in accordance with approved program*	█														
Perform cost settlements in accordance with approved program*	█														
Perform on-site audits in accordance with approved program*	█														
Process HF 911 requests, prepare and send rates, notify provider and core MMIS and complete mass adjustments	█														
Prepare semi-annual acuity analysis and submit to DHS		█													
Prepare rates for those provider types that receive annual rate updates effective July 1 and submit to DHS	█														
Send annual rate notification to provider and core MMIS		◆ 7/15													
Prepare and send NF rates to provider and core MMIS to include pay-for-performance add-on and complete mass adjustments	█														
Prepare annual pay-for-performance report and submit to DHS			█												
Prepare annual NF Employee Turnover and Evaluation report and submit to DHS					█										
Prepare annual analysis of the relationship between Iowa Medicaid payment rates and those of other third-party payers and submit to DHS											█				
<b>Perform Nursing Facility Quarterly Rate Setting Tasks</b>	◆														
Preliminary CMI files received from Medical Services Unit				◆			◆			◆			◆		
Review final case mix rosters generated by Medical Services Unit				█			█			█			█		
Receive final CMI file from Medical Services Unit				◆			◆			◆			◆		

Task █ Milestone ◆ Summary ◆

\* We have provided a separate detailed list of tasks and completion dates from receipt of cost report to delivery of final report.

Provider Cost Audits and Rate Setting Component Draft Project Plan  
 Rate Setting, Cost Settlements, and Cost Audits Function (RFP Section 6.7.1)  
 Operations Phase Year 1: July 1, 2010 - June 30, 2011

Task Name	Q3 '10			Q4 '10			Q1 '11			Q2 '11			Q3 '11		
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Prepare quarterly NF rate sheets including final review				■			■			■			■		
Prepare quarterly NF budget and submit to DHS for review	■				■			■			■				
Mail rate sheets to providers	◆				◆			◆			◆				
Send rates to core MMIS contractor	◆				◆			◆			◆				
Send cumulative rate listing, quarterly rate file, CMI listing and RUG-III report to DHS	◆				◆			◆			◆				

Task  Milestone  Summary 

\* We have provided a separate detailed list of tasks and completion dates from receipt of cost report to delivery of final report.

Provider Cost Audits and Rate Setting Component Draft Project Plan

Rate Setting, Cost Settlements, and Cost Audits Function (RFP Section 6.7.1)

Proposed Detailed List of Tasks and Completion Dates for Cost Settlements, Desk Reviews and On-Site Audits

Task Name	Q3 '10				Q4 '10			Q1 '11			Q2 '11		
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
<b>Cost settlements - Example tasks and timeline for completing all CAH, RHC, FQHC and HHA cost reports received November 30, 2010</b>													
Receive completed cost report													
Acknowledge cost report, create work papers and assemble notebook													
Request PS&R report from MMIS													
Download PS&R report from Onbase													
Perform first level review and cost settlement calculation													
Perform review procedures													
Finalize settlement including interim rate adjustments, as necessary													
Final review of settlement													
Enter adjustments into cost report database													
Send final settlement and NPR to provider. Update MMIS if interim rate is adjusted													
If overpayment set up amount owed to state in A/R system. If underpayment submit gross adjustment to MMIS through Onbase													
All settlements completed													
Record payments as received in A/R and submit gross history adjustments to MMIS through Onbase													
If payment not received submit gross adjustment to MMIS through Onbase to offset future payments													
Monitor MMIS and record offsets in A/R													
<b>Desk review - Example tasks and timeline for completing a desk review for cost report received September 30, 2010</b>													
Receive completed cost report													
Acknowledge cost report, input cost report into database and assemble notebook													
Perform desk review, including risk assessment procedures													
Request additional data from provider, if necessary													
Receive additional information and complete remaining desk review steps													

Task Milestone

Summary

Provider Cost Audits and Rate Setting Component Draft Project Plan

Rate Setting, Cost Settlements, and Cost Audits Function (RFP Section 6.7.1)

Proposed Detailed List of Tasks and Completion Dates for Cost Settlements, Desk Reviews and On-Site Audits

Task Name	Q3 '10				Q4 '10			Q1 '11			Q2 '11		
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Perform review procedures													
Prepare final desk review report													
Perform final review of desk review report													
Enter adjustments into cost report database													
Issue final desk review report package to DHS													
Send final desk review report to provider including rate notification or per diem summary. Update rates in MMIS and ISIS when necessary													
Complete mass adjustment when necessary													
<b>On-site audit - Example tasks and timeline for completing an audit beginning on July 1, 2010</b>													
Assemble audit notebook													
Request PS&R report from MMIS when appropriate based on provider type													
Perform prefield risk assessment procedures													
Perform scheduling and other administrative procedures													
Perform on-site field audit													
Send provider letter with a detailed list of outstanding information													
Receive additional information and complete remaining audit procedures													
Perform audit review procedures													
Perform necessary tasks to resolve issues raised during review													
Complete draft audit report package													
Deliver draft audit report package to DHS and provider													
Resolve provider concerns													
Prepare final audit report package													
Perform review of final audit report package													

Task  Milestone  Summary 

Provider Cost Audits and Rate Setting Component Draft Project Plan

Rate Setting, Cost Settlements, and Cost Audits Function (RFP Section 6.7.1)

Proposed Detailed List of Tasks and Completion Dates for Cost Settlements, Desk Reviews and On-Site Audits

Task Name	Q3 '10				Q4 '10			Q1 '11			Q2 '11		
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Enter adjustments into cost report database													
Issue final audit report package to DHS					◆	10/29							
Notify provider and core MMIS contractor of any rate revisions based on audit adjustments					◆	10/29							
Complete mass adjustment when necessary													

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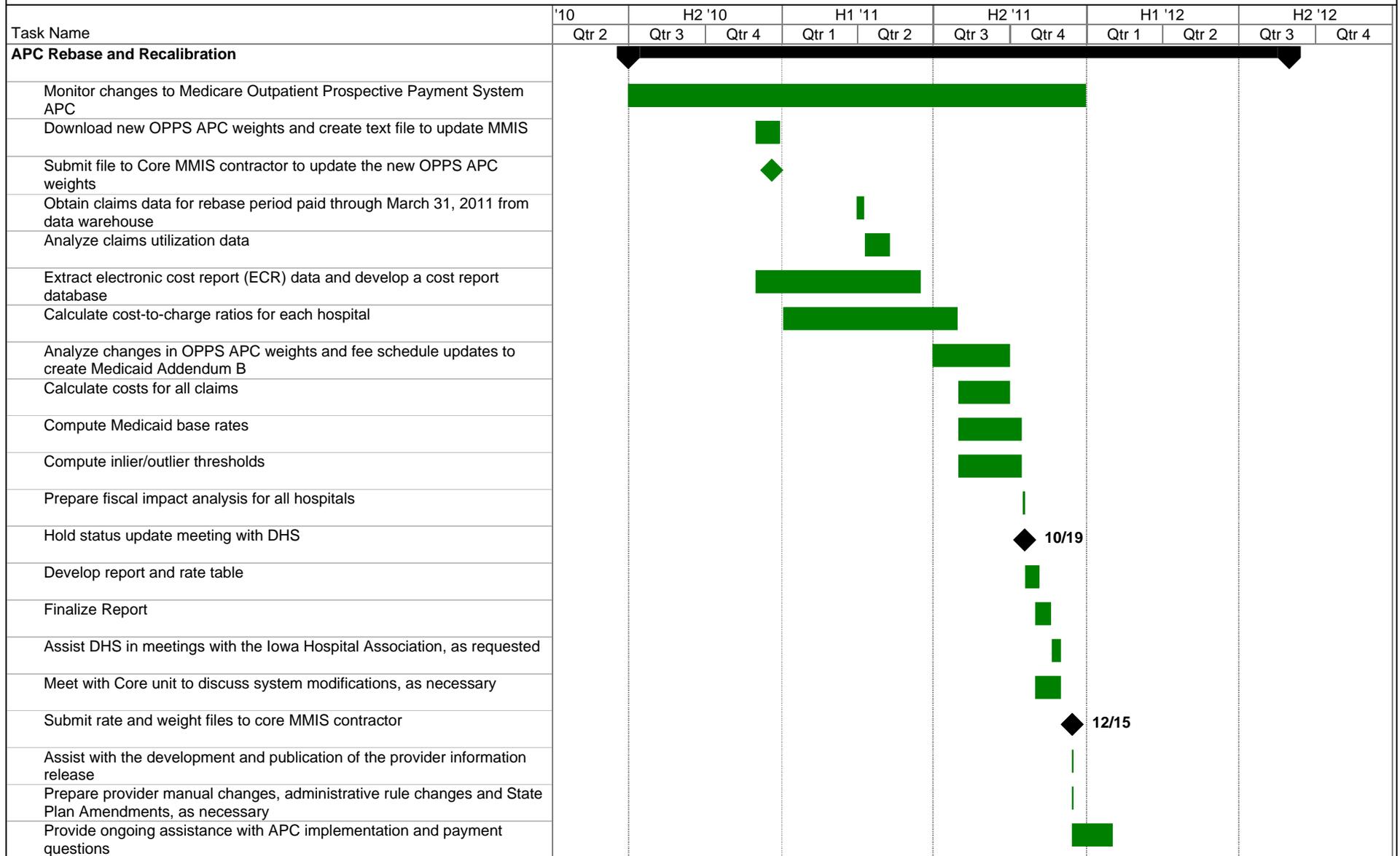
Task		Milestone	◆	Summary	
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Provider Cost Audits and Rate Setting Component Draft Project Plan  
 State Maximum Allowable Cost Program Function (RFP Section 6.7.2)  
 Operations Phase Year 1: July 1, 2010 - June 20, 2011

Task Name	Q3 '10			Q4 '10			Q1 '11			Q2 '11			Jul	
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun		
Weekly status meeting with DHS	█	█	█	█	█	█	█	█	█	█	█	█	█	█
Update and maintain SMAC program reimbursement rates	█	█	█	█	█	█	█	█	█	█	█	█	█	█
Periodically examine SMAC rates, published pricing information, the Federal upper limit, service provider's acquisition cost information, and other available Iowa pharmaceutical market indicators to determine adequacy of the SMAC rates	█	█	█	█	█	█	█	█	█	█	█	█	█	█
Provide support by telephone, fax, e-mail, website or other means to investigate and respond to service provider, regulatory or other stakeholder questions and concerns regarding the SMAC program	█	█	█	█	█	█	█	█	█	█	█	█	█	█
Analyze and monitor important trends in reimbursement, service utilization, and fiscal outcomes. Review findings with DHS	█	█	█	█	█	█	█	█	█	█	█	█	█	█
Prepare and submit quarterly to DHS an update on SMAC program operation and utilization trends				█			█			█				█
Assist DHS in development, evaluation and implementation of policies supporting the SMAC program	█	█	█	█	█	█	█	█	█	█	█	█	█	█
Prepare provider manual changes, administrative rule changes, or State Plan Amendments to reflect policy and/or rate changes as necessary	█	█	█	█	█	█	█	█	█	█	█	█	█	█
Coordinate with other contractors to update and maintain the SMAC reference file for claims processing	█	█	█	█	█	█	█	█	█	█	█	█	█	█
Perform annual acquisition cost study		█	█	█										
Submit draft annual SMAC rate changes based on annual acquisition cost study					◆	10/21								
Coordinate a review of proposed SMAC drugs and rates with the DUR Board of Pharmacy and Therapeutics Committee, as requested by DHS	█	█	█	█	█	█	█	█	█	█	█	█	█	█
Prepare provider information release and notify pharmacy providers of changes to SMAC reimbursement rates	█	█	█	█	█	█	█	█	█	█	█	█	█	█
Notify POS contractor of changes to SMAC reimbursement rates	█	█	█	█	█	█	█	█	█	█	█	█	█	█
Assist DHS in managing relationships with the Iowa Pharmacy Association and other industry representatives, as requested by DHS	█	█	█	█	█	█	█	█	█	█	█	█	█	█
Provide web-based reference materials such as the SMAC drug groups, rates by NDC code, and the Federal Upper Limit for Iowa Medicaid pharmacy providers	█	█	█	█	█	█	█	█	█	█	█	█	█	█

Task █ Milestone ◆ Summary ▾

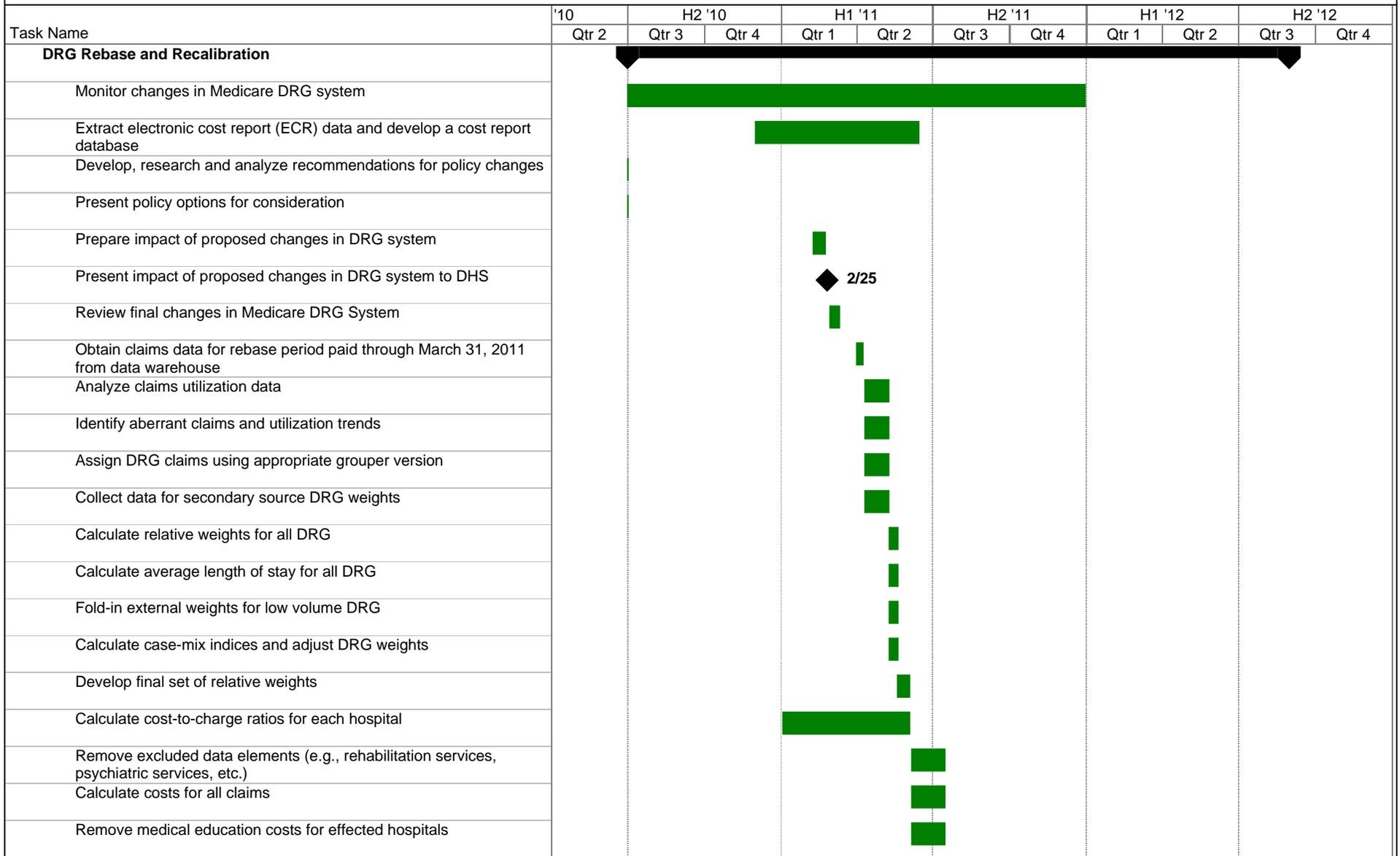
Provider Cost Audits and Rate Setting Component Draft Project Plan  
 Rebasing and Diagnosis Related Group and Ambulatory Payment Classification Recalibration Function (RFP Section 6.7.3)  
 July 1, 2010 - August 31, 2012



Task Milestone

Summary

Provider Cost Audits and Rate Setting Component Draft Project Plan  
 Rebasing and Diagnosis Related Group and Ambulatory Payment Classification Recalibration Function (RFP Section 6.7.3)  
 July 1, 2010 - August 31, 2012



Task Milestone

Summary

**Provider Cost Audits and Rate Setting Component Draft Project Plan**  
**Rebasing and Diagnosis Related Group and Ambulatory Payment Classification Recalibration Function (RFP Section 6.7.3)**  
**July 1, 2010 - August 31, 2012**

Task Name	'10	H2 '10			H1 '11		H2 '11		H1 '12		H2 '12	
	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	
Compute Medicaid base rates						■						
Compute inlier/outlier thresholds						■						
Prepare fiscal impact analysis for all hospitals												
Hold status update meeting with DHS						◆ 7/19						
Develop report and rate table						■						
Finalize Report						■						
Assist DHS in meetings with the Iowa Hospital Association, as requested						■						
Meet with Core unit to discuss system modifications, as necessary						■						
Submit rate and weight files to core MMIS contractor												
Assist with the development and publication of the provider information release												
Prepare provider manual changes, administrative rule changes and State Plan Amendments, as necessary												
Provide ongoing assistance with DRG implementation and payment questions												
Create direct medical education (DME) and DSH calculation worksheets (i.e., for GME and DSH fund payments)												
Notify providers of updated DME and DSH allocations												■
												◆ 8/31

Task  Milestone 

Summary 



Provider Cost Audits and Rate Setting Component Draft Project Plan  
 Reimbursement Technical Assistance and Support (RFP Section 6.7.4)  
 Operations Phase Year 1: July 1, 2010 - June 30, 2011

Task Name	Q3 '10			Q4 '10			Q1 '11			Q2 '11				
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Submit methodology to CMS for approval if changes in methodology were made												◆ 5/1		
Monitor changes in federal and state law and update or make changes to methodology as deemed necessary														
<b>Other Technical Assistance</b>	◆													
Provider support for the Payment Error Rate Measurement (PERM) project														
Provide technical assistance for the development, implementation and monitoring of NF provider tax														
Provide technical assistance for the development, implementation and monitoring of new programs directed by legislature														
Provide technical assistance implementing updates to MDS and Resource Utilization Group logic														
Provide technical assistance for development and monitoring of medical assistance budget														

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Task	◆	Milestone	◆	Summary	◆
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Provider Cost Audits and Rate Setting Component Draft Project Plan  
 IowaCare (RFP Section 6.7.5)  
 Operations Phase Year 1: July 1, 2010 - June 30, 2011

Task Name	Jun	Q3 '10			Q4 '10			Q1 '11			Q2 '11			Jul
		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
Prepare IowaCare budget projections as requested		■												
Monitor IowaCare account balance		■												
<b>Monthly IowaCare Analysis</b>		◆												
Export IowaCare claims from data warehouse and import into database														
Prepare monthly IowaCare expenditure analysis		■	■	■	■	■	■	■	■	■	■	■	■	■
Submit monthly IowaCare expenditure analysis		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
<b>Annual IowaCare Reconciliation</b>														
Receive cost report and DSH surveys from IowaCare network providers														
Export IowaCare claims from data warehouse and import into database														
Calculate cost-to-charge ratios and cost out each claim														
Determine shortfall or longfall for each claim														
Compile Medicaid cost and payment data, DSH survey data and calculate hospital-specific DSH limit														
Reconcile claims with prospective interim payments and determine provider specific Enhanced DSH and Enhanced medical education payments														
Prepare annual reconciliation of IowaCare funding sources														
Submit annual reconciliation of IowaCare funding sources														

◆ 1/31

**Provider Cost Audits and Rate Setting Component Draft Project Plan**  
**Turnover Phase: January 1 - June 30 of Final Contract Year**

Task Name	1st Quarter			2nd Quarter		
	Jan	Feb	Mar	Apr	May	Jun
Meet with DHS and incoming contractor	█	█	█	█	█	
Develop turnover plan and submit to DHS	█					
Develop listing of files, software, applications, interfaces and documentation and submit to DHS		█				
Work with DHS to transfer previous years work papers, correspondence procedure manuals and other needed information to incoming contractor				█	█	
Transfer of responsibilities to incoming contractor						█

Task █

## 8. Project Organization

### 8.1 Organization Charts (RFP Section 7.2.8.1)

Myers and Stauffer is pleased to make the same project team available that currently serves the IME, thus ensuring a seamless contract transition. Myers and Stauffer's proposed key personnel meet and exceed all required qualifications as outlined in RFP Section 6.1.1.1.1. The organizational chart on the following page shows all positions currently performing the work described in the RFP. Our staffing plan remains the same through all phases of the project, providing consistent, experienced staff throughout the transition, operations and turnover phases.

The table below includes counts of FTE workers in each staff position in each organizational unit during each project phase. The organizational chart identifies the percent of allocation of key personnel to the IME.

Position	FTEs Operations
Account/Transition Manager	1
Quality Assurance	0.15
Operations Manager	1
Accountants (all levels)	24
Accounting Assistants	4
Programmers	1.75
Pharmacist Consultant	0.75
Admin. Support	1
Subject Matter Experts (RNs)	0.25
<b>TOTAL FTE</b>	<b>34.10</b>

Job descriptions for all positions within the organization for all phases of the contract are included below. The job descriptions reflect the minimum requirements for the staff positions identified on the organizational chart.

**Managers** – Managers are the principal client contact persons. Projects are assigned to managers who coordinate all client services specified in the contract. He/she has the authority to commit the firm to timeframes and delivery of contract services, and respond to client needs, including discussion of contract changes within the firm's policies and procedures. He/she keeps the owners informed of problems and issues that arise on engagements and recommends solutions. Advancement to manager is based on the needs of the firm and individual qualifications.

**Supervisors** - Supervisors provide day-to-day management oversight, develop and deliver staff training programs and provide supervision of project personnel. In some cases, duties may be similar to managers. They coordinate project staffing, scheduling, and review activities. They communicate with clients and providers regarding routine and non-routine matters, and assist in presentations to clients and other groups as well as assist in developing, organizing, and writing documents such as audit programs, manuals, reports, and proposals. They also assist in addressing informal reconsideration and appeal issues. Supervisors report to managers, members, or principals.

**Seniors** - Seniors have sufficient experience to be in-charge of large engagements. They train, coordinate and supervise Staff on team assignments toward completion of designated tasks. Seniors usually are certified public accountants and have at least three to four years of relevant experience. Seniors have an in-depth understanding of one or more practice areas and have achieved sufficient command of procedures and techniques to serve as lead person on a field audit (if applicable) or oversee a project task of similar scope. They assist in preparation of position statements and production of documents for informal reconsideration and appeals.

**Staff** - Staff are guided by a senior who provides direction, answers questions and reviews engagement progress. Staff are familiar with the

policies and procedures of the firm. As staff gain experience and proficiency, they are given more difficult assignments and greater responsibility. They have sufficient knowledge and understanding of routinely assigned tasks to enable their successful completion without close supervision. Experienced Staff will serve as informal training resource for new employees. After gaining some experience, a staff level accountant may be an in-charge on small field assignments. Staff are college graduates and are usually certified public accountants or CPA candidates.

**Programmers/Analysts** -

Programmers/Analysts are generally experienced in Visual Foxpro, SQL or other data base applications. They have the ability to effectively identify project requirements, develop system designs in a manner consistent with the firm's overall quality control standards, and complete projects (or supervise their completion) in a timely manner. They are able to communicate, verbally and written, with accountants and other programmers to understand project needs, solve problems, document, and design efficient solutions.

**MDS Nurses** - MDS nurses have extensive medical backgrounds and many years of experience with Medicare and various state Medicaid long-term care programs as well as the Minimum Data Set (MDS) and the RUG-III classification methodology including presenting workshops on the proper completion of the instrument and the

development of appropriate supporting documentation. They possess excellent organization and communication skills as their responsibilities involve considerable interaction with state agency clients and provider groups. They work closely with project management to insure the successful implementation of state policies and procedures as well as compliance with applicable laws and regulations.

**Pharmacist Consultant –** Pharmacists serve in the operation and support of a SMAC program by recommending and evaluating drug selection criteria, assisting in the assessment of market sources for drugs, assessing and researching therapeutic equivalency ratings for drugs, assisting in the identification of narrow therapeutic ratio drugs, monitoring other drug issues (shortages, recalls, scientific controversy, etc.), providing pharmaco-economic observations and analysis, assisting with market research and reimbursement rate issues, serving as a professional resource for state staff and peers, providing expert testimony or opinion as necessary, reviewing clinical issues and questions, and by reviewing provider and recipient utilization trends and cases, as necessary. Pharmacists have extensive clinical and academic experience, have attained at least an R.Ph. designation, are knowledgeable of local and national pharmacy operations and laws and practice standards, and are licensed to practice in at least one state.

**Accounting Assistant -** Support staff assist other project staff in the successful completion of project tasks. They have excellent communication and organizational skills, good judgment, and the ability to coordinate multiple tasks in a dynamic environment. Qualifications include maturity and proficiency with word processing applications, spreadsheets, and power point.

## 8.2 Staffing (RFP Section 7.2.8.2)

Myers and Stauffer proposes to continue providing the services performed under the current contract by utilizing its existing project leadership team. The proven experience of Amy Perry and Jeff Marston along with the existing IME staff infrastructure will continue to provide the IME with the “Best of Breed” for the provider cost audits and rate setting component.

Amy Perry, CPA, account manager, has been employed with the firm since 1991 and has held numerous positions of increasing responsibility. Ms. Perry’s career with the firm began as a staff accountant in our Topeka, Kansas, office. She was promoted to manager in 1999 and relocated to our Kansas City, Missouri, office in 2001. Ms. Perry managed and supervised several of the firm’s large Medicaid engagements in the states of Louisiana and North Carolina.

In 2004, Ms. Perry relocated to the IME to serve as the account and implementation manager. She was

fully dedicated to the IME and managed Myers and Stauffer's provider cost audits and rate setting services. In 2006, she became a member (partner) of the firm. Ms. Perry directed and coordinated the implementation efforts for the State of Iowa's 1115c waiver known as IowaCare as well other new programs such as Remedial Services and Habilitation Services.

Ms. Perry managed and was actively involved in assisting IME with the transition from an APG reimbursement methodology to APC methodology for outpatient hospital services.

Jeff Marston, operations manager, has been employed with the firm since 2004. Mr. Marston has more than 14 years of health care experience. In 2004, Mr. Marston relocated to the IME and served as operation manager. He was fully dedicated to the IME and supervised the desk review and cost settlement functions. He was instrumental in the implementation of the 100 percent cost-based reimbursement methodology for CMHCs.

Both Ms. Perry and Mr. Marston will be 100 percent dedicated to the Iowa Medicaid Enterprise project. Neither will be reassigned or replaced, except as allowed for in the RFP, through at least the first six months of operation.

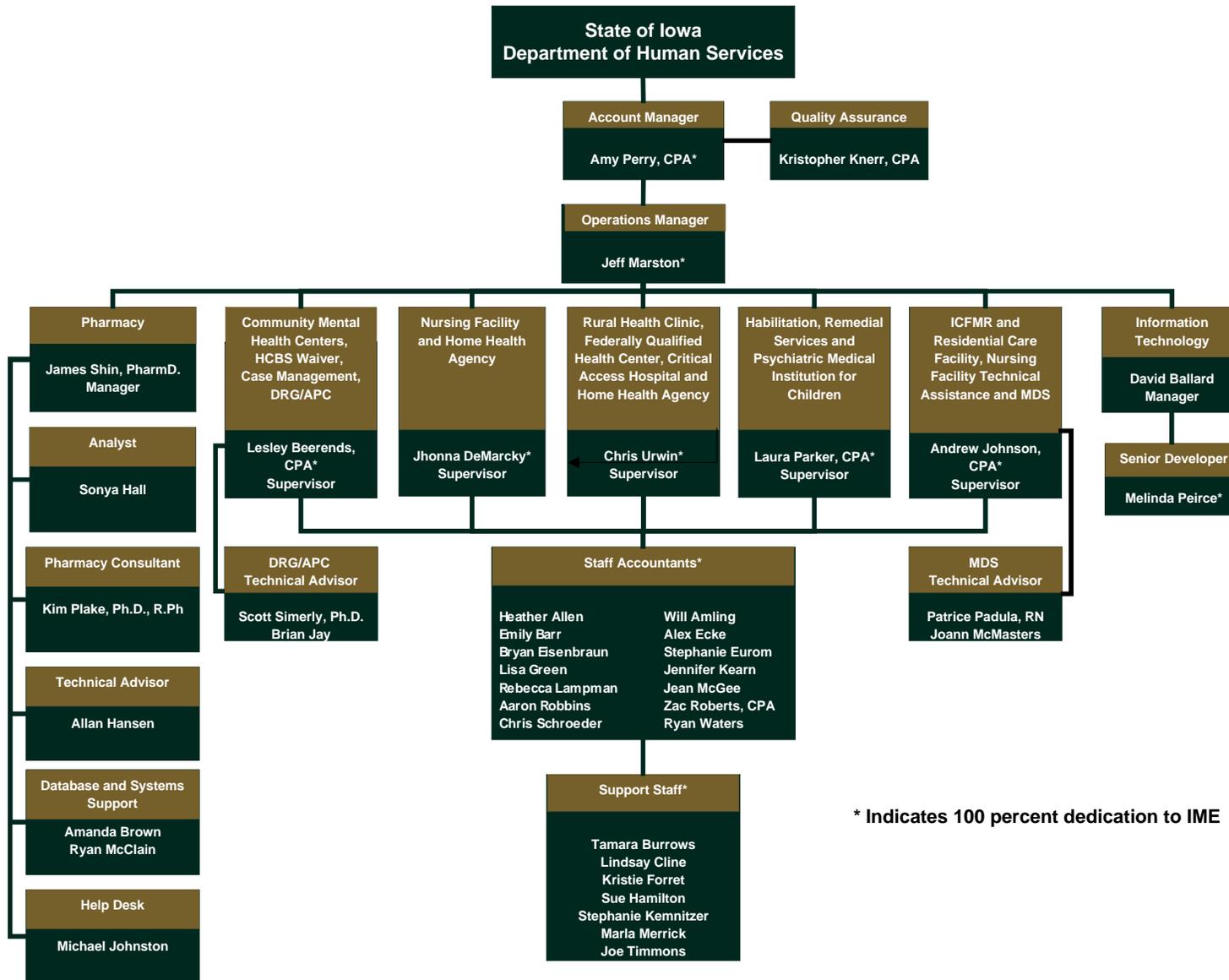
### 8.3 Key Personnel (RFP Section 7.2.8.3)

Resumes and references for key personnel address all requirements in

RFP Section 6.1.1.1.2 and 6.1.1.1.3. They are included on the following pages. All staff identified as key personnel are employed by Myers and Stauffer and have current IME experience.

### 8.4 Subcontractors (RFP Section 7.2.8.4)

Myers and Stauffer does not propose any subcontractors for this project. The personnel, facilities and equipment included in this proposal will perform the tasks in this project.



\* Indicates 100 percent dedication to IME

Amy Perry, CPA

*Member*

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PROJECT TITLE

Account Manager

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CERTIFICATION

Certified Public Accountant

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EXPERIENCE RELEVANT TO THIS PROJECT

Myers and Stauffer LC, September 1991 - Present

Ms. Perry, a member with more than 15 years of experience with the firm, provides consulting and public accounting services to state Medicaid agencies regarding health care reimbursement issues. She currently serves as the manager of the Iowa office. Her responsibilities include supervising project staff and planning and organizing day-to-day project operations. She also has the responsibility for keeping abreast of current statutes, rules and regulations that govern the industry and researching and evaluating the impact of state and federal legislation on provider reimbursement issues.

In 2004, Ms. Perry established the firm's Iowa office and hired and trained approximately 15 staff including CPAs, CPA candidates, computer professionals and accounting technicians. Prior to that she served as manager on many projects of the firm whose primary focus was the design and development of nursing facility rate setting systems for state Medicaid agencies and preparing analyses to support the Medicare upper payment limit and justification of rates to comply with federal requirements. She has been active in all phases of case mix development and maintenance for projects in Louisiana, North Carolina, Montana, Colorado, Hawaii, Iowa and New Jersey. She also prepared exhibits used in the presentation of the case mix system to the Iowa, Kansas, Colorado and Montana legislatures.

Ms. Perry's experience with nursing facility and ICF/MR rate setting includes researching and developing alternative reimbursement methodologies with emphasis on case mix reimbursement. Her experience includes all phases of design, development, implementation, and maintenance. She has prepared pro forma reimbursement models and financial and statistical analyses that allow states to define multiple reimbursement variables that can be changed interactively. This type of modeling provides states the ability to evaluate multiple options quickly and efficiently. She also assists states with their regulatory process formulating state plan/rule language, reviewing regulations, and drafting responses to questions from CMS and other interested parties and preparing analyses.

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## OTHER PROFESSIONAL EXPERIENCE

Ms. Perry's auditing, desk review, consulting and rate setting experience for state agencies includes the following states: Alaska, Colorado, Florida, Georgia, Hawaii, Iowa, Kansas, Kentucky, Louisiana, Missouri, Montana, New Jersey, Nevada, North Carolina, and Washington.

She assisted Nevada and North Carolina implement a provider tax program for nursing facilities including preparing analyses to submit to CMS requesting waiver approval.

She has assisted Kansas, New Jersey, Georgia, Colorado, Washington, Montana and Louisiana in preparing analyses to support the Medicare upper payment limit and Medicare/Medicaid rate differential calculations. She had the responsibility for evaluating the impact of state and federal legislation on these calculations.

Ms. Perry has experience in researching and developing alternative reimbursement methodologies for paying nursing facilities for their capital and property-related expenses. She completed a nursing facility reimbursement study for the state of Washington and assisted the states of Nevada and Louisiana in the development and implementation of a Fair Rental Value system.

Ms. Perry served as project manager for an engagement with the state of Kansas to review the adequacy of reimbursement rates and provide rate adjustment recommendations based on cost data collected from the Community Service Providers (CSP) and Community Developmental Disability Organizations (CDDO) along with relevant economic and market data.

Ms. Perry has performed desk review and rate setting engagements in accordance with Medicaid reimbursement regulations as well as applying Medicare reimbursement regulations that are contained in the Medicare Provider Reimbursement Manual (HIM-15). These engagements necessitate an in-depth understanding of the application of rules specific to the cost reporting and rate setting activities that were performed.

During the Boren era, she prepared studies and analyses to support the Medicare upper payment limit and findings and assurances. She also prepared cost reimbursement rate analyses and regression analyses for litigation purposes and presentation to policy makers and stakeholders.

She researched and prepared a logical analysis on the findings and assurances required to assist the Kansas Department of Social and Rehabilitation Services in the development of a findings process. Analysis included development of a structured process, presented by both verbiage and flowcharts, to comply with federal requirements.

She served as senior analyst for the preparation of long term care and hospital findings for the Missouri Department of Social Services and the Alaska Department of Health and Social Services. She also assisted in the preparation of the 1992 and 1993 studies and analyses that support the Wyoming Health Care Financing findings.

She participated in the design and implementation phases of the Kansas Living Independence for Everyone (LIFE) HCBS waiver for the frail elderly and the physically disabled.

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## EDUCATION

B.S., Accounting, Northeast Missouri State University, Kirksville, Missouri, 1990

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## AFFILIATIONS

American Institute of Certified Public Accountants  
Kansas Society of Certified Public Accountants

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## PRESENTATIONS

“Current Trends in Nursing Facility Rate Setting,” Myers and Stauffer Workshop, Indianapolis, Indiana, 2003

“RUG-III Case Mix Reimbursement System,” North Carolina Medicaid, 4 venues, 2003

“Louisiana Medicaid Nursing Facility Case Mix Reimbursement,” Gulf States Association of Homes and Services for the Aging, 2003

“Nursing Facility Case Mix Reimbursement,” Louisiana Medicaid, 4 venues, 2002  
“New Medicaid Reimbursement System in Iowa,” Iowa Association of Homes and Services for the Aging, West Des Moines, Iowa, 2001

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## REFERENCES

Gene Gessow  
158 Taber Avenue  
Providence, RI 02906  
Phone: (401) 474-2768  
E-mail: [egessow@aol.com](mailto:egessow@aol.com)

Robert Schlueter  
Iowa Medicaid Enterprise  
Provider Services Unit  
Account Manager  
100 Army Post Rd.

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Des Moines, IA 50315  
Phone: (515) 725-1399  
E-mail: [rschlue@dhs.state.ia.us](mailto:rschlue@dhs.state.ia.us)

Kent Bordelon, Deputy Assistant Secretary II  
Department of Health and Hospitals  
BHSF - Rate and Audit Review  
1201 Capitol Access Road, 2<sup>nd</sup> Floor  
Baton Rouge, LA 70821-0546  
Phone: (225) 342-6116  
E-mail: [Kent.bordelon@la.gov](mailto:Kent.bordelon@la.gov)

## Kris Knerr, CPA, CGFM

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*Member*

### PROJECT TITLE

Quality Assurance

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### CERTIFICATION

Certified Public Accountant  
Certified Government Financial Manager

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### EXPERIENCE RELEVANT TO THIS PROJECT

Myers and Stauffer LC, August 1992 – Present

A member (owner/partner) with Myers and Stauffer, Mr. Knerr is responsible for providing consulting and public accounting services to state agencies regarding pharmacy and other health care reimbursement issues. His Medicaid pharmacy experience includes the following engagements:

- Indiana State Maximum Allowable Cost Program - 2001 to present
- Iowa State Maximum Allowable Cost Program - 2002 to present
- Idaho State Maximum Allowable Cost Program - 2004 to present
- Mississippi State Maximum Allowable Cost Program - 2007 to present
- Alabama State Maximum Allowable Cost Program - 2008 to present
- Louisiana State Maximum Allowable Cost Program – 2009 to present
- Illinois State Maximum Allowable Cost Program – 2004 to 2009
- Wyoming State Maximum Allowable Cost Program – 2004 to 2008

Mr. Knerr has served as project director for all of these engagements. In this capacity, his responsibilities have included oversight and hands-on in the following areas: development of goals and implementation strategies; data collection (survey and annual rebasing) process; compilation of the proposed drug list; development of rate updating criteria; fiscal impact modeling, cost avoidance and utilization/trend reporting; liaison for stakeholder outreach; State MAC Web site development; pharmacy Help Desk; and generally as a resource for developing and recommending changes to administrative rules, State Plan Amendments, policy manuals, and in addressing questions or issues raised by the General Assembly, the Governor's office, and the Centers for Medicare and Medicaid Services (CMS).

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## OTHER PROFESSIONAL EXPERIENCE

Mr. Knerr has experience modeling, analyzing, drafting and implementing Medicaid regulatory changes. This includes assisting state Medicaid clients in all aspects of program design and implementation strategy, operational support, identification of program refinements, and compilation of empirical evidence regarding policy issues for presentation to state Medicaid personnel. In addition, he provides consultation in defense of litigation brought forth by Medicaid providers in various state and administrative forums. He has served as quality assurance director for a number of engagements and performed analysis and review of provider cost data and relevant economic data used in developing findings to support state Medicaid agency assurances to CMS. A brief summary of other engagements include:

- Iowa Nursing Facility Case Mix – 2000 to present

He has served as the project director on the state of Iowa's development of a case mix reimbursement system for nursing facilities. Mr. Knerr developed reimbursement strategies to address the treatment of nursing services within the case mix system, as well as strategies to address non-nursing services including administration, environmental, support care and capital costs. He presented and defended the Department's case mix system proposal at numerous task force meetings, met with legislators to explain the new system and presented testimony to the Human Services Appropriations subcommittee.

- Indiana Nursing Facility Case Mix - 1995 to present

He has served as project manager on the state of Indiana's case mix reimbursement system development and implementation project since the project began in 1995. This multi-faceted project included the design, development and implementation of an automated system to collect MDS 2.0 data from over 525 Medicaid certified nursing facilities, the design and modeling of alternative case mix reimbursement methodologies and ongoing operations of the case mix reimbursement system.

Mr. Knerr coordinated case mix work group meetings, prepared and presented alternative case mix and capital reimbursement methodologies, performed fiscal impact modeling and analyses, drafted state regulations and criteria and responded to technical issues brought forth by the state and provider association representatives.

- Kentucky Nursing Facility Case Mix - 1998 to present

Mr. Knerr has provided project consulting to the Kentucky Department for Medicaid Services on the Development of a RUG-III Case Mix Reimbursement System. He has presented at case mix work group meetings, prepared case mix reimbursement models and fiscal impact analyses, developed training programs for state and provider groups and responded to technical issues brought forth by the state and work groups.

Prior to his tenure with Myers and Stauffer, Mr. Knerr worked as a financial analyst with an economic consulting group. In that capacity, he was responsible for evaluating and interpreting the economic impact resulting from circumstances related to specific personal and business litigation. He identified and implemented applied economic and financial theories and also formulated and established case valuation plans.

Mr. Knerr also has four years of general accounting experience with a medium-sized computer service organization. He managed day-to-day activities of the finance department including preparation of financial statements and planning and implementation of operational, capital and cash flow budgeting. He performed analysis and review of issues relating to generally accepted accounting principles. He also had management and supervision responsibility for 20 technical and professional full-time personnel.

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## EDUCATION

B.A., Accounting, University of South Florida, Tampa, Florida, 1984

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## AFFILIATIONS

American Institute of Certified Public Accountants

Indiana CPA Society

Association of Government Accountants

American Public Human Services Association

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## PRESENTATIONS

“Current Status of State Medicaid Case Mix Systems,” National Case Mix Conference 2003, Putting Policy into Action: Are we making a Difference, Baltimore, Maryland; March 2003.

“Unanticipated Acuity Changes: The Impact on Government Assistance Budgets,” Case Mix 2001 Conference, New Frontiers in Health Information, Niagara Falls, Canada; October 2001.

“Components of the Medicare Prospective Payment System” and “Impact on State Medicaid Programs,” Myers and Stauffer Home Health Workshop, Kansas City, Missouri; December 2000.

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## REFERENCES

Gene Gessow

158 Taber Avenue

Providence, RI 02906

Phone: (401) 474-2768

E-mail: [egessow@aol.com](mailto:egessow@aol.com)

Faith Laird, Director  
FSSA Division of Aging  
402 W. Washington Street, W454  
Indianapolis, IN 46207-7083  
Phone: (317) 232-0604  
E-mail: [Faith.Laird@fssa.in.gov](mailto:Faith.Laird@fssa.in.gov)

Selma Gearhardt, Pharm.D.  
Pharmacy Services Specialist  
Idaho Department of Health and Welfare  
3232 Elder Street  
Boise, ID 83705  
Phone: (208) 364-1826  
E-mail: [GearharS@dhw.idaho.gov](mailto:GearharS@dhw.idaho.gov)

Jeffrey Marston

*Manager*

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PROJECT TITLE

Operations Manager

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EXPERIENCE RELEVANT TO THIS PROJECT

Myers and Stauffer LC, October 2004 – Present

Mr. Marston, a manager with Myers and Stauffer, is responsible for managing the auditing, desk reviews, and cost settlements for thirteen different provider types. The provider types include, but are not limited to: acute care hospital, nursing facility, home health, home and community-based waivers (HCBS) and rural health clinic. He also manages the Purchase of Social Services/Rehabilitation Treatment Support Services (POSS/RTSS) contract with the Iowa Department of Human Services. This includes final review of desk reviews and conducting field audits.

He supervises the hospital rebasing and recalibration for Medicaid reimbursement. This includes calculating inpatient and outpatient base rates, cost-to-charge-ratios, statewide averages, and calculating disproportionate hospital share and graduate medical education payments for qualifying hospitals.

He also supervises the hospice rate setting, in accordance with the Medicare rate setting methodology.

Mr. Marston is also actively involved with implementing reimbursement methodology and cost reports for new Iowa Medicaid services as well as relevant fiscal impact analysis. This also includes on-going policy and procedure analysis for current Medicaid services which includes updating the State Plan Amendment and drafting administrative rules.

He also works with the other Iowa Medicaid staff to develop Iowa Medicaid fee schedule reimbursement. This includes the annual updates from CMS for new procedures and pharmaceuticals as well as on-going updates deemed necessary by the Iowa Medicaid Policy staff. This requires an extensive knowledge of the AMA CPT/HCPCS codes, Medicare Resource-Based Relative Value System (RBRVS), and average wholesale price (AWP) methodology.

He also was actively involved with the Iowa PERM audit by assisting with questions regarding claims and reimbursement methodology.

Mr. Marston has conducted cost report trainings for providers and presented reimbursement methodology of various provider types to members of the Iowa legislature. He also assists with Request for Information from the Iowa legislature when the proposed bill effects health care reimbursement.

Mr. Marston leads teams to conduct field audits of Medicaid cost reports for various provider types.

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#### OTHER PROFESSIONAL EXPERIENCE

Previous to being employed by Myers and Stauffer, Mr. Marston was a cost accountant at BryanLGH Medical Center from 2000-2004. His job responsibilities required an extensive knowledge of the medical center's departments, AMA CPT/HCPCS, ICD-9 procedure and surgical codes, and hospital reimbursement methodologies related to Medicare, Medicaid, and private insurance. His job duties included calculating the annual cost-to-charge ratios for the departments, updating the hospital charge master for new procedure codes by determining the cost, assisting with preparation of the Medicare cost report, meeting with department managers to determine the cost budget. Mr. Marston also assisted in the monthly department profit and loss reports as well as the yearly report for the board of directors.

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#### EDUCATION

B.B.A., Accounting, University of Nebraska-Lincoln, 1997, Dean's List

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#### REFERENCES

Gene Gessow  
158 Taber Avenue  
Providence, RI 02906  
Phone: (401) 474-2768  
E-mail: [egessow@aol.com](mailto:egessow@aol.com)

Robert Schlueter  
Iowa Medicaid Enterprise  
Provider Services Unit  
Account Manager  
100 Army Post Rd.  
Des Moines, IA 50315  
Phone: (515) 725-1399  
E-mail: [rschlue@dhs.state.ia.us](mailto:rschlue@dhs.state.ia.us)

Tonya Sickels  
Iowa Medicaid Enterprise

Medical Services Unit  
Manager, Quality and Accountability  
Account Manager  
100 Army Post Rd.  
Des Moines, IA 50315  
Phone: (515) 725-1332  
E-mail: [tsickel@dhs.state.ia.us](mailto:tsickel@dhs.state.ia.us)

James Shin, PharmD

*Manager*

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PROJECT TITLE

Manager - Pharmacy

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LICENSURE

Illinois Registered Pharmacist, 2002 – Present

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EXPERIENCE RELEVANT TO THIS PROJECT

Myers and Stauffer LC, October 2004 – Present

Dr. Shin is a manager with Myers and Stauffer. He has specialized training in managed care and pharmacoeconomics research. He is a graduate of the University of Illinois, College of Pharmacy and worked with the Maryland Medicaid program through his post-doctoral fellowship at the University of Maryland, School of Pharmacy. He is currently licensed in the State of Illinois and has expertise in pharmacy reimbursement methodologies, formulary management, and has experience working in community and outpatient pharmacy settings. His academic interests have included extensive research on clinical and economic issues involving the use of pharmaceuticals in commercial insurance and Medicaid populations. Dr. Shin has specialized training in directing and analyzing managed care pharmacy issues in both the private and government insured sectors. He has been involved with various pharmacy and therapeutics committees and has been called upon to present relevant issues to these communities. Dr. Shin is familiar with issues pertaining to Medicaid pharmacy coverage. He has worked on Medicaid State MAC Program and other pharmacy issues with the States of Illinois, Indiana, Idaho, Iowa, Mississippi, Wyoming, Alabama, and Louisiana.

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OTHER PROFESSIONAL EXPERIENCE

*Pharmacoeconomics and Outcomes Research Postdoctoral Fellow*, University of Maryland School of Pharmacy, July 2003 - September 2004

Dr. Shin analyzed pharmacy and medical claims data for diabetic and chronic obstructive pulmonary disease patients enrolled with Maryland Medicaid, and utilized SAS analytical procedures such as univariate frequency distribution, bivariate analysis, multivariate logistic regression, and propensity scoring to address trends within the utilization of pharmacy products and medical services. He explored pharmacy and medical claims data for analysis of demographic and resource utilization information to determine their influence on health outcomes, prescription

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drug use, and medical resource utilization. Dr. Shin was involved with the successful completion of proposals accepted by the Internal Review Board and provided clinical consultation for projects concurrent with the fellowship. Dr. Shin acted as a preceptor and mentor for students within the department.

*Managed Care Pharmacy Practice Resident, Humana Inc. & Louisville VA Medical Center, July 2002 - June 2003*

Dr. Shin designed and implemented an outcomes study to compare overall cost effectiveness of rheumatoid arthritis medications and a program to implement promotional materials for generic drug utilization. He oversaw the proceedings, operation, and budget for an appropriate antibiotic utilization campaign and performed individual and population-based drug utilization reviews. Dr. Shin served as client support by answering questions regarding the benefits appropriated to the customer, analyzed metrics of projects to measure the financial impact of interventions, and provided clinical pharmacy services in various clinics at the VA Medical Center, including anticoagulation, home health service, infectious disease consultation, and general medicine clinics.

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## EDUCATION

PharmD, University of Illinois College of Pharmacy, 2002

B.S., Honors, Major: Chemistry, Minor: Mathematics, Loyola University, Chicago, Illinois, 1998

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## AFFILIATIONS

Academy of Managed Care Pharmacy  
International Society for Pharmacoeconomics and Outcomes Research  
American Society of Health-System Pharmacists  
Phi Lambda Sigma Leadership Society  
Kappa Psi Pharmaceutical Fraternity

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## PRESENTATIONS

“Drug Pricing Benchmarks in a Changing Pharmaceutical Landscape.” (Podium) Western Medicaid Pharmacy Administrator’s Association Meeting; Wisconsin Dells, Wisconsin; September 2009.

“Heart Failure Risk of Thiazolidinediones in a Medicaid Managed Care Organization Population.” (Poster) American Society of Health-System Pharmacists Midyear Clinical Meeting; Orlando, Florida; December 2004.

“Prescription and Medical Resource Utilization Among Initial Metformin and Thiazolidinedione Patients.” (Poster) International Society for Pharmacoeconomics and Outcomes Research Annual Meeting; Arlington, Virginia; May 2004.

“Prescription and Medical Resource Utilization Among Initial Metformin and Thiazolidinedione Patients.” (Poster) Academy of Managed Care Pharmacy Annual Meeting; San Francisco, California; April 2004.

“Disparities in Incident Use of TZDs Compared with Metformin in a Medicaid Population,” (Podium) University of Maryland School of Pharmacy Professional Seminar; Baltimore, Maryland; November 2003.

“Designing a Benefit Structure that Encourages Utilization of Higher Value Drugs,” Shifting Utilization to Higher Value Drugs Conference, Chicago, Illinois; June 2003.

“Impact of Various Interventions to Increase Generic Drug Utilization in a National Health Plan Population,” (Poster) Academy of Managed Care Pharmacy Annual Meeting, Minneapolis, Minnesota; April 11, 2003.

“Cox-2s and the Health Plan Perspective,” (Podium) Kentucky Society of Health-System Pharmacists, Lexington, Kentucky; September 2002.

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## PUBLICATIONS

Shaya FT, Shin JY, Mullins CD, Fatodu H, Gu A, Saunders E. Medicaid Managed Care: Disparities in the Use of Thiazolidinediones Compared with Metformin. *J Nat Med Assoc.* 2005; 97(4): 493-497.

Shaya FT, Shin JY, Mullins CD, El Khoury A, Garber H. Risk of Heart Failure with use of Thiazolidinediones within a Medicaid Population. *Pharmacy and Therapeutics.* 2005; 30(5): 273-281.

Shaya FT, Shin JY, Wong W, Proveaux W. Clinical and Economic Evaluation of Fluoroquinolones. *Expert Review of Pharmacoeconomics and Outcomes Research.* 2004; 4(4): 469-477.

Shaya FT, Wong W, Shin JY, Martin L, Samant N. Formulary Decision-Making Considerations: Cox-2 Inhibitors. *Managed Care Interface.* 2004; 17(11):29-36, 41.

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## REFERENCES

Gene Gessow  
158 Taber Avenue

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Providence, RI 02906  
Phone: (401) 474-2768  
E-mail: [egessow@aol.com](mailto:egessow@aol.com)

Michael Sharp, R.Ph.  
Director of Pharmacy  
Office of Medicaid Policy and Planning  
402 W. Washington St.  
Indianapolis, Indiana 46204  
Phone: (317) 234-3635  
E-mail: [Michael.sharp@fssa.in.gov](mailto:Michael.sharp@fssa.in.gov)

Selma Gearhardt, PharmD  
Pharmacy Services Specialist  
Department of Health and Welfare  
3232 Elder Street  
Boise, Idaho 83705  
Phone: (208) 364-1826  
E-mail: [GearharS@dhw.idaho.gov](mailto:GearharS@dhw.idaho.gov)

Lesley Beerends, CPA

*Supervisor*

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PROJECT TITLE

Supervisor – Community Mental Health Centers, HCBS Waiver, Case Management, DRG/APC

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CERTIFICATION

Certified Public Accountant

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EXPERIENCE RELEVANT TO THIS PROJECT

Myers and Stauffer LC, June 2005 – Present

Ms. Beerends, supervisor with Myers and Stauffer, performs cost report desk reviews, audits and cost settlements for hospitals, targeted case management, habilitation, and rural health centers in accordance with state and federal regulations. She performs final review of completed desk reviews and offers training and assistance to others as needed.

She assists state officials with designing reimbursement methodology and cost reporting procedures for new Medicaid programs as well as relevant fiscal impact analysis. This includes on-going policy and procedure analysis for current Medicaid services which includes updating the State Plan Amendment and drafting administrative rules. Ms. Beerends provides technical assistance and cost report training for Medicaid providers.

In 2008, Ms. Beerends was actively involved in the development and implementation of the APC payment methodology for outpatient hospital services for the State of Iowa. This included preparation of data models to price-out APG claims to ensure budget neutrality was met when transitioning to the new APC methodology. She also assists with the DRG and APC recalibration and rebasing project for the state of Iowa. This includes determination of hospital rates and case mix index factors, calculation of DRG and APC relative weights and outlier thresholds, cost-to-charge-ratios, fiscal impact studies, management of databases, statistical analyses, calculation of disproportionate share and graduate medical education payments for qualifying hospitals. She reviews and analyzes federal and state legislative initiatives and participates in policy discussions related to DSH and upper payment limit (UPL). She also provides analysis of Medicaid claims data for financial and policy support and to assist providers with claims billing and payment issues.

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Ms. Beerends is responsible for completion of the Iowa Care monthly expenditure report and yearly Iowa Care reconciliation process including claims analysis of large datasets.

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#### OTHER PROFESSIONAL EXPERIENCE

Ms. Beerends other professional experience includes hospital and consulting experience as well as Medicare analysis and auditing. Mr. Beerends was a senior accountant for Central DuPage Hospital. She participated in the development of the operating budget by conducting departmental budget training, assisting departments with budget completion, and performing financial modeling; compiled and assessed monthly departmental financial statements and assisted department managers with questions and analysis; developed pro forma and product line reports to determine the impact of financial decisions or scenarios and business unit valuations; and implemented and maintained the cost accounting system including departmental micro-costing.

As a senior compliance consultant for Arthur Andersen, LLP, Ms. Beerends investigated and tested compliance with applicable state and federal laws for health care providers such as hospitals, nursing homes, HMOs, and home health agencies; completed specialized projects that included producing the Medicare and Medicaid cost reports for a large children's hospital; and assisted clients in revising and implementing policies and procedures to ensure compliance with third-party regulatory standards.

Ms. Beerends was a Medicare analyst/auditor for Wellmark, Inc. Her responsibilities included completing Medicare audits of hospitals, home health agencies (HHA, and skilled nursing facilities) in accordance with CMS regulations. Ms. Beerends was responsible for the 1999 audit of the Medicare Division policies and procedures to ensure that Wellmark, Inc. met all CMS requirements to be a Part B Carrier.

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#### EDUCATION

M.B.A., Northern Illinois University, DeKalb, Illinois, 2005  
B.A., Accounting, Simpson College, Indianola, Iowa, 1996

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#### REFERENCES

Robert Schlueter  
Iowa Medicaid Enterprise  
Provider Services Unit  
Account Manager  
100 Army Post Rd.  
Des Moines, IA 50315

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Phone: (515) 725-1399  
E-mail: [rschlue@dhs.state.ia.us](mailto:rschlue@dhs.state.ia.us)

Maureen Taus, Vice President of Finance  
Central DuPage Hospital  
25 N. Winfield Road  
Winfield, IL 60190  
Phone: (630) 933-6342  
E-mail: [Maureen\\_Taus@cdh.org](mailto:Maureen_Taus@cdh.org)

Lee Piekarz, Senior Manager  
Deloitte & Touche, LLP  
111 S. Wacker Drive  
Chicago, IL 60606-4301  
Phone: (312)-946-2763  
E-mail: [rlpiekarz@deloitte.com](mailto:rlpiekarz@deloitte.com)

Jhonna DeMarcky

*Supervisor*

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PROJECT TITLE

Supervisor – Nursing Facility and Home Health Agency

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EXPERIENCE RELEVANT TO THIS PROJECT

Myers and Stauffer LC, April 2005 – Present

Ms. DeMarcky, supervisor with Myers and Stauffer, is responsible for conducting audits on long term care facilities in the state of Iowa. Her duties also include conducting the supervisory review of staff's desk reviews on Nursing Facilities and on cost settlements for home health agencies. She also consults with the state on exception to policy issues regarding the cost settlement process, billing issues found during the cost settlement process and developing edits in the Medicaid Management Information Systems (MMIS) to eliminate the billing issues. She also provides EPSDT cost information to the state for consideration of eliminating the current EPSDT fee schedule.

Her responsibilities also include preparing the monthly account receivables report for fiscal management and monitor outstanding accounts receivable to ensure that staff is pursuing collections efforts. She also will determine when an outstanding accounts receivable is uncollectible and will assist staff in transferring it to revenue collections department. She also works on miscellaneous projects as assigned.

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OTHER PROFESSIONAL EXPERIENCE

Prior to working for Myers and Stauffer, Ms. DeMarcky held staff accountant and accounts payable manager positions in various industries. Her duties included general ledger analysis and journal entries, preparation of month-end and year-end close, and preparation of internal management reports and financial statements in accordance with GAAP.

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EDUCATION

B.S. Accounting and Management/Marketing (dual majors), Felician College, Lodi and Rutherford, New Jersey, 2002

Masters of Business Administration, Drake University College of Business and Public Administration, Expected Graduation Date December 2010

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---

REFERENCES

Joe Aguero  
Croda Inc.  
300-A Columbus Circle  
Edison, NJ 08837  
Phone: (732) 417-0800  
E-mail: [J.Aguero@crodausa.com](mailto:J.Aguero@crodausa.com)

Robert Schlueter  
Iowa Medicaid Enterprise  
Provider Services Unit  
Account Manager  
100 Army Post Rd.  
Des Moines, IA 50315  
Phone: (515) 725-1399  
E-mail: [rschlue@dhs.state.ia.us](mailto:rschlue@dhs.state.ia.us)

Jeremy Morgan  
5116 Aspen Drive  
Norwalk, IA 50211  
Phone: (515) 681-4991  
E-mail: [jeremymorgan@maximus.com](mailto:jeremymorgan@maximus.com)

# Christopher Urwin

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*Supervisor*

## PROJECT TITLE

Supervisor – Rural Health Clinic, Federally Qualified Health Center, Critical Access Hospital and Home Health Agency

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## EXPERIENCE RELEVANT TO THIS PROJECT

Myers and Stauffer LC, April 2009 – Present

Mr. Urwin, a supervisor with Myers and Stauffer, performs supervisory level reviews of Medicaid cost reports for critical access hospitals, nursing facilities, rural health clinics, and federally qualified health centers. Mr. Urwin ensures proper program reimbursement is made to each facility type. Mr. Urwin effectively completed supervisory reviews and finalized audits of Nursing Facility cost reports within time guidelines. Mr. Urwin completed supervisory reviews of tentative and final cost settlements for critical access hospitals, federally qualified health centers, and rural health clinics. He trained new staff members and worked to ensure each staff thoroughly understood Medicaid reimbursement guidelines.

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## OTHER PROFESSIONAL EXPERIENCE

**Business Operations Manager (2004 – 2009), Business Operations Analyst (2003 -2004),**

IPCS (Affiliate of Sprint PCS) 2004 – 2009

- Ensure operational excellence of retail and some indirect locations through monthly audits to maximize company earnings.
- Maintain working knowledge of all operational policies and procedures.
- Manage a staff of 12 employees, and coordinate additional projects as assigned by company executives.
- Coordinated and effectively completed the opening of eight new retail locations.
- Performed monthly compliance audits to ensure operational excellence of 16 retail locations.
- Worked with the operations Team and accounting team to develop the “Scorecard” method for monthly audits and to cover Sarbane-Oxley compliance requirements.
- Worked in conjunction with the assistant controller to coordinate inventory audits of all retail and warehouse locations in order to be compliant with requirements.
- Assisted with completion of policy and procedure manual for the operations department.

- Worked with human resources department to investigate and uncover fraudulent activities within the sales force.

**Healthcare Consultant, RSM McGladrey, Inc., 2002-2003**

- Assisted various clients in preparing Medicare and Medicaid cost reports and other regulatory reports.
- Maintained a good understanding of healthcare reimbursement regulations and effectively assisted clients and coworkers in the completion of Medicare, Medicaid, and various other regulatory cost reports on a timely basis.
- Completed detailed reviews of disproportionate share payments for several hospitals. Identified additional Medicaid eligible days and increased reimbursement by several hundred thousand dollars for each facility.
- Understood various facilities' accounting structures in order to utilize general ledger, trial balance, and financial statements in order to complete regulatory reports.

**Senior Provider Auditor (2001-2002),, Provider Auditor II (2000-2001),  
Provider Auditor I, (1999-2000), United Government Services, LLC, 1999-2002**

- Ensured proper reimbursement made to various healthcare facilities based on Medicare regulations. Complexity of audits increased with each promotion.
- Maintained a good understanding of Medicare reimbursement regulations and effectively completed audits of various healthcare entities, thereby safeguarding millions of dollars to the Medicare program.
- Coordinated special audits, such as wage index reviews, enabling supervisor to spend time on larger projects.
- Worked closely with representatives from the Benefits Integrity Unit, Federal Bureau of Investigation, and Office of General Counsel, promptly disclosed fraud discovered during audit and effectively prevented the provider from continuing to fraud by obtaining a program suspension.
- Selected to committee and developed new templates, standardizing Federally Qualified Health Center audit work papers on a company-wide basis, thus reducing overall audit time.
- Advanced personal knowledge of various software programs and taught coworkers, eliminated the need for outside consultants, which saved the company thousands of dollars.

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**EDUCATION**

B.A., Accounting and Business Administration, Mount Saint Clare College,  
Clinton, Iowa, 1999

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**REFERENCES**

Brian Cochuyt  
Regional Retail Sales Manager

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Verizon Wireless  
131 E 2nd Street  
Coal Valley, IL 61240  
Phone: (309) 798-9587  
E-mail: [brianchuyt@yahoo.com](mailto:brianchuyt@yahoo.com)

Diana Bollaert  
Supervisor of Provider Audit  
Genesis Hospital  
4115 35th Avenue  
Moline, Illinois 61265  
Phone: (309) 762-0775  
E-mail: [Dlbollaert@aol.com](mailto:Dlbollaert@aol.com)

Joe Banaszek  
Commercial Sales Manage  
IPCS Wireless, Inc.  
5000 Tremont Avenue Ste 301  
Davenport, Iowa 52807  
Phone: (563) 505-2901  
E-mail: [jbanaszek@ilpcs.com](mailto:jbanaszek@ilpcs.com)

Laura Parker, CPA

*Supervisor*

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PROJECT TITLE

Supervisor – Habilitation, Remedial Services and Psychiatric Medical Institution for Children

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CERTIFICATION

Certified Public Accountant

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EXPERIENCE RELEVANT TO THIS PROJECT

Myers and Stauffer LC, December 2005 – Present

Ms. Parker, supervisor with Myers and Stauffer, oversees the cost audit and rate setting functions for the Iowa Medicaid Habilitation Services, Remedial Services and Psychiatric Mental Institutions for Children. These functions include supervising four staff accountants and one accounting assistant, final review of completed cost report desk reviews, maintenance of provider payment rates, annual analysis of payment rates and the provision of technical assistance and cost report training for Medicaid providers. Ms. Parker also assists state officials in designing reimbursement methodology and cost reporting procedures, prepares fiscal impact analysis for proposed program changes or new Medicaid programs. Additionally, Ms. Parker offers assistance as needed for several other Iowa Medicaid programs.

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OTHER PROFESSIONAL EXPERIENCE

Office of Inspector General, July 2002 – December 2005

Prior to joining Myers and Stauffer, Ms. Parker was employed by the US Department of Health and Human Services, Office of Inspector General, Office of Audit Services as an auditor and an auditor in charge. Her responsibilities included applying practical, analytical and creative thinking to identify weaknesses in federal award programs within a ten-state region, and determining program compliance pursuant to federal and state regulations as well as other applicable criteria. She conducted entrance and exit conferences as well as interviews with auditees, developed audit findings using audit software and various computer applications, and lead audit teams and managed completion of various audit tasks throughout the audit, including writing audit reports.

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## EDUCATION

B.A., Accounting, Simpson College, Indianola, Iowa, 2002

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## REFERENCES

Greg Tambke  
Audit Manager  
Dept of Health and Human Services,  
Office of Inspector General, Office of Audit Services  
2425 Hyde Park Road  
Jefferson City, MO 65109  
Phone: (573) 893-8338 x30  
E-mail: [gtambke@oig.hhs.gov](mailto:gtambke@oig.hhs.gov)

Kristy Litwiler  
Assistant Controller  
Grandview College  
1200 Grandview Ave  
Des Moines, IA 50316  
Phone: (515) 263-2941  
E-mail: [klitwiler@gvc.edu](mailto:klitwiler@gvc.edu)

Mathew Flannery  
Auditor  
Veteran Affairs Regional Office  
210 Walnut  
Federal Building  
Des Moines, IA 50309  
Phone: (515) 323-7441  
E-mail: [mathew.flannery@va.gov](mailto:mathew.flannery@va.gov)

Andrew Johnson, CPA

*Supervisor*

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PROJECT TITLE

Supervisor – Intermediate Care Facility for Mentally Retarded and Residential Care Facility, Nursing Facility Technical Assistance and MDS

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CERTIFICATION

Certified Public Accountant

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EXPERIENCE RELEVANT TO THIS PROJECT

Myers and Stauffer LC, September 2000 to Present

Mr. Johnson, a supervisor with Myers and Stauffer, manages long-term care cost report rate setting and hospice rate calculations for the Iowa Medicaid Enterprise. His duties include consulting with the state on rate setting issues, including assisting with exceptions to policy and provider communication. He develops quarterly budgets for compliance with regulations, preparing annual budgets for state appropriation bills, calculating pay for performance add-on payments and working with other state contractors to recommend state medical assistance policy. Mr. Johnson's audit responsibilities include verifying accuracy of data received from other state contractors, implementing changes as needed into rates and recommending penalties as required by rule. He also provides analysis for Iowa legislative and CMS requests for information. Mr. Johnson has worked with other state contractors and state and federal agencies concerning rate appeals, fraud investigations and regulatory compliance.

Mr. Johnson is consulting with the State of Iowa and other state contractors in the implementation of the MDS 3.0 and RUG IV Grouper. He participates in workgroups consisting of various stakeholders required by legislative mandates including Direct Care Worker Wages, Nursing Facility Pay-for Performance and the development of a Uniform Cost Report. Mr. Johnson worked with multiple state contractors on the implementation of the National Provider Identifier for the State of Iowa.

Mr. Johnson was instrumental in the transition from the prior contractors to the Iowa Medicaid Enterprise, writing procedures, developing staff and interpreting regulations for developing an internal rate-setting program. Mr. Johnson also performs analytical reviews and on-site audits for providers receiving state medical assistance.

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Mr. Johnson performed Medicaid long-term care cost report reviews for the firm's other state agency clients. His responsibilities included review of provider documentation and performing analytical reviews. He was also responsible for incorporating both financial and MDS audits into rates.

Mr. Johnson led teams assisting the state of Minnesota on conducting time studies at nursing facilities. The data collected was used to establish weights for RUG scores of special needs units (i.e. Huntington disease, Alzheimer disease and traumatic brain injury) to be used in implementing a case-mix reimbursement system.

Along with cost report reviews, Mr. Johnson assisted the state of North Carolina with updating the state's private ICF/MR Medicaid reimbursement process. The project included analyzing cost data to develop rate medians. Those medians were used to model rate impact for the state and individual providers. The project also required analysis between implementing either NC-SNAP or DDP assessment tools into the reimbursement methodology.

In addition, Mr. Johnson has worked on assisting the states of Indiana and Iowa on the electronic submission of long-term care cost reports. The projects included designing programs that can be transferred by electronic means from providers to the rate setting contractors. The programs have been designed to meet state filing requirements as well as assist the rate setting contractors to detect any deficiencies in the report.

He was involved in modeling revisions to the Residential Care Assistance Program (RCAP) reimbursement system in the state of Indiana. Mr. Johnson has projected expenditures to assist in budget analysis and to evaluate the effect of proposed changes to the reimbursement rates. He has also assisted in the modeling of the new reimbursement systems including the design of the new cost report form for the RCAP program.

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#### OTHER PROFESSIONAL EXPERIENCE

Mr. Johnson previously served as a staff accountant for five years at Charles A. Spillman and Company, PC. In this position, he audited financial statements and prepared tax returns for both corporate and individual clients. His clients included doctors' and lawyers' offices, manufacturers, and contractors. Mr. Johnson also performed budget analysis and prepared forecasts and projections for management purposes as well as for obtaining financing. He was the team leader on several software consulting engagements. He prepared income and payroll tax returns for both federal and state governments.

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## EDUCATION

B.S., Accounting, Indiana University/Purdue University at Indianapolis, Indiana,  
Kelley School of Business, Indianapolis, Indiana, 1999

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## AFFILIATIONS

American Institute of Certified Public Accountants  
Iowa CPA Society

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## REFERENCES

Gene Gessow  
158 Taber Avenue  
Providence, RI 02906  
Phone: (401) 474-2768  
E-mail: [egessow@aol.com](mailto:egessow@aol.com)

Robert Schlueter  
Iowa Medicaid Enterprise  
Provider Services Unit  
Account Manager  
100 Army Post Rd.  
Des Moines, IA 50315  
Phone: (515) 725-1399  
E-mail: [rschlue@dhs.state.ia.us](mailto:rschlue@dhs.state.ia.us)

Jeremy Morgan  
5116 Aspen Drive  
Norwalk, IA 50211  
Phone: (515) 681-4991  
Email: [jeremymorgan@maximus.com](mailto:jeremymorgan@maximus.com)

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David Ballard

*IT Project Manager*

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PROJECT TITLE

Manager – Information Technology

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SKILLS

Accounting Software	Medicaid/Medicare
Apache Web Server	MS Internet Information Server
C/C++	MS Office
Clipper	MS-DOS
COBOL	MySQL
Curriculum Development	Novell Netware
dBase	PHP
ETL (Extract,Translate,Load)	RUP
Formatting Objects (FOP)	Software Documentation
Foxbase for Macintosh	SQL Server
Foxpro for Dos	Telecom
FoxPro for Windows 2.6	Training Documentation
Government Contracting (State and Federal)	Transact-SQL
Computer Instructor (Software, Hardware, Networking, SQL)	Visual Basic 6
Insurance Industry	Visual Foxpro 3/5/6/7/8
Linux	MS Visual Studios 2005
	Windows 98/ME/NT/2000
	XML

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EXPERIENCE RELEVANT TO THIS PROJECT

Myers and Stauffer, May 2005 – Present

As an IT project manager and programmer for Myers and Stauffer, Mr. Ballard is responsible for developing documentation and conducting research, which will lead to a company IT Portal Web system to support project management and software development. Mr. Ballard is utilizing Visual FoxPro 8 to maintain the company's Iowa Medicaid rate setting application. Mr. Ballard is managing a development and upgrade project for the Kentucky office using Visual FoxPro 8. He is using RUP process to build documents prior to actual coding. The team consists of coders, testers, and business analysts. With two other project managers, Mr. Ballard started a PMO within the company to manage companywide projects, team with business units, and provide a consistent level project management effort. Mr. Ballard's accomplishments include creating a change control policy to control additions to the system. The policy cut down on unneeded software

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development by 50 percent. Mr. Ballard is currently overseeing a project to redevelop the Iowa IMCARS system using Microsoft Visual Studios, Visual C#, SQL Server, and ASP.Net.

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#### OTHER PROFESSIONAL EXPERIENCE

Mr. Ballard has over 34 years of combined work experience that includes 12 years of U.S. Navy radar, computer, communications, and teaching experience; and more than 22 years experience as a programmer using Clipper, Dbase, Foxpro, Visual Foxpro, C/C++, Visual Basic, Cobol, XML, and PHP; a DBA of MySQL, MS SQL Server, Xbase, and Access; Project Management using RUP; and technical instructor teaching database administration, networking, programming, and applications.

- Programmer; April 2002 – May 2005 Encompass Health Management Systems, West Des Moines, Iowa
- Instructor; February 2002 – March 2002 Vatterott College, Des Moines, Iowa
- Software Engineer; January 2001 – January 2002 Megaforce, Overland Park, Kansas
- Software Engineer; May 1996 – October 2000 Computer Task Group, West Des Moines, Iowa
- Programmer/Analyst; November 1995 - May 1996 Contractor, Virginia Beach, Virginia
- Programmer/Analyst; August 1992 – November 1995 User Technology Associates, Arlington, Virginia
- Programmer/Analyst; January 1992 – June 1992 SDC, Inc., Virginia Beach, Virginia
- Programmer Analyst; September 1991 – January 1992 MIC, Inc, Virginia Beach, Virginia
- Programmer/Analyst; January 1991 – September 1991 Contractor, Virginia Beach, Virginia
- Senior Systems Specialist; August 1987 – January 1991 Integrated Systems Analysts, Arlington, Virginia
- Chief Fire Controlman ( Electronics and Missile Systems); August 1975 – August 1987 US Navy, Various Locations

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#### EDUCATION

August 1998 C++ For Programmers, Des Moines, IA

May 1984 US Navy Service School, Virginia Beach, Virginia, completed computer and communications school.

June 1984 US Navy Instructional School, Norfolk, Virginia, Certified Navy Instructor

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April 1977 US NAVY Service School, completed 16 months of training that began with basic electronics and finished with radar systems

Cerritos Junior College, Norwalk, California

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## REFERENCES

Gene Gessow  
158 Taber Avenue  
Providence, RI 02906  
Phone: (401) 474-2768  
E-mail: [egessow@aol.com](mailto:egessow@aol.com)

Cathy Vanderlinden, RN  
Registered Nurse  
Iowa Foundation for Medical Care  
1776 West Lakes Parkway  
West Des Moines, Iowa 50266  
Phone: (515) 223-2900  
No known e-mail address

Mitch Wilson  
Programmer  
Iowa Foundation for Medical Care  
1776 West Lakes Parkway  
West Des Moines, Iowa 50266  
Phone: (515) 223-2900  
No known e-mail address

Scott W. Simerly, Ph.D.

*Manager*

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PROJECT TITLE

DRG/APC Technical Advisor

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EXPERIENCE RELEVANT TO THIS PROJECT

Myers and Stauffer LC, October 1996 – Present

Dr. Simerly joined Myers and Stauffer in 1996 and serves as a manager for the firm's inpatient and outpatient hospital reimbursement and physician reimbursement engagements with government health care agencies.

Dr. Simerly leads the firm's DRG recalibration and rebasing projects for the states of Iowa, Kansas, New Jersey, New Mexico, and West Virginia. He also leads the firm's outpatient prospective payment system engagements including the implementation of an APC system for West Virginia and a conversion of the Iowa APG system to an APC system. His responsibilities include the determination of hospital rates and case mix index factors, calculation of DRG relative weights and outlier thresholds, fiscal impact studies, management of databases, preparation of and other statistical analyses. He was involved in similar projects for the states of Colorado, North Carolina and Oregon.

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OTHER PROFESSIONAL EXPERIENCE

Dr. Simerly has provided analysis for a per diem inpatient hospital reimbursement system for the state of Louisiana. He is also involved in the evaluation of an outpatient prospective payment system for this state. His responsibilities include determining peer groups and payment rates.

Dr. Simerly assisted in the evaluation of the reimbursement of high cost drugs under the Health Care Financing Administration's proposed ambulatory patient classifications (APC) outpatient prospective payment system. He has developed specifications and procedures for a statewide health information database on subcontract with the Kansas Department of Insurance (through Miller and Newberg, Consulting Actuaries). He consulted with the state on database capabilities and design of appropriate queries.

In West Virginia, besides the annual updating of the DRG system he is responsible for an annual review of the RBRVS system and the determination of the annual rate update.

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He has also constructed modifiable reimbursement models comparing Kansas and Alaska physician reimbursement to surrounding states, Medicare and private insurance rates. In addition, he has performed statistical analysis of pharmacy survey information for engagements with the states of Kansas and Kentucky.

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#### EDUCATION

M.B.A., West Virginia University, Morgantown, West Virginia, 1996  
Ph.D., Chemistry, University of Illinois, Urbana, Illinois, 1991  
B.S., Chemistry, Iowa State University, Ames, Iowa, 1986

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#### PRESENTATIONS

“Price vs. Cost Reimbursement,” Myers and Stauffer Workshop, Indianapolis, Indiana, 2003.

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#### PUBLICATIONS

“Controls on the Premature Discharge by Hospitals to Post-Acute Providers,” Rutgers Center for State Health Policy, May 2008.

“Synthesis and Characterization of Tetratolyhydroporphyrins and their N-Methylated Derivatives,” Manuscript in preparation (Fall 1996).

“Synthesis, Characterization and Crystal Structure of [PPN][Re<sub>7</sub>C(CO)<sub>21</sub>P(OPh)<sub>3</sub>]. Stereodynamic Comparison with Isoelectronic Heptarhenium Carbido Clusters,” *Inorganic Chemistry*, 1992, 31, 5416.

“Comparative Reactivity Studies of [Re<sub>7</sub>C(CO)<sub>21</sub>Rh(CO)<sub>2</sub>]<sup>2-/1-</sup>. Evidence of Enhanced Inter- and Intramolecular Lability for a Metal Cluster Radical,” American Chemical Society Meeting, August 1990.

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#### REFERENCES

Ron Smith  
Kansas Health Policy Authority  
Room 900-N - Landon State Office Building  
900 SW Jackson Street  
Topeka, KS 66612  
Phone: (785) 296-4574  
E-mail: [Ron.Smith@KHPA.KS.gov](mailto:Ron.Smith@KHPA.KS.gov)

Michael Keevey  
Department of Human Services  
Division of Medical Assistance and Health Services  
7 Quakerbridge Plaza

---

Trenton, NJ 08619  
Phone: (609) 588-2980  
E-mail: [Michael.keevey@dhs.state.nj.us](mailto:Michael.keevey@dhs.state.nj.us)

Gloria Long  
PEIA Deputy Director for Insurance Programs & Services  
601 57th Street  
Charleston, WV 25304  
Phone: (304) 558-7850  
E-mail: [glong@wvadmin.gov](mailto:glong@wvadmin.gov)

Brian A. Jay

*Supervisor*

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PROJECT TITLE

DRG/APC Technical Advisor

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EXPERIENCE RELEVANT TO THIS PROJECT

Myers and Stauffer LC, November 2002 to Present

Mr. Jay serves as a supervisor for Myers and Stauffer. He performs analysis of state hospital reimbursement systems for Kansas, Louisiana, New Jersey, West Virginia and Iowa and physician reimbursement systems for West Virginia and California. He is responsible for reviews of hospital cost reports to determine actual costs for establishment of DRG base rates. Mr. Jay's duties include cost analysis of claims, review and modeling of hospital claims data to revise yearly payment procedures, and calculation of hospital rates and DRG or APC relative weights. He is also responsible for compilation of projected fiscal impact analysis of recommended changes in payment policies.

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OTHER PROFESSIONAL EXPERIENCE

Mr. Jay has performed analysis to create inpatient hospital reimbursement procedures for the states of Kansas, West Virginia, New Jersey and Iowa. His responsibilities include modeling recommended changes in payment procedures on historical claims data.

In addition to the annual update of the West Virginia inpatient DRG hospital reimbursement system, Mr. Jay has performed annual updates of the physician reimbursement system.

He performed data analysis of iterative computing algorithms to determine necessary conditions to insure calculation of solution. He also analyzed algorithms with regard to optimizing speed and computing resources required.

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EDUCATION

M.S., Mathematics, University of Connecticut, Storrs, Connecticut, 2001  
B.S., Mathematics, Temple University, Philadelphia, Pennsylvania, 1998

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REFERENCES

Robert J. Bollaro

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Department of Human Services  
Division of Medical Assistance and Health Services  
7 Quakerbridge Plaza  
Trenton, NJ 08619  
Phone: (609) 588-2980  
E-mail: [Robert.J.Bollaro@dhs.state.nj.us](mailto:Robert.J.Bollaro@dhs.state.nj.us)

Ron Smith  
Kansas Health Policy Authority  
Room 900-N - Landon State Office Building  
900 SW Jackson Street  
Topeka, KS 66612  
Phone: (785) 296-4574  
E-mail: [Ron.Smith@KHPA.KS.gov](mailto:Ron.Smith@KHPA.KS.gov)

Kent Hill  
Director of Financial Analysis and Rate Setting  
350 Capitol Street  
Room 251  
Charleston, WV 25301-3709  
Phone: (304) 558-4750  
E-mail: [Kent.S.Hill@wv.gov](mailto:Kent.S.Hill@wv.gov)

Patrice Padula RN

*Manager*

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PROJECT TITLE

Nurse Consultant

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CERTIFICATION

Registered Nurse, Licensed in the States of North Carolina, Louisiana, Indiana  
Resident Assessment Coordinator – Certified, RAC-CT  
Certified Nurse Executive, C-NE

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EXPERIENCE RELEVANT TO THIS PROJECT

Myers and Stauffer LC, 1995 to Present

Patrice Padula, a manager and consultant with Myers and Stauffer, has more than 34 years of experience in the nursing field as a registered nurse in which 23 years have been dedicated to Long Term Care. Ms. Padula interprets and analyzes data collected from the MDS 2.0 and teaches the RUG-III resident classification system in both the 34 and 53 grouper. Ms. Padula has assisted several states in designing and developing a case mix medical record review process for case mix systems and trained appropriate personnel and providers. Ms. Padula has also assisted in the development and design of an electronic case mix review software program. She trains and supervises clinicians on the case mix medical record review. She has published supportive documentation guidelines for various case mix states and is a certified resident assessment coordinator.

Ms. Padula served on the Correction Policy Committee for the Centers for Medicare and Medicaid Services (CMS) to develop and design the MDS correction policy nationally. She initiated and facilitated a monthly seven-state conference call for the purpose of case mix discussions as well as a quarterly national Medicaid case mix teleconference call that includes 34 states, CMS, and other national contractors and state personnel.

Currently, Ms. Padula is involved in the transition of the MDS 2.0 to MDS 3.0. She is actively working with CMS in this effort. She is also assisting in the updating of various MDS review programs and protocols including Supportive Documentation Guidelines, documentation tracking tools and MDS 3.0 application to the RUG-III classification methodology.

Ms. Padula's relevant experience includes:

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- North Carolina Division of Medical Assistance – February 2003 to Present

Currently, Ms. Padula serves as assistant project manager. In this capacity, she assisted in the design and implementation of the North Carolina MDS Validation review. She trained and supervises RNs in the field and developed the entire review process, from the work plan, work papers, and provider education, state facility training to the follow-up reports to the facility. She also provides technical direction to the Myers and Stauffer help desk, which assists facility staff regarding report questions. In addition, Ms. Padula has developed and presented state training workshops throughout the project.

Ms. Padula also coordinated with the North Carolina Division of Medical Assistance (DMA) the training of RNs to complete the MDS in the adult care home population. She modified the MDS 2.0 specifically for this population of clients. Once the minimum data sets were complete, the data was entered and analyzed and compared to North Carolina long-term care population. A report was presented to DMA with an analysis of this data comparison in August 2003 and December 2003.

- Louisiana Department of Health and Hospitals – September 2001 to Present

Ms. Padula currently serves as assistant project manager. In that capacity, she assisted in the design and implementation of the Louisiana Medicaid case mix review. She trained and supervises RNs in the field and developed the entire review process, from the work plan, work papers, and provider education, state facility training to the follow-up reports to the facility. She also provides technical direction to the Myers and Stauffer help desk, which currently assists facility staff regarding report questions. In addition, Ms. Padula has developed and presented state training workshops throughout the project annually.

- Indiana Office of Medicaid Policy and Planning – November 1995 to Present

As nurse consultant, Ms. Padula's responsibilities include development of training materials and providing training on various topics to providers statewide. She works closely with state personnel, performs facility visits throughout the state, and trouble-shoots program and user problems. In addition, she assists with clinical help desk calls. Ms. Padula has been directly involved in the development of the state case mix audit/review program for Medicaid since its inception.

- Kentucky Department of Medicaid Services – September 1999 to Present

As nurse consultant, Ms. Padula presented training seminars for the Commonwealth of Kentucky regarding the RUG-III resident 34-classification system, various state specific reports and implementation of the 1997 Update 3-Page Quarterly. Ms. Padula has been directly involved in the development of the case mix state audit/validation program for Medicaid and most recently the refinement of the reimbursement system. Ms. Padula presented seven seminars in

2008, preparing providers for transition from a Medicaid point in time reimbursement system to a time weighted reimbursement system.

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#### OTHER PROFESSIONAL EXPERIENCE

Director of Nursing, Ohio and Indiana - 1986 to 1995  
Director of Nursing, Indiana 1985 to 1986  
Registered Nurse/Nurse Supervisor, Indiana 1974 to 1985

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#### EDUCATION

C-NE – Certified Nurse Executive – Certified, 2009  
RAC-CT - Resident Assessment Coordinator - Certified, 2007  
CRNAC - Certified Registered Nurse Assessment Coordinator, 2002-2006  
B.A., Health Care Administration, Capital University, 1993  
A.D., Nursing, Sinclair Community College, 1974

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#### AFFILIATIONS

American Association for Long Term Care Nursing  
American Association of Nurse Executives  
American Association for Nurse Assessment Coordinators

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#### PRESENTATIONS

Ms. Padula has presented both nationally and internationally. A list of presentations may be made available upon request.

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#### REFERENCES

Judy Montfort, RN  
Nurse Service Administrator  
Department for Medicaid Services  
Long Term Care and Community Alternatives  
275 East Main Street, 6W-B  
Frankfort, Kentucky 40621  
Phone: (502) 564-5707  
E-mail: [judy.montfort@ky.gov](mailto:judy.montfort@ky.gov)

Lana Ryland, RN  
RN Manager  
Rate and Audit Review  
Louisiana Department of Health and Hospitals  
Bienville Building  
628 N. 4<sup>th</sup> Street  
Baton Rouge, LA 70821-9030

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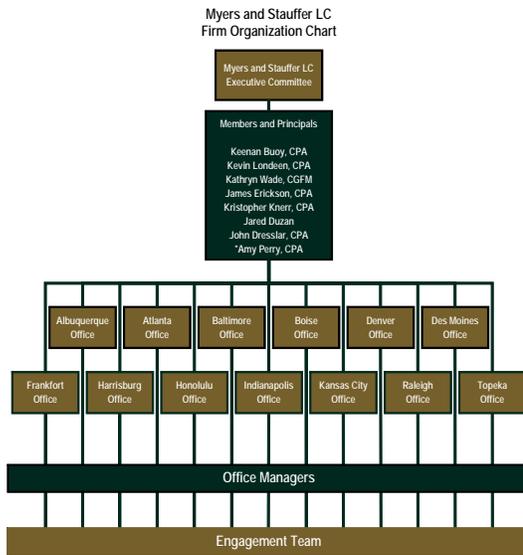
Phone: (225) 342-5255  
E-mail: [ana.ryland@la.gov](mailto:ana.ryland@la.gov)

Faith Laird, RN  
Deputy Director  
Division of Aging  
402 W. Washington St.  
P.O. Box 7083, MS21, Rm. W454  
Indianapolis, Indiana 46207-7083  
Phone: (317) 232-0604  
E-mail: [faith.laird@fssa.in.gov](mailto:faith.laird@fssa.in.gov)

## 9. Corporate Qualifications

### 9.1 Corporate Organization (RFP Section 7.2.9.1)

The following chart displays the corporate organizational structure of Myers and Stauffer. Amy Perry, CPA, a member with the firm, will continue to serve as account manager and have oversight of the Iowa Medicaid Enterprise project within the firm.



\* indicates oversight of IME project

#### History of the Organization (RFP Section 7.2.9.1 a)

Myers and Stauffer's certified public accounting practice is intentionally restricted to providing cost report verification, payment audits, rate setting and consulting services to state and federal agencies managing

government-sponsored health care programs. Staffed with professionals who have extensive knowledge and hands-on experience performing audits, desk reviews and a wide array of rate setting and consulting services, we have earned a reputation for being creative and innovative in assisting our clients to adapt to an ever-changing health care delivery system.

With 13 offices located nationwide, Myers and Stauffer's national practice has served Medicaid agencies in more than 35 states. We have performed engagements addressing many different categories of health care providers, including nursing facilities, hospitals, home health agencies, federally qualified health centers, rural health clinics and intermediate care facilities for the mentally retarded.

Our experience includes providing audit and desk review services, assisting in the development of state reimbursement systems, defending reimbursement rates and audit findings from health care providers' administrative and judicial challenges, and performing data management and analysis services to assist our clients in better managing their health care programs.

Medicare principles of reimbursement, cost reporting

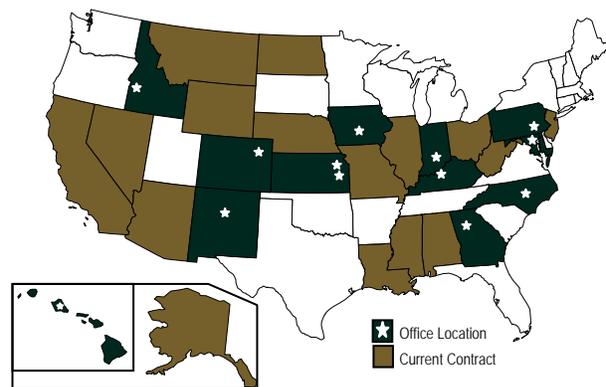
processes, policies and guidelines form the foundation upon which many Medicaid payment systems are built. Successfully serving state Medicaid agencies for more than 30 years, Myers and Stauffer professionals are familiar with the intricacies of the Medicare program – including Medicare cost reporting processes, allowable cost regulations, reimbursement and rate setting regulations and policies, and administrative processes that execute program requirements.

Our state Medicaid agency clients look to us to anticipate issues that will emerge and to ensure that the data needed to address problems is readily available. We are comfortable with change and believe it is our responsibility to assist our clients in evaluating their programs. As a result, our Medicaid clients are at the forefront of transitions to nursing facility case mix reimbursement and APC outpatient hospital reimbursement, and are involved with intergovernmental transfer and provider tax and other federal funding enhancement activities.

Myers and Stauffer is not your typical audit firm. While our skills and expertise with health care related audit and verification activities are unsurpassed, we are also a very talented consulting firm at the forefront of issues being addressed by Medicaid programs across the nation.

Myers and Stauffer's expertise has been gained from many diverse

experiences. Although no two state programs are exactly alike, our current experience working with more than 25 state Medicaid agencies, as illustrated on the following map, enables us to draw upon the best practices in the country to address the unique health care reimbursement needs in Iowa.



Our prior Medicaid cost report audit experience is extensive and spans a 30-year history. We have assisted our Medicaid clients in defending provider appeals and class action lawsuits. When requested, we have provided testimony as either fact or expert witnesses. Myers and Stauffer has extensive rate setting experience and has developed complex computer programs in support of our Medicaid agency clients' reimbursement systems.

Project Oversight Staff  
(RFP Section 7.2.9.1 b)

Myers and Stauffer's proposed project management team meets and exceeds all required qualifications. Managing this important project efficiently and professionally will be indispensable to the firm. Amy Perry,

CPA, will serve as the partner responsible for project direction activities. She will continue to serve as account manager and attend project meetings, direct activities of the project team, and be available to DHS staff on a daily basis. She is responsible for reviewing deliverables and coordinating the professional resources based on the work plan. Ms. Perry has been with the firm for 18 years with the past five years being dedicated to managing the provider cost audits and rate setting component of the IME. During these five years she has demonstrated her expertise and ability to perform the required services of this RFP.

Legal Structure  
(RFP Section 7.2.9.1 c)

Myers and Stauffer LC is a limited liability company organized in the State of Kansas and licensed to practice in Iowa.

In the fall of 1998, Myers and Stauffer LC entered into a transaction with Century Business Services, Inc (CBIZ). This transaction resulted in the creation of CBIZ M&S Consulting Services, LLC. CBIZ M&S Consulting Services LLC is wholly owned by CBIZ, Inc. As part of this business model, Myers and Stauffer LC acquires office space, personnel, and other business resources from CBIZ M&S Consulting Services, LLC. These resources, including personnel, are assigned exclusively to serve the clients of Myers and Stauffer LC.

The American Institute of Certified Public Accountants (AICPA) has reviewed our business structure and refers to this model as an alternative practice structure. AICPA professional standards provide specific guidance regarding independence within alternative practice structure firms. These professional standards are published in the Independence, Integrity and Objectivity section of the AICPA Code of Professional Conduct at ET Section 101.16.

Myers and Stauffer adheres to all professional standards of the AICPA, including the requirements of ET Section 101.16, preserving our independence with all health care providers addressed by the RFP. Myers and Stauffer LC avoids any conflicts of interest and circumstances that could create any real or perceived conflict of interest. Unlike our competitors, Myers and Stauffer LC does not accept health care providers as clients.

To further assert our ongoing compliance with professional standards, our firm is audited by an independent peer reviewer once every three years. The first outside peer review was completed for the year ending March 31, 1989, and subsequently every three years thereafter (i.e., 1992, 1995, 1998, 2001, 2004 and 2007). Since the inception of the AICPA Quality Review Program, Myers and Stauffer has been found to be in compliance with AICPA professional standards.

Myers and Stauffer LC is a member-owned certified public accounting firm and will perform all work area services outlined in the RFP.

Iowa Business License  
(RFP Section 7.2.9.1 d)

Myers and Stauffer is licensed to practice as a CPA firm in the State of Iowa. A copy of the firm's professional license and certificate of authority from the Iowa Secretary of State is included.



**STATE OF IOWA**

IOWA DEPARTMENT OF COMMERCE  
PROFESSIONAL LICENSING AND REGULATION



**STATE OF IOWA**

IOWA DEPARTMENT OF COMMERCE  
PROFESSIONAL LICENSING AND REGULATION

THE PERSON NAMED BELOW, HAVING MET THE REQUIREMENTS  
AND BEING IN GOOD STANDING IN OTHER RESPECTS, IS ISSUED

THIS IS TO CERTIFY THAT THE BELOW NAMED  
HAS BEEN GRANTED A PERMIT TO PRACTICE  
AS A FIRM OF CPA'S  
PERMIT NO. 2009-521 EXPIRES: 06/30/10

MYERS AND STAUFFER, LC  
9265 COUNSELORS ROW  
SUITE 200  
INDIANAPOLIS, IN 46240

Online license verification now available at: [www.LicensedInIowa.gov](http://www.LicensedInIowa.gov)

**Professional Licensing Bureau**

1920 SE Hulsizer Road  
Ankeny, Iowa 50021

The Professional Licensing Division licenses and regulates the following professions:

Accountants: <http://www.state.ia.us/iacc>  
(515) 281-5910

Architects: <http://www.state.ia.us/iarch>  
(515) 281-5910

Engineers & Land Surveyors: <http://www.state.ia.us/engls>  
(515) 281-4126

Interior Designers: <http://www.state.ia.us/ideb>  
(515) 281-5910

Landscape Architects: <http://www.state.ia.us/lsarch>  
(515) 281-7393

Real Estate Appraisers: <http://www.state.ia.us/iapp>  
(515) 281-4126

Real Estate Sales and Brokers: <http://www.state.ia.us/irec>  
(515) 281-7393

# IOWA

No. W00238771  
Date: 04/25/2000

## SECRETARY OF STATE

490FLC-000240079  
MYERS AND STAUFFER LC

### CERTIFICATE OF AUTHORITY

The Secretary of State acknowledges receipt of the following document:

Application for Certificate of Authority

The document was filed on April 24, 2000, at 08:12 AM, and the Certificate of Authority is effective as of April 24, 2000, at 08:12 AM.

The amount of \$100.00 was received in full payment of the filing fee.



*Chester J. Culver*  
\_\_\_\_\_  
CHESTER J. CULVER SECRETARY OF STATE



Community Partnership  
Relationships  
(RFP Section 7.2.9.1 e)

Myers and Stauffer's practice is limited solely to providing consulting services to state and federal governmental entities. Thus, our partnership relationship is dedicated to the Iowa Department of Human Services exclusively.

Similar Services  
(RFP Section 7.2.9.1 f)

The services described in the RFP represent a continuation of the tasks that Myers and Stauffer currently provides to the State. By virtue of this experience, our firm and our project team have a detailed knowledge of the State's reimbursement methodologies and the procedures necessary to properly administer them. As the incumbent contractor, we have provided the following services to DHS:

- Provider cost audits.
- Design, development and implementation of a case mix reimbursement system for nursing facilities.
- State MAC/utilization management.
- Reimbursement, upper payment limit.
- ICF/MR provider assessment.
- Payment accuracy measurement.

The following list includes similar projects on which Myers and Stauffer is presently working. We have been performing many of these projects

for several consecutive years. This list demonstrates that Myers and Stauffer has successfully completed projects virtually identical to the tasks identified in the RFP for several Medicaid programs. Furthermore, our ongoing multi-state experience further enhances our ability to perform the services under this project. For example, we will be able to draw upon our experience working with other Medicaid programs to update their DRG reimbursement systems when we perform this service for Iowa. The same benefits will also be present within the audit and other attest service areas.

We continually demonstrate the benefits of working with a CPA firm completely dedicated to public health care program support for its Medicaid agency clients, and we look forward to continuing to provide these benefits to Iowa.

Other Contracts  
(RFP Section 7.2.9.1 g)

The following table identifies Myers and Stauffer's current projects with state Medicaid agencies including contact information for the clients' contract administrators.

<b>State</b>	<b>Client</b>	<b>Project Description</b>	<b>Contact Person</b>	<b>Telephone</b>	<b>E-mail</b>
Alabama	Alabama Medicaid Agency	State Maximum Allowable Cost Reimbursement for Drugs	Kelli Littlejohn	(334) 353-4525	Kelli.Littlejohn@medicaid.alabama.gov
Alaska	Department of Health and Social Services	Medicaid Provider Audit	Douglas Jones	(907) 269-0361	<a href="mailto:douglas.jones@alaska.gov">douglas.jones@alaska.gov</a>
Alaska	Department of Health and Social Services	Disproportionate Share Hospital Audits	Neal Kutchins, CPA	(907) 334-2467	neal.kutchins@alaska.gov
Colorado	Department of Health Care Policy and Financing	Audit and Rate Setting for LTC Facilities	Diane Taylor	(303) 866-2336	<a href="mailto:Diane.taylor@state.co.us">Diane.taylor@state.co.us</a>
Colorado	Department of Health Care Policy and Financing	NF, Hospital, ICF/MRs Upper Limit Calculation	Diane Taylor	(303) 866-2336	<a href="mailto:Diane.taylor@state.co.us">Diane.taylor@state.co.us</a>
Georgia	Department of Community Health	Disproportionate Share Hospital (DSH) Consulting and Upper Payment Limit (UPL) Calculation	Carie Summers	(404) 657-4859	csummers@dch.state.ga.us
Georgia	Department of Community Health	Disproportionate Share Hospital Audits	Alec Steele	(404) 657-9541	asteel@dch.ga.gov
Georgia	Department of Community Health	NF Case Mix Services	Alec Steele	(404) 657-9541	asteel@dch.ga.gov
Hawaii	Department of Human Services	Audit and Rate Reimbursement Functions for Hawaii Medicaid Fee for Service Program	Reuben Shimazu	(808) 692-7983	rshimazu@mediciad.dhs.state.hi.us
Hawaii	Department of Human Services	Medicaid Case Mix Implementation	Reuben Shimazu	(808) 692-7983	rshimazu@mediciad.dhs.state.hi.us

<b>State</b>	<b>Client</b>	<b>Project Description</b>	<b>Contact Person</b>	<b>Telephone</b>	<b>E-mail</b>
Idaho	Department of Health and Welfare	Rate Calculations and Audits of Health Care Providers	Leslie Clement	(208) 334-5747	ClementL@dhw.idaho.gov
Idaho	Department of Health and Welfare	DSH, UPL and IGT	Leslie Clement	(208) 334-5747	ClementL@dhw.idaho.gov
Idaho	Department of Health and Welfare	Payment Error Rate Measurement	Leslie Clement	(208) 334-5747	ClementL@dhw.idaho.gov
Idaho	Department of Health and Welfare	State Maximum Allowable Cost Reimbursement for Drugs	Selma Gearhardt	(208) 364-1826	<a href="mailto:GearharS@dhw.idaho.gov">GearharS@dhw.idaho.gov</a>
Indiana	Office of Medicaid Policy and Planning	Hospital Payment Rate Setting and Audit Services	Pat Nolting	(317) 232-4318	Pat.nolting@fssa.in.gov
Indiana	Office of Medicaid Policy and Planning	Medicaid LTC Auditing Services	Pat Nolting	(317) 232-4318	Pat.nolting@fssa.in.gov
Indiana	Office of Medicaid Policy and Planning	Medicaid LTC Rate Setting Services	Pat Nolting	(317) 232-4318	Pat.nolting@fssa.in.gov
Indiana	Office of Medicaid Policy and Planning	Disproportionate Share Hospital, Intergovernmental Transfers, and Upper Payment Limits	Pat Nolting	(317) 232-4318	Pat.nolting@fssa.in.gov
Indiana	Office of Medicaid Policy and Planning	Payment Error Rate Measurement	Catherine A. Snider	(317) 234-2927	catherine.snider@fssa.in.gov
Iowa	Department of Human Services	Provider Tax, UPL and IGT	Patricia Ernst-Becker	(515) 725-1347	pernstb@dhs.state.ia.us
Iowa	Department of Human Services	Medicaid Enterprise Provider Audit and Rate Setting	Patricia Ernst-Becker	(515) 725-1347	pernstb@dhs.state.ia.us

State	Client	Project Description	Contact Person	Telephone	E-mail
Iowa	Department of Human Services	Payment Error Rate Measurement	Shellie Goldman	(515) 281-7315	
Iowa	Department of Human Services	Non-Traditional Medicaid Program	Deborah Johnson	(515) 725-1012	
Kansas	Department of Social and Rehabilitation Services	Recalibration and Rebased of DRG Reimbursement System	Ron Smith	(785) 296-4374	<a href="mailto:Ron.smith@khpa.gov">Ron.smith@khpa.gov</a>
Kansas	Department on Aging	Database Management and Rate Setting Services	Bill McDaniel	(785) 296-0700	Bill.McDaniel@aging.ks.gov
Kansas	Kansas Health Policy Authority	Disproportionate Share Hospital	Ron Smith	(785) 296-4374	<a href="mailto:Ron.smith@khpa.gov">Ron.smith@khpa.gov</a>
Kentucky	Department for Medicaid Services	UPL Calculations	Sharon Mercer	<b>(502) 564-7540</b>	
Kentucky	Department for Medicaid Services	Rate Setting for NF, IMD, PNF, ICF/MR/DD, Hospital, Hospice and Swing Bed Providers	Sharon Mercer	<b>(502) 564-7540</b>	
Louisiana	Department of Health and Hospitals	UPL/DSH Calculations and DSH Audit	<b>Debbie Gough</b>	<b>(225) 342-5201</b>	<a href="mailto:dgough@dhh.la.gov">dgough@dhh.la.gov</a>
Louisiana	Department of Health and Hospitals	Case Mix Rate Setting System and Develop and Operate MDS Validation Program	<b>Kent Bordelon</b>	Phone: (225) 342-1838	<a href="mailto:Kent.bordelon@la.gov">Kent.bordelon@la.gov</a>
Maryland	Department of Health and Mental Hygiene	Auditing, Accounting, and Consulting Services	James Miller	(410) 767-5427	<a href="mailto:millerj@dhh.state.md.us">millerj@dhh.state.md.us</a>

<b>State</b>	<b>Client</b>	<b>Project Description</b>	<b>Contact Person</b>	<b>Telephone</b>	<b>E-mail</b>
Maryland	Department of Health and Mental Hygiene	Agreed Upon Procedures, Related Accounting and Consulting Services for Managed Care Organizations (MCO'S)	James Miller	(410) 767-5427	<a href="mailto:millerj@dhmh.state.md.us">millerj@dhmh.state.md.us</a>
Maryland	Department of Health and Mental Hygiene	Disproportionate Share Hospital Audits	James Miller	(410) 767-5427	<a href="mailto:millerj@dhmh.state.md.us">millerj@dhmh.state.md.us</a>
Mississippi	Division of Medicaid	UPL Calculations and DSH Consulting	Dave Maatallah	(601) 359-6130	rbdam@medicaid.state.ms.us
Mississippi	Division of Medicaid	State Maximum Allowable Cost Reimbursement for Drugs	Judith P. Clark	(601) 359-6296	
Missouri	Department of Social Services	Payment Error Rate Measurement	Chris Stout	573-751-5958	chris.stout@dss.mo.gov
Montana	Department of Public Health and Human Services	Audits, Rate Setting and Consulting of Health Care Providers	Kelly Williams	(406) 444-4147	kewilliams@mt.gov
Montana	Department of Public Health and Human Services	Disproportionate Share Hospital Audits	Kelly Williams	(406) 444-4147	kewilliams@mt.gov
Nebraska	Department of Health and Human Services	Disproportionate Share Hospital Audits	Margaret Booth	(402) 471-9380	<a href="mailto:Margaret.Booth@nebraska.gov">Margaret.Booth@nebraska.gov</a>
New Jersey	Department of Health and Senior Services	LTC Facility Auditing	Ron Hibbs	(609) 588-3430	<a href="mailto:Ronald.hibbs@doh.state.nj.us">Ronald.hibbs@doh.state.nj.us</a>

<b>State</b>	<b>Client</b>	<b>Project Description</b>	<b>Contact Person</b>	<b>Telephone</b>	<b>E-mail</b>
New Jersey	Department of Human Services	Development and Implementation of an Inpatient Hospital Reimbursement System	Bob Bollaro	(609) 588-2668	<a href="mailto:Robert.J.Bollaro@dhs.state.nj.us">Robert.J.Bollaro@dhs.state.nj.us</a>
New Mexico	Human Services Department	Nursing Facility Audit, AUP's	Anna Bransford	(505) 827-3127	anna.bransford@state.nm.us
New Mexico	Human Services Department	Hospital Audit and Desk Review	Anna Bransford	(505) 827-3127	anna.bransford@state.nm.us
New Mexico	Human Services Department	UPL Calculations and DSH Consulting	Anna Bransford	(505) 827-3127	anna.bransford@state.nm.us
North Carolina	Department of Health and Human Services	MDS/Clinical Documentation Review and Training	Margaret Comin	(919) 855-4355	<a href="mailto:Margaret.comin@ncmail.net">Margaret.comin@ncmail.net</a>
North Carolina	Department of Health and Human Services	Medicaid Audit and Cost Report Analyses Program	Jim Flowers	(919) 647-8060	Jim.Flowers.dma@dhhs.nc.gov
North Carolina	Department of Health and Human Services	Disproportionate Share Hospital Audits	Roger Barnes	(919) 855-4183	Roger.Barnes.dma@dhhs.nc.gov
North Dakota	Department of Human Services	Medicaid Disproportionate Share Hospital Audit, Hospital Upper Payment Limit Calculations and Supplemental Payment and Critical Access Hospitals Cost Settlement	Barbara Fischer	701) 328-4578	bxfischer@nd.gov

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<b>State</b>	<b>Client</b>	<b>Project Description</b>	<b>Contact Person</b>	<b>Telephone</b>	<b>E-mail</b>
Pennsylvania	Department of Public Welfare	Case Mix Rate Calculation and Analysis	Bonnie Rose	(717) 772-2570	brose@state.pa.us
West Virginia	Public Employees Insurance Agency	PPS/RBRVS	Gloria Long	(304) 558-7850	glong@wvadmin.gov
Wyoming	Department of Health	Medicaid LTC Reimbursement Auditing	Lura Crawford	(307) 777-5382	lura.crawford@health.wyo.gov
Wyoming	Department of Health	Disproportionate Share Hospital Audits	Renee Propps	(307) 777-5081	renee.propps@health.wyo.gov
Wyoming	Department of Health	Payment Error Rate Measurement	Christine Bates	(307) 777-3594	christine.bates@health.wyo.gov

## 9.2 Corporate Experience (RFP Section 7.2.9.2)

Relevant Governmental Experience  
with Functional Areas of RFP

(RFP Section 7.2.9.2 a)

Myers and Stauffer provides data collection, management and analysis services to help our government clients assess Medicaid recipient health care needs, utilize resources and establish reimbursement/payment rates. We have experience working on both state-specific and nationwide issues. This experience provides our staff with direct knowledge of resident assessments, resource utilization measurement, payment options and verification systems available to government programs. We are able to draw upon this knowledge to assist our existing and new clients in addressing their unique health care challenges.

### ***Rate Setting, Cost Settlements and Cost Audits***

Myers and Stauffer's experience includes assisting Medicaid agencies with long term care facility reimbursement issues on engagements covering a wide spectrum of services. The list of long term care facility services we provide to states includes:

- Cost report desk reviews and audits.
- Cost report design and database development.
- Computerized payment/rate systems.

- Case mix reimbursement systems, including services that support:

1. Case mix weights, time studies and service screening initiatives.
2. Electronic MDS collection systems by providing clinical and MDS submission training, maintaining a help desk for technical assistance of provider submission, producing information newsletters and performing data verification/validation.
3. Payment system design, modeling and presentations of alternative payment systems and rule promulgation.
4. MDS verification design, provider training and technical support.

- Housing and administering the MDS/OASIS standard state data collection systems, including the provision of support for providers and agencies.
- Serving as state contract manager for HCFA's Multistate Nursing Home Case Mix and Quality (MNHCMQ) demonstration project.
- Consulting to states on Medicare cost reporting, and definitions of allowable costs and reimbursement issues that have an impact on Medicaid nursing facility cost and reimbursement.

- Assisting with state plan development, preparing Medicaid justifications and assisting with developing required assurances that must be submitted to CMS.
- Drafting Medicaid reimbursement regulations.
- Providing testimony in rate appeals or settlement disputes.
- Providing training to a Medicare Fiscal Intermediary on the prospective payment system including the RAI process, RUG classification and documentation to support the billing process.

Myers and Stauffer's experience

includes audits and desk reviews of nursing facilities, intermediate care facilities for the mentally retarded, hospitals, federally qualified health centers, rural health clinics, home health agencies and community residential facilities for developmentally disabled.

Myers and Stauffer processes nearly 5,000 cost reports annually, performing a variety of services including cost report verification, rate calculation and reimbursement settlement reconciliations. The following table illustrates our current annual cost report responsibilities, but does not reflect the multiple functions, such as desk reviews,

<i>Number of Health Care Provider Cost Reports Processed Annually for State Medicaid Agency Clients</i>							
<i>State</i>	SNF/NF	Hospital	ICF/MR	FQHC RHC	HHA	Other	Total
Colorado	206						206
Hawaii	31	27	3	14			75
Idaho	74	76	63	42	74		329
Indiana	475	54	500	8	175		1,212
Kansas	370	145	40				555
Kentucky	276	105	12				393
Louisiana	263		521			32	816
Maryland	254	30	4	6		29	323
New Jersey	140						140
New Mexico	80	48	41	24	40		233
Pennsylvania	660						660
Wyoming	36		4	1		13	54
<b>Total</b>	<b>2,865</b>	<b>485</b>	<b>1,188</b>	<b>95</b>	<b>289</b>	<b>74</b>	<b>4,996</b>

audits and rate calculations performed on an individual cost report.

Our Medicare/Medicaid cost settlement experience has been obtained under contract with state Medicaid agencies or under subcontracts for Medicare fiscal intermediaries (FI). In addition to our FI subcontracting experience, we have also obtained Medicare cost settlement experience by performing cost settlements for Medicaid programs that adopted Medicare retrospective cost settlement principles within the Medicaid state plan. Our Medicare/Medicaid cost settlement experience includes the states and provider services listed below.

As the chart illustrates, we have performed cost settlement services for several states for many years. Our staff is knowledgeable of Medicare/Medicaid reimbursement principles, settlement (cost reporting) software programs, and the proper application of settlement (claims) data issues.

### ***State Maximum Allowable Cost Program Rate Setting***

Myers and Stauffer has performed state maximum allowable cost (SMAC) rate setting activities for the states of Alabama, Indiana, Iowa, Idaho, Illinois, Louisiana, Mississippi and Wyoming. For these engagements, Myers and Stauffer participated in meetings with state officials and other stakeholders including local pharmacist associations. These meetings aided in making strategic policy and implementation decisions that would gain maximum cost savings while preserving the best possible relationship with the pharmacy industry. In all of these states, Myers and Stauffer provided critical assistance in SMAC policy design and subsequent rulemaking. After significant review of multi-source drug utilization, collection of acquisition cost data from participating pharmacies and statistical analysis, Myers and Stauffer has continuously set SMAC rates specific to the unique environments of each state and assisted in efforts to present new rates to the industry.

Medicare/Medicaid Cost Settlement Experience							
State	Service Term	Provider Type					
		NF	Hospital I/P	Hospital O/P	FQHC	RHC	HHA
Idaho	1992 – Present	Y	Y	Y	Y		
New Mexico	1995 – Present			Y	Y	Y	Y
Indiana	1995 – Present			Y	Y	Y	
Kentucky	1998 – Present		Y	Y	Y	Y	
Montana	1991 - Present				Y		
North Carolina	1998 - Present	Y	Y	Y	Y	Y	

In addition, Myers and Stauffer has conducted more than 40 pharmacy cost surveys in response to federal Medicaid regulations in more than a dozen states. Since 2006, our firm has performed pharmacy dispensing cost studies for Minnesota, Indiana, Louisiana, California, Idaho and Nevada.

We have reviewed and processed more than 15,000 pharmacy cost surveys and performed field visits at more than 600 pharmacies across the country. Our responsibilities have included developing the survey instrument, conducting desk reviews of information submitted by pharmacies, performing cost allocations and statistical analyses, and developing reimbursement options and recommendations. Several of our recent pharmacy studies have included the development of payment models. By virtue of this extensive experience, we have acquired a detailed understanding of the operations of retail pharmacies, including cost structures and the relationships that are part of distribution networks. We have collected and analyzed data from thousands of pharmacies, ranging from small independent operations to the largest national chains.

In conducting our pharmacy consulting practice, we have developed internal tools and resources to assist our state agency clients in evaluating their pharmacy programs. In addition to specialized application programs, we maintain online databases of *current and*

*historical* drug information, including National Drug Codes (NDC), generic code number (GCN), average wholesale price (AWP), federal upper limits (FUL), package sizes, etc. Similarly, we maintain a database of the current and historical state reimbursement formulas and related information (e.g., co-pays). In addition to these resources and in the course of our various pharmacy engagements, we have built proprietary databases, covering such areas as pharmacy costs, ingredient acquisition cost by product and type of pharmacy, and third-party and cash customer revenue by product and type of pharmacy.

Our Medicaid pharmacy practice includes analysis of policy issues and litigation support.

Myers and Stauffer's consulting practice has assisted states in the study and implementation of pharmacy reimbursement policy. In addition to cost and statistical analyses, our services have included policy analysis, provider relations, development of regulations and state plan amendments (and assistance in securing CMS approval), and litigation support.

***Rebasing and Diagnosis Related Group and Ambulatory Payment Classification Recalibration***

Myers and Stauffer has provided DRG rate setting and related consulting services to seven states: Alaska, Colorado, North Carolina, Kansas, Indiana, New Mexico and Oregon. The DRG system in Kansas was designed by Myers and Stauffer

and replaced their former per-diem reimbursement system. The firm has provided these states with reimbursement system options to address issues related to neonatal, psychiatric, and rehabilitation services. In servicing these DRG rate setting engagements, we have developed and refined specialized computer software tools that allow us to conduct the routine portions of the rate setting and modeling processes with superior efficiency. As a result, project team members are able to spend more time on analysis.

The firm's expertise in hospital rate setting is further enhanced through various hospital project work that we have performed in a number of other states. In recent years, Myers and Stauffer has provided rate setting, reimbursement system development support, and hospital cost report audits to government agencies in 12 states (including the seven DRG projects discussed above).

The firm also provides hospital cost report review, analysis and cost settlements for the states of Indiana, Idaho and New Mexico. We conduct hospital cost report audits for Medicaid agencies in New Mexico, Indiana, and Kentucky, and we conducted on-site financial studies of hospital cost reports for the Commonwealth of Pennsylvania as part of its initiative to develop new cost finding rules.

Myers and Stauffer has extensive experience with DRG and APC/APG grouping software and is a working partner with 3M (a common supplier

of inpatient and outpatient grouping software).

Myers and Stauffer is currently assisting West Virginia and Iowa with the development and refinement of ambulatory patient classification (APC)-based outpatient prospective payment systems (OPPS). In preparation for these engagements, Myers and Stauffer invested resources in the development of grouped classification systems for outpatient hospital services (APGs and APCs) for several years. As part of this process, Myers and Stauffer provided analytical services to CMS under contract with Kathpal Technologies. We were contracted to evaluate the reimbursement of high cost drugs under the then-proposed Medicare APC OPPS. Our recommendations resulted in the creation of additional APCs specifically for the purpose of reimbursement of certain drugs.

Myers and Stauffer has also provided hospital outpatient reimbursement system review and rate setting services to several states. For example, the State of Indiana utilizes a less complex prospective reimbursement system that includes Medicare's ambulatory surgery center (ASC) group payment rates; CPT-code fee schedules for laboratory, radiology services and other "stand-alone" services; and state-specific fee schedules for emergency room and treatment room services. The system incorporates partial bundling.

Myers and Stauffer analyzed the appropriateness and adequacy of rates in each of these areas based on provider costs, and has provided DHS with a set of recommendations for various rate adjustments. Our project was data-intensive, involving the summarization and analysis of two years of claims data, along with cost report and other information. The deliverables included fiscal impact models supporting the proposed rate adjustments.

In other related activities, Myers and Stauffer reviews and analyzes hospital outpatient claims data for the State of New Mexico and uses this to finalize cost settlements to providers under that state's retrospective reimbursement methodology. We provided consultation to the State of Alaska on the adequacy of outpatient rates and informally consulted on outpatient fee schedules and related matters with several of our inpatient hospital rate setting clients.

Myers and Stauffer has provided reimbursement analysis and rate setting assistance for physician services (including anesthesiology) and other ancillary services billed on the CMS-1500 to the states of West Virginia, Alaska, Indiana and Kansas. In these engagements, we worked with our state Medicaid agency clients to clarify policy objectives, studied comparative practices in neighboring states, prepared analyses of reimbursement policy options, conducted extensive claims data analyses, provided rate recommendations and developed fiscal impact models. The scope of

our engagement with Alaska required us to analyze and summarize physician claims data from both Alaska and the State of Washington.

### ***Reimbursement Technical Assistance and Support***

Myers and Stauffer specializes in reimbursement system design and rate setting for Medicaid programs. Over the past several years, we have designed reimbursement systems and set rates for Medicaid programs in 15 states. Areas of expertise include:

- Inpatient hospital: DRG, per diem and TEFRA-like systems.
- Outpatient hospital services: cost and price-based systems (APC and APG).
- ICF/MR: prospective price and cost-based reimbursement systems.
- Nursing facility and other LTC facilities: prospective cost and price-based reimbursement systems, including RUG case mix systems.
- Physician and practitioner reimbursement systems, procedural coding, fee schedule maintenance, and coverage policies and procedures.
- Dental reimbursement, maintenance and development of fee schedule, analysis of utilization trends, analysis of charges and growth factors.
- Transportation, basic/advanced life support ambulance, taxi, wheelchair vans, and common carrier analyses, procedure code

- maintenance, analysis of inflation factors, and fee development.
- Home health services: retrospective and prospective reimbursement systems.
  - Pharmacy dispensing fee and ingredient reimbursement (State MAC) systems.
  - Other ancillary medical services, such as durable medical equipment, medical supplies, blood factors, and physician administered drugs.

We are one of a few firms nationally that specialize in these areas. Our services include statistical and fiscal impact modeling, comparison with national practices, setting weights and defining allowable costs, developing computerized rate setting systems for client use, database development and drafting supporting regulations and state plan amendments.

Myers and Stauffer has a thorough understanding of the Medicaid health care environment, including eligibility guidelines, claims data, and coverage/payment policies and procedures. We have developed computer systems and analysis tools to efficiently conduct PERM eligibility reviews through standardized analytical protocols, quality assurance procedures, and a proprietary PERM information system, known as PERIS. We have worked closely with our clients on many high profile quality improvement projects that require a detailed knowledge of the Medicaid

and CHIP environments. We have extensive experience with Payment Error Rate Measurement (PERM) studies, and specialize in the review of Medicaid and CHIP eligibility determinations.

Myers and Stauffer has assisted its clients with payment error rate measurement projects since the beginning of the payment accuracy measurement (PAM) program in 2001.

As part of the PAM and PERM pilot projects, Myers and Stauffer conducted eligibility reviews for the states of Georgia, Indiana, Iowa, Kentucky and South Carolina. Over the course of the PERM demonstration, we completed 12 studies for the aforementioned states, as well as Idaho, although services provided to Idaho did not include eligibility review services. Myers and Stauffer successfully served as the PERM eligibility review contractor for the Indiana and Iowa Medicaid and CHIP programs for their participation in the federal fiscal year 2008 PERM requirements. We currently serve as the PERM eligibility review contractor for the Missouri and Wyoming Medicaid programs for their participation in the federal fiscal year 2009 PERM requirements.

***Disproportionate Share Hospital***

Myers and Stauffer has worked with several Medicaid programs assisting with the design, implementation and ongoing administration of their DSH programs. We help states to do the following:

- Fully utilize their federal DSH allotment.
- Comply with federal DSH eligibility and payments rules.
- Calculate DSH payments from reliable data sources.
- Direct their DSH funds where the needs are greatest.

Historically, states have used the DSH programs, when coupled with other federal funding mechanisms (IGT, CPE, and provider taxes), to increase federal participation in the funding of the Medicaid programs. To help our clients realize their goals for the DSH program, we have assisted in the following areas:

- Collecting data for use in the DSH program. Data sources typically include cost report information, Medicaid paid claims data, and hospital DSH survey information.
- Performing desk reviews and on-site audits of hospital DSH data.
- Calculating DSH eligibility/payments using federal criteria, as well as state specific criteria.
- Developing detailed DSH payment system models to assist Medicaid programs and hospital industry representatives in evaluating alternative DSH payment eligibility/payment methodologies.
- Drafting state plan language to implement alternative DSH payment systems.

- Attending meetings and assisting with the drafting of correspondence with CMS to facilitate state Medicaid programs obtaining federal approval of their DSH programs.

To accomplish these activities thoroughly and efficiently, we have several engagement tools that we rely upon when performing our DSH consulting projects:

- An internal work group established to study and evaluate federal DSH policies. This group produced a comprehensive document of current federal DSH regulations developed for the purpose of helping to ensure that our projects are performed in compliance with federal statutes.
- Detailed provider DSH surveys to assist our clients with the collection of needed information from hospitals when determining Medicaid DSH eligibility and payments under their approved state plans.
- Desk review and on-site audit programs for use in verifying the accuracy of DSH data.
- Sophisticated spreadsheets for modeling alternative DSH payment methodologies, and for determining DSH eligibility and payments under their approved programs.

All of these tools help to ensure our clients' satisfaction with our Medicaid DSH consulting and audit services. We believe our firm is unique in its ability to assist

Medicaid programs. Not only can we help Medicaid programs (and their hospital providers) develop DSH payment methodologies to address specific needs, but also, as a CPA firm, we can help ensure that the payment system is based on information that is accurate and defensible. Few, if any, other firms are able to provide this full spectrum of services to their clients.

Other bidders may assert that they have performed Medicaid DSH audits, however, since this is a new federal requirement, it is too early for DSH audits to have been performed in accordance with the December 19, 2008, Federal Rule. Furthermore, you may receive proposals from CPA firms that attempt to substitute a lower level service (i.e., agreed upon procedures) in place of an audit, the latter of which is required by the federal regulation. We caution the State to ensure that the final work product truly complies with a *certified* public audit of the Medicaid DSH program. Any lower level of service may subject the state to findings of inadequacy by CMS and/or the OIG.

Federal Medicaid DSH statutes and regulations are complex. Having worked with Medicaid programs gathering Medicaid and uninsured data and assisting states with the development of DSH payment systems that comply with federal statutes, regulations and other guidance from CMS has prepared us to perform the DSH audits thoroughly and in compliance with

federal requirements. We are confident when you look at the totality of our experience assisting states with DSH calculations, auditing hospital representations of uninsured services provided and payments received that Myers and Stauffer truly has the most broad-based relevant experience of any other CPA firm that may propose on this engagement. Moreover, CPA firms that do not have this broad-based DSH experience will likely struggle to properly apply complex federal criteria to the unique circumstances of DSH hospitals and Medicaid program features in Iowa during performance of the engagement. For example, independence requirements in the context of DSH audits are complicated. Firms without adequate experience in this area can easily misinterpret these standards. It is in the State's best interest to avoid similar misinterpretations that could affect the outcome of the Medicaid DSH audit.

In response to new DSH regulations required by the December 19, 2008, Federal Register, Myers and Stauffer has been contracted to perform DSH audits for 13 state Medicaid programs.

Our DSH assistance varies based on the individual state and its methodology, but normally includes such services as sending and receiving survey information, populating a database with variables used to calculate eligibility and reimbursement levels, performing desk and on-site reviews of reported

uninsured services and payments received, and preparing preliminary DSH payment calculations for the state's review and acceptance.

We have also assisted states in designing DSH payment methodology, preparing state plan amendments and communicating the DSH methodology to CMS.

We are currently under contract to perform DSH audits for the following state Medicaid programs:

- Alaska Department of Health and Social Services
- Georgia Department of Community Health
- Idaho Department of Health and Welfare
- Indiana Office of Medicaid Policy and Planning
- Kentucky Department for Medicaid Services
- Louisiana Department of Health and Hospitals
- Maryland Department of Health and Mental Hygiene
- Nebraska Department of Health and Human Services
- New Jersey Division of Medical Assistance and Health Services
- New Mexico Human Services Department
- Montana Department of Public Health and Human Services
- North Carolina Department of Health and Hospitals

- North Dakota Department of Human Services

Relevant Commercial Experience

(RFP Section 7.2.9.2 b)

Myers and Stauffer's practice serves governmental health care programs exclusively. The firm does not have a commercial practice.

Other Experience with Governmental Health Care Programs

(RFP Section 7.2.9.2 c)

Myers and Stauffer's practice is focused exclusively on serving governmental health care agencies. This experience was described in the relevant governmental experience section.

Project Summaries

(RFP Section 7.2.9.2 d)

We have included five project summaries to demonstrate Myers and Stauffer's most relevant government experience with the areas identified in the RFP. Myers and Stauffer served as the primary contractor for all projects listed.

<b>Project Summary 1</b>	
Title of Projects	<ul style="list-style-type: none"> <li>▪ Development of a Case Mix Reimbursement System for Nursing Facilities</li> <li>▪ Revenue Maximization</li> <li>▪ Technical Assistance</li> <li>▪ State Maximum Allowable Cost Reimbursement for Drugs</li> </ul>
Client Organization	Iowa Department of Human Services
Client Reference, Name, Title and Telephone Number	Eileen Creager, Bureau Chief Phone: (515) 281-5169
Original Contract Start/End Dates	2000 to Present
Total Contract Value	Year Ending December 31, 2008: Approximately \$3,300,000
Average Staff Hours in FTEs during Operations/ Workload Statistics	Approximately 28.5 FTE
Brief Description of Scope of Work	Myers and Stauffer's experience with the state of Iowa includes assisting in the development and implementation of a case mix reimbursement system for nursing facilities participating in the Iowa Medicaid Program. The firm was subsequently engaged to provide federal revenue maximization including upper payment limit calculations and develop State Maximum Allowable Cost (SMAC) reimbursement rates. Myers and Stauffer was also engaged to provide technical assistance on an ongoing basis.

<b>Project Summary 2</b>	
Title of Projects	<ul style="list-style-type: none"> <li>▪ Nursing Facility Audits</li> <li>▪ Long Term Care Rate Setting Services</li> <li>▪ Develop Case Mix Reimbursement System for Nursing Facilities</li> <li>▪ Disproportionate Share Hospital, Intergovernmental Transfers, and Upper Limit Payments</li> <li>▪ FQHC and RHC Rate Setting and Auditing Services</li> <li>▪ Rate Setting, Auditing, and Cost Settlement of Health Clinics</li> <li>▪ Hospital Payment Rate Setting and Audit Services including Outpatient and Inpatient Services</li> <li>▪ State Maximum Allowable Cost Reimbursement for Drugs</li> <li>▪ Utilization Management and Cost Containment</li> </ul>
Client Organization	Indiana Office of Medicaid Policy and Planning
Client Reference, Name, Title and Telephone Number	Karen Filler, Supervisor of LTC Reimbursement Phone: (317) 232-4651
Original Contract Start/End Dates	1982 to Present
Total Contract Value	Year Ending December 31, 2008: Approximately \$7,500,000
Average Staff Hours in FTEs during Operations/ Workload Statistics	Approximately 80 FTE
Brief Description of Scope of Work	Myers and Stauffer provides extensive Medicaid reimbursement consulting services to the state of Indiana. Our services include establishing Medicaid reimbursement rates for long term care providers such as nursing facilities, group homes and home health providers, accounting, auditing, data management, research and consulting. We conduct cost report desk reviews and audits and are responsible for rate setting for the state's prospective payment systems for outpatient and inpatient hospital services. We rebase prospective inpatient hospital rates (DRG and per diem) and set payment rates for the state's outpatient hospital prospective payments system. We provide utilization management and cost containment strategies.

<b>Project Summary 3</b>	
Title of Projects	<ul style="list-style-type: none"> <li>▪ Rate Calculations and Audits of Nursing Facilities, Intermediate Care Facilities for the Mentally Retarded, Federally Qualified Health Centers and Other Health Care Providers</li> <li>▪ Medicaid Nursing Facility Case Mix Rate Setting System</li> <li>▪ Hospital Cost Settlements and Rate Setting</li> <li>▪ State Maximum Allowable Cost Reimbursement for Drugs</li> <li>▪ Disproportionate Share Hospital Audits</li> <li>▪ Payment Error Rate Measurement</li> </ul>
Client Organization	Idaho Department of Health and Welfare
Client Reference, Name, Title and Telephone Number	Leslie Clement, Administrator Phone: (208) 334-5747
Original Contract Start/End Dates	1992 to Present
Total Contract Value	Year Ending December 31, 2008: Approximately \$1,850,000
Average Staff Hours in FTEs during Operations/ Workload Statistics	Approximately 18 FTE
Brief Description of Scope of Work	Myers and Stauffer has several ongoing concurrent engagements with the Idaho Department of Health and Welfare. These projects involve performing audits and rate calculations for nursing facilities, intermediate care facilities for the mentally retarded, federally qualified health centers and other health care providers in Idaho. We perform approximately 120 annual audits of Medicaid cost reports of health care providers. In addition, we provide rate calculations, interim and final cost settlements, and disproportionate share calculations for in-state and out-of-state hospital providers. We also calculate final cost settlements for hospital-based home health agencies and provide SMAC reimbursement consulting for the state's pharmacy program..

<b>Project Summary 4</b>	
Title of Projects	<ul style="list-style-type: none"> <li>▪ Audits and Rate Setting for Nursing Facilities, ICF/MR, HHA, Hospitals, FQHC, RTC, Hospices and ARTC</li> <li>▪ Waiver Validation Study</li> <li>▪ Disproportionate Share Hospital Audits</li> </ul>
Client Organization	New Mexico Human Services Department
Client Reference, Name, Title and Telephone Number	<p>Anna Bransford, Financial Manager</p> <p>Phone: (505) 827-3127</p>
Original Contract Start/End Dates	December 1995 to Present
Total Contract Value	Year Ending December 31, 2008: Approximately \$1,400,000
Average Staff Hours in FTEs during Operations/ Workload Statistics	Approximately 12 FTE
Brief Description of Scope of Work	<p>Myers and Stauffer has been engaged to perform annual desk reviews, field audits and settlement services of selected providers' financial and statistical records and rate setting for DRG and TEFRA hospitals since 1995. In addition, Myers and Stauffer was engaged to perform annual desk reviews, field audits and rate setting services for nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR), residential treatment centers (RTC), and accredited residential treatment centers (ARTC). The firm provided these services as a subcontractor from 1993 to 2002. Beginning in 2002, Myers and Stauffer became the sole contractor.</p> <p>Myers and Stauffer also provided cost-based financial information and a comprehensive rate analysis to evaluate the established rate structure and review policy and procedure issues in support of the Developmental Disabilities Waiver Program.</p>

<b>Project Summary 5</b>	
Title of Projects	<ul style="list-style-type: none"> <li>▪ Accounting, Auditing and Consulting</li> <li>▪ Disproportionate Share Hospital Audits</li> <li>▪ Agreed Upon Procedures, Related Accounting and Consulting Services for Managed Care Organizations</li> </ul>
Client Organization	Maryland Department of Health and Mental Hygiene
Client Reference, Name, Title and Telephone Number	James Miller, Deputy Director of Management and Program Analysis Phone: (410) 767-5427
Original Contract Start/End Dates	2006 to Present
Total Contract Value	Year Ending December 31, 2008: Approximately \$4,000,000
Average Staff Hours in FTEs during Operations/ Workload Statistics	Approximately 32 FTE
Brief Description of Scope of Work	<p>Myers and Stauffer provides nursing facility, hospital, residential treatment center, ICF-alcoholic and state facility auditing and rate setting services to all three regions in the state to ensure that medical assistance reimbursements are in compliance with state and federal laws and regulations. Myers and Stauffer was recently engaged to perform the federal DSH audit of the state's 2005 and 2006 DSH payments in accordance with the December 19, 2008, final Medicaid DSH rule. Myers and Stauffer provides agreed upon procedures and related accounting services to assure that Managed Care Organization's (MCO) expenditures are in compliance with State and Federal laws and regulations.</p>

### 9.3 Corporate References (RFP Section 7.2.9.3)

Myers and Stauffer has the reputation of being professional, knowledgeable, courteous and timely with its projects. The following three clients are able to provide a reference regarding the firm's performance providing services similar to the services described in the RFP. Reference letters are included on the following pages.

Reference One  
Anna Bransford  
Financial Manager  
New Mexico Human Services  
Department  
2025 S. Pacheco, Ark Plaza  
Santa Fe, NM 87505  
Phone: (505) 827-3127  
E-mail: [anna.bransford@state.nm.us](mailto:anna.bransford@state.nm.us)

Reference Two  
Leslie Clement, Administrator  
Idaho Department of Health and  
Welfare, Division of Medicaid  
P.O. Box 83720  
Boise, ID 83720-0036  
Phone: (208) 334-5747  
Fax: (208) 364-1811  
E-mail: [ClementL@dhw.idaho.gov](mailto:ClementL@dhw.idaho.gov)

Reference Three  
James Miller  
Deputy Director of Management and  
Program Analysis  
Maryland Department of Health and  
Mental Hygiene  
Office of Planning and Finance  
201 West Preston Street, Room 218  
Baltimore, Maryland 21201  
Phone: (410) 767-5427  
E-mail: [millerj@dhhm.state.md.us](mailto:millerj@dhhm.state.md.us)



# New Mexico Human Services Department

Bill Richardson, Governor  
Pamela S. Hyde, J.D., Secretary

Medical Assistance Division  
P.O. Box 2348  
Santa Fe, New Mexico 87504  
Phone: 505-827-3100

July 28, 2009

RE: Medicaid DSH Program Experience

To Whom It May Concern:

I am pleased to offer this letter as a professional reference for the firm of Myers and Stauffer LC. Myers and Stauffer has served the dual function of Medicaid audit/rate setting contractor for the state of New Mexico for more than 13 years.

Myers and Stauffer performs annual desk reviews, field audits and settlement services of selected providers' financial and statistical records and rate setting for outpatient hospital services, TEFRA hospitals and Distinct Part Units, FQHCs and HHAs. Myers and Stauffer has also assisted in designing our disproportionate share hospital (DSH) payment methodology and annually perform the DSH calculations for eligible hospitals, and were recently selected as our DSH audit contractor. Their work involves audit and reimbursement issues and requires an understanding of the entire reimbursement system, including facility operations and health care issues.

The New Mexico Medical Assistance Division chose to combine and subsequently outsource the audit/rate setting function in 1995 and have seen the benefits in increased program efficiencies, cost savings and overall effectiveness of the Medicaid program. I have found it personally beneficial to have access to a consultant that can serve as a resource on many reimbursement issues.

Myers and Stauffer staff are highly competent, accessible and thorough. They have a comprehensive understanding of the Medicaid reimbursement field and conduct themselves in a professional manner when working with state agency personnel as well as with providers of health care services. They are sensitive to the budget restraints within which state agencies must operate.

It is without reservation that I recommend the firm Myers and Stauffer to other state Medicaid programs. Should you have any questions, please do not hesitate to contact me at 505-827-3127.

Sincerely,

A handwritten signature in cursive script that reads "Anna Bransford".

Anna Bransford, Financial Manager  
Program Administration Bureau



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

DIRK KEMPTHORNE - Governor  
KARL B. KURTZ - Director

DAVIDA. ROGERS - Administrator  
DIVISION OF MEDICAID  
P.O. Box 83720  
Boise, ID 83720-0036  
PHONE 208-334-5747  
FAX 208-364-1811

April 27, 2005

To Whom It May Concern:

I am pleased to offer this professional reference for Myers and Stauffer LC. I have personally worked with Myers and Stauffer since 2001 in my capacity as an Idaho Medicaid Division Deputy Administrator.

Myers and Stauffer first began consulting to the state of Idaho in 1992, establishing its Boise office in April of that year to exclusively serve as the State's audit and rate setting contractor. The State's contract for these services has been up for renewal four times since then, with Myers and Stauffer as the successful bidder each time. Myers and Stauffer provides traditional audit, desk review, and rate setting/settlement calculations for a wide variety of provider types including nursing facilities, ICFs/MR, hospitals, FQHCs, HHAs and RHCs. In this capacity, the firm has developed a detailed understanding of the Idaho Medicaid reimbursement environment.

Over the years, Myers and Stauffer has established itself as more than an audit contractor for the state of Idaho. We have utilized the firm's nationwide consulting resources and multi-state experience on many occasions to address a multitude of issues facing the Idaho Medicaid program. Myers and Stauffer has met every challenge and, in doing so, has developed a valuable consulting relationship with our staff. They have also developed a reputation among the Idaho Medicaid provider community for common sense, data driven recommendations. They are the contractor we turn to first when a question arises. For example, Myers and Stauffer has provided the following services in addition to the rate setting contract:

- Transitioned our ICF/MR program from retrospective reimbursement to a prospective payment system in 1996.
- Developed our case-mix reimbursement system for nursing facilities, which was implemented July 1, 1999.
- Maintains our CMS database containing MDS and OASIS data.
- Provides training to providers regarding the submission of MDS and OASIS data and an ongoing help desk to assist providers with the transmission process.
- Performs annual disproportionate share hospital (DSH) calculations.
- Developed a State Maximum Allowable Cost (State MAC) program for reimbursement of generic drugs to pharmacy providers.

April 27, 2005

Page 2 of 2

Myers and Stauffer is sensitive to the budget restraints within which our state agency operates. It assigns highly competent staff to each of our projects and is accessible at all staffing levels. We have found the firm to be thorough, timely and accurate in its assignments. The staff have a comprehensive understanding of the Medicaid reimbursement field and conduct themselves in a highly professional manner when working with both state agency personnel and providers of health care services. Myers and Stauffer personnel have proven to be a valuable and effective resource for the state of Idaho.

It is without hesitation that the Idaho Division of Medicaid recommends Myers and Stauffer LC to other state Medicaid agencies requiring assistance in the field of health care reimbursement. Our Department has benefited from the firm's corporate commitment to our state, and considers the firm a "strategic partner" in addressing health care reimbursement needs for the most vulnerable populations in our state.

Sincerely,

A handwritten signature in cursive script that reads "Randy May".

RANDY MAY  
Deputy Administrator

RM/ksl



STATE OF MARYLAND

DHMH

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Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

May 8, 2008

To Whom It May Concern:

I am pleased to offer a professional reference for Myers and Stauffer LC (MSLC). I have worked directly with Myers and Stauffer LC for nearly two (2) years in my capacity as the Deputy Director of Management and Program Analysis in the Office of Finance of Maryland's Department of Health and Mental Hygiene (DHMH).

In July 2006, Myers and Stauffer LC opened its office in Baltimore, Maryland in response to a successful bid on audit and consulting services with our Department. To date, my experience has been that they are thorough, highly competent and able to meet time constraints as required. The scope of the contracts we have with Myers and Stauffer LC includes the following:

- Receipt and acceptance of Nursing Facility, Federally Qualified Healthcare Center (FQHC), Intermediate Care Facility for the Mentally Retarded (ICF/MR) and Hospital Cost Reports
- Desk review verifications of Nursing Facility, FQHC, ICF/MR and Hospital Cost Reports
- Limited scope field verifications of Nursing Facility, ICF/MR and Hospital Cost Reports
- Settlement Calculations based on results of cost report verifications
- Rate setting desk reviews to assist DHMH in setting annual interim rates
- Rate setting calculations for out of state hospitals
- Initial Rate Calculations for newly enrolled Providers
- Interim Rate Revisions as requested by Providers
- Support in Appeals for both Nursing Home and Hospital settlements
- Agreed Upon Procedures on financial data submitted by Medicaid Managed Care Organizations (MCOs)
- Special projects as assigned

Toll Free 1-877-4MD-DHMH • TTY for Disabled - Maryland Relay Service 1-800-735-2258

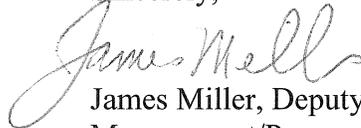
Web Site: [www.dhmh.state.md.us](http://www.dhmh.state.md.us)

In addition to services specifically required in our contracts, MSLC has demonstrated a willingness to partner with our agency and take an active role in helping us design and implement improvements to our systems. The firm played a significant role in the implementation of electronic cost reporting by Nursing Facilities in our State. This was a project that was in process for many years and has been successfully completed with Myers and Stauffer's assistance.

Myers and Stauffer LC is very responsive to our needs and staff members are accessible at all levels. Through Myers and Stauffer LC, we now have on-line access to the current status of audits in process and a section of their website is dedicated to Maryland's cost report forms and templates. These newly implemented resources have been a great improvement in communication between the Department, our contractor and the provider community.

I highly recommend Myers and Stauffer LC to other agencies seeking assistance with health care audit or consulting. The firm's partners and staff are knowledgeable, professional and have the broad-based health care experience that I find extremely valuable to our program. If you have any questions or would like to discuss my experiences with the firm, please contact me via phone at 410-767-5427 or e-mail [millerJ@dhhm.state.md.us](mailto:millerJ@dhhm.state.md.us).

Sincerely,



James Miller, Deputy Director  
Management/Program Analysis  
Office of Finance

#### 9.4 Felony Disclosures (RFP Section 7.2.9.4)

Neither Myers and Stauffer, nor any of its owners, officers or primary partners, have ever been convicted of a felony. We understand this is a continuing disclosure requirement. We agree that any such matter, which occurs after submission of the Bid Proposal and/or execution of a contract, will be disclosed in a timely manner in a written statement to the Department.

#### Collection and Remission of State Sales and Use Taxes

- RFP Attachment G: Certification of Compliance with Pro-Children Act of 1994
- RFP Attachment H: Certification Regarding Lobbying
- RFP Attachment I: Business Associate Agreement
- RFP Attachment J: Proposal Certification of Available Resources

#### 9.5 Certifications and Guarantees (RFP Section 7.2.9.4)

Myers and Stauffer agrees to the certifications and guarantees that appear in RFP Section 9 Attachments. The following attachments are included:

- RFP Attachment B: Proposal Certification
- RFP Attachment C: Certification of Independence and No Conflict of Interest
- RFP Attachment D: Certification Regarding Debarment Suspension Ineligibility and Voluntary Exclusion
- RFP Attachment E: Authorization to Release Information
- RFP Attachment F: Certification Regarding Registration,

# 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 Professional Services 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.

Amy C. Perry 12/3/09  
Name Date

Member

Title

Myers and Stauffer LC

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.

Amy C. Perry 12/3/09  
Name Date

Member  
Title

Myers and Stauffer LC  
Name of Bidder Organization

# Attachment E: Authorization to Release Information

## AUTHORIZATION TO RELEASE INFORMATION

Myers and Stauffer LC (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.

Amy C. Perry 12/3/09  
Name Date

Member  
Title

Myers and Stauffer LC  
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

Myers and Stauffer LC [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).

Myers and Stauffer LC [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.

Amy C. Perry 12/3/09  
Name Date

Member  
Title

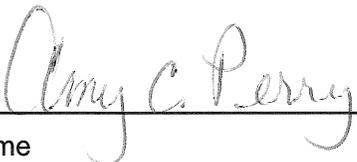
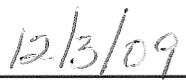
Myers and Stauffer LC  
Name of Bidder Organization

# 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.

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Name Date

Member  
 Title

Myers and Stauffer LC  
 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 constitute 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, 1<sup>st</sup> Floor, DDM  
Des Moines, IA 50319

Contract Information	
Contract Number	Contract Title
Contractor Contact Information	
<b>Contact Person for this Incident:</b>	Amy Perry
<b>Contact Person's Title:</b>	Member
<b>Contact's Address:</b>	100 Army Post Road, Des Moines, IA 50315
<b>Contact's E-mail:</b>	aperry@mslc.com
<b>Contact's Telephone No.:</b>	(515) 725-1258

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
N/A	N/A
Detailed Description of the Breach	
N/A	
Types of Unsecured Protected Health Information involved in the Breach (such as full name, SSN, Date of Birth, Address, Account Number, Disability Code, etc).	
N/A	
What steps are being taken to investigate the breach, mitigate losses, and protect against any further breaches?	
N/A	
Number of Individuals Impacted	If over 500, do individuals live in multiple states?
N/A	N/A    YES   NO

Signature: Amy C. Perry                      Date: 12/3/09



## 10. Appendix

- A. Sample NF and ICF/MR Desk Review Program - Confidential
- B. Sample CAH Cost Settlement Program - Confidential
- C. Sample FQHC Cost Settlement Program – Confidential
- D. Sample CMHC Desk Review and Cost Settlement Program – Confidential
- E. Sample NF/ICF/MR Audit Program - Confidential
- F. Sample Audit Questionnaire - Confidential
- G. Sample SMAC Reports – Confidential
- H. Sample DRG and APC Rebase and Recalibration Reports – Confidential