Iowa Medicaid Enterprise Professional Services Request for Proposal

RFP MED-10-001

Incorporating Amendments 01 and 02

Release Date: September 17, 2009
Proposal Due Date: December 10, 2009

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

Fields of Opportunities

STATE OF IOWA

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

DEPARTMENT OF HUMAN SERVICES
CHARLES J. KROGMEIER, DIRECTOR

September 17, 2009

Dear bidders:

Thank you for your interest in the Iowa Medicaid Enterprise Professional Services Procurement. You are invited to submit bid proposals in accordance with the attached Request for Proposals (RFP) # MED-10-001. The Department of Human Services (the Department) will select contractors to provide the services described in this RFP.

Bidders may offer bid proposals on any or all components. Each individual component proposal must be self-sufficient. Bidders must submit each component proposal separately according to the submittal requirements described by this RFP.

The Department will hold a bidders' conference on the date listed in RFP Section 2.1 Procurement Timetable at 10:00 a.m., Central Time, in the auditorium at the Wallace Building, which is a state office building located at 502 E 9th Street in Des Moines, Iowa, 50309. Although attendance at the bidders' conference is not a mandatory requirement for submission of a proposal, the Department strongly encourages bidders to attend. For the purpose of clarifying the RFP's contents, bidders may submit written questions by Wednesday, October 21, via e-mail to: *medicaidrfp@dhs.state.ia.us*. **All bid proposals must be submitted by December 10, 2009, at or before 3:00 p.m. to**:

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

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

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

The Department looks forward to receiving your bid proposals.

Regards,

Mary Tavegia
Issuing Officer, RFP MED-10-001
Iowa Department of Human Services

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REVISION HISTORY

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

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

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

Revision History Table

Section	Revision Description
Amendment 01	
6.2.1.2.h	Perform the functions of a CMS-designated Quality Improvement Organization (QIO) **or CMS-designated QIO-like organization** on behalf of the Iowa Medicaid Program in accordance with 42 CFR 431.630.
6.2.3.1.d	Contract with a CMS-designated QIO **or CMS-designated QIO-like organization** to perform prior authorization and preadmission review of selected services.
Amendment 02	
1.1	Removed SURS component, which will be included in a separate RFP for a Program Integrity component. That component also will include common analytical tools and associated analytical resources for use throughout the IME plus SURS and MARS services and system functions.
3.3.77.b	Disease management ~~(Medical Services)~~
6.0	• 6.1 General Requirements for All Components • 6.2 Medical Services • 6.3 Pharmacy Medical Services • 6.4 Provider Services • 6.5 Member Services • 6.6 Revenue Collections ~~• 6.7 Surveillance and Utilization Review Services (SURS)~~ • 6.7~~8~~ Provider Cost Audits and Rate Setting (PCA) • 6.8~~9~~ Estate Recovery Services
6.1.1.1.c	Medical director (only for the Medical Services **and Member Services contractors**).
6.1.1.1.1	Figure 4, Key Person column: Medical director (Medical Services **and Member Services units** only)
6.1.1.1.1	Figure 4, Qualifications column: **Medical Services contractor's medical director will be the Chief Medical Director for the IME.**
6.1.1.1.1	Figure 4, Special Requirements column: **Medical Services Medical Director ~~M~~must be on site and** 100 percent dedicated to the Iowa Medicaid project.

6.1.3.4.3.1.a	Services performed by the Medical Services contractor that are included in annually reported performance standards are care management, prior authorization (except pharmacy prior authorization), ~~disease management, enhanced primary care case management,~~ long term care assessments, ~~lock-in and member education,~~ and reduction in the use of emergency room care, together with the identification and promotion of best practices for acute, long term and preventive health care under the direction of the medical director.
6.1.3.4.3.1.a.1	$~~6~~ 10 million in SFY 2011
6.1.3.4.3.1.b	~~Should the activities cause the state to realize state savings in any year in excess of the above savings for the year, the excess (but not any deficit) shall be credited towards the state savings for the succeeding year.~~
6.1.3.4.3.1.c	Became 6.1.3.4.3.1.b.
6.1.3.4.3.2.c	~~Should the activities cause the state to realize state savings in any year in excess of the above savings for the year, the excess (but not any deficit) shall be credited towards the state savings for the succeeding year.~~
6.1.3.4.3.2.d	Became 6.1.3.4.3.2.c.
6.1.3.4.3.2.e	Became 6.1.3.4.3.2.d.
6.1.3.4.3.4.d	Services performed by the Member Services contractor that are included in annually reported performance standards are lock-in and member health education program (MHEP), disease management, and enhanced primary care management. The Member Services contractor's performance will result in measurable state savings (including cost avoidance) as follows: 1. $15 million in SFY 2011, $16 million in SFY 2012 and $17 million in SFY 2013 2. In every subsequent option year, an increase of 7 percent more than the SFY 2013 state savings or an increase of 7 percent more than the highest overall state savings in any year after SFY 2011, whichever is higher
6.1.3.4.3.6	~~6.1.3.4.3.6 Surveillance and Utilization Review Services~~ ~~a. The SURS contractor will recover no less than 350 percent of the total state cost of SURS activities.~~ ~~b. Should the activities described in this subsection cause the state to realize state savings in any year in excess of the above specified state savings for the year, the excess (but not any deficit) shall be credited towards the state savings in the succeeding year.~~ 6.1.3.4.3.6~~7~~ Provider Cost Audit and Rate Setting
6.1.3.4.3.6.c	~~Should the activities cause the state to realize state savings in any year in excess of the above savings for the year, the excess (but not any deficit) shall be credited towards the state savings for the succeeding year.~~
6.1.3.4.3.7	6.1.3.4.3.~~8~~7 Estate Recovery Services
6.1.3.4.3.7.b	~~Should the activities cause the state to realize state savings in any year in excess of the above savings for the year, the excess (but not any deficit) shall be credited towards the state savings for the succeeding year.~~
6.1.3.4.3.8	6.1.3.4.3.8 is no longer used.
6.2	Medical Services includes an array of professional and medical activities to support claims adjudication, program evaluation and quality assessment including the following functions: general medical and professional support; ~~disease management; care management;~~ prevention and promotion, which includes early and periodic screening, diagnosis and treatment (EPSDT) support; prior authorization for medical and professional services (excluding pharmacy prior authorizations), quality of care evaluation for managed care and long-term care (LTC) participants, and LTC reviews. The following topics describe the functions associated with the Medical Services component:

	• 6.2.1 Medical Support ~~• 6.2.2 Disease Management~~ ~~• 6.2.3 Enhanced Primary Care Management~~ • ~~6.2.4~~ 6.2.2 Children's Health Care Prevention and Well-Child-Care Promotion • ~~6.2.5~~ 6.2.3 Medical Prior Authorization • ~~6.2.6~~ 6.2.4 Long-Term Care (LTC) Reviews ~~• 6.2.7 Lock-In~~ • ~~6.2.8~~ 6.2.5 Quality of Care • 6.2.6 Health Information Technology ~~6.2.9 Medicaid Value Management Program~~
6.2.1.2.k	Use the medical and professional staff and consultants to support the Department in responding to appeals on prior authorizations or other denials of coverage including claims inquiries, requests for exceptions to policy related to coverage of services, or other medical issues. The medical and professional staff or consultants, as appropriate, are required to attend appeal hearings and provide expert testimony in respect to their decisions on prior authorizations or other medical necessity cases. Medical and professional staff and consultants will also attend meetings with providers or other stakeholder groups in support of the Department programs and as requested by the Department. **The Medical Services contractor's medical director will be the ultimate authority for medical decisions and will coordinate with the medical director of the Member Services contractor.**
6.2.2	~~6.2.2 Disease Management~~ ~~Disease management is an innovative intervention for improving care, outcomes, and costs for individuals with certain disease conditions. The use of quality indicators that reflect accepted guidelines for members with specified disease processes and address many of the disease-related objectives of Healthy People 2010 that can improve the quality of care for members and use resources efficiently.~~ ~~Disease management is an organized, proactive approach to healthcare delivery that engages the member in self-management of their disease. Because many diseases are controlled primarily by the member living with the disease, an emphasis on self-management support is a means to change behaviors to improve disease control and health status. Key components of disease management are identification of the population with specified diseases, evaluation of candidates for disease management based on cost effectiveness guidelines, and use of recognized practice guidelines or performance standards for managing identified members. It is also imperative that the providers of service associated with members be involved with the education and intervention developed by the contractor.~~ ~~The Medical Services contractor will be required to develop a limited disease management protocol for non-HMO members, for presentation and approval by the Department. The contractor may propose a risk-based provision that would allow the contractor to assume limited risk for the outcomes of the disease management population, in exchange for receiving a bonus for positive outcomes. Performance standards will be identified and agreed upon in the final contract based upon the disease management approach that the successful bidder proposes.~~ ~~The data sources for the Disease Management function are:~~ ~~a. Service utilization data from paid claims, encounters and Healthplan Employer Data and Information Set (HEDIS) findings~~ ~~b. Medical profile indicators from disease management protocols~~ ~~6.2.2.1 State Responsibilities~~ ~~a. Approve the clinical guidelines and requirements for enrollment in the disease management program.~~ ~~b. Review and approve the contractor's proposal for and any expansion to the disease~~

	~~management program.~~ ~~c. Monitor the activities of the contractor as they relate to the educational activities and clinical regimens developed and applied by the contractor.~~ ~~d. Require changes in the plan for management of individually identified members or the program parameters as a whole, based on review of contractor's activity.~~ ~~e. Supply access to the MMIS data Point of Sale (POS) data or enterprise data warehouse tools and data stored therein.~~ ~~6.2.2.2 Contractor Responsibilities~~ ~~a. Meet the following objectives:~~ ~~1. Improvement of health status for selected members with chronic conditions.~~ ~~2. Reductions in costs for high users of services who have specific medical maladies covered under the disease management program.~~ ~~3. Design of protocols for better management of chronic diseases.~~ ~~b. Maintain the following interfaces:~~ ~~1. MMIS and Data Warehouse/Decision Support (DW/DS) system for information on providers, members, services and costs~~ ~~2. Communication with providers participating in the disease management protocols~~ ~~3. Any contractor that may analyze data~~ ~~c. Obtain all data files necessary to accomplish the goals of the program.~~ ~~d. Use recognized guidelines to review disease classes that may be amenable to intervention. This universe will include, at a minimum, diabetes, congestive heart failure, asthma and juvenile asthma. The contractor may suggest other disease processes that might show significant positive health outcomes and subsequent reductions in overall cost to the Department.~~ ~~e. Undertake studies as directed by the Department.~~ ~~f. Prepare an annual proposal identifying potential diseases and/or individual members for development of a program in disease management and present the proposal to the Department. Include any criteria that the Department requests.~~ ~~g. Submit clinical guidelines and enrollment requirements to the Department for approval prior to enrolling members in the disease management program.~~ ~~h. Enroll members in the disease management program.~~ ~~i. Develop reports and other monitoring devices as requested by the Department to demonstrate the results of the program.~~ ~~j. Report on clinical outcomes experienced by the enrolled members on a proposed schedule approved by the Department. These reports would include self assessments of health status and physician assessments of member health status.~~ ~~k. Obtain Department approval before undertaking outreach to members or providers of service regarding disease management programs. Report outcomes of the Department-approved outreach to the Department.~~ ~~l. Develop and obtain Department approval of the methodology to be used in reviewing Medicaid utilization data to identify new diseases to be added as disease management candidates.~~ ~~m. Report to the Department, annually, on the cost effectiveness of the disease management program, including base line service utilization data and overall health status, intervention during the year, new baseline health status and cost, plus changes in utilization and cost. Outline the methodology for this analysis based on claims data to a level of detail that enables Department staff to substantiate the report's content.~~ ~~n. Any enrolled member who has designated a primary care or primary medical provider will have that provider involved with the management of the member. This means that the active medical management of the member may only be done with the consultation and approval of the primary~~

	~~medical provider.~~ ~~o. Coordinate with the Iowa Plan for persons enrolled in the Iowa Plan with physical diseases that have a mental health or substance abuse issue or who are referred from the Iowa Plan due to physical issues'.~~ ~~p. Prepare a monthly report of member participation in disease management program, their service utilization and cost.~~ ~~q. Send enrolled members a satisfaction survey within 10 business days of the member's sixth and twelfth month of enrollment.~~ ~~6.2.2.3 Performance Standards~~ ~~a. Complete initial health status assessments for each member within 30 days of enrollment.~~ ~~b. Complete health status assessments on all members who have been enrolled for at least one year within 30 days of the anniversary date of the member's enrollment.~~ ~~c. Make recommendations for at least six studies that the Department agrees are valid.~~
6.2.3	~~6.2.3 Enhanced Primary Care Management~~ ~~In addition to the MediPASS primary care case management program, the Department operates an enhanced primary care management program for members with high costs or high utilization of services. A primary care provider is responsible for providing or authorizing certain Medicaid services for these members. Medicaid members in the enhanced primary care management program receive all Medicaid services to which they are entitled. Iowa Medicaid State Plan services are included, except emergency services, transportation, family planning, mental health and substance abuse services; annual eye examinations, and school-based or well-child clinics. All optional services and other services not specifically mentioned above are not managed.~~ ~~The data sources for the enhanced primary care management function are:~~ ~~a. Interviews with member, family, service providers, current service workers, or case managers or other applicable sources~~ ~~b. Copies of medical records or previously accessed/authorized services plans~~ ~~c. Program policies for LTC eligibility~~ ~~d. Claim information~~ ~~e. Care management member satisfaction survey~~ ~~6.2.3.1 State Responsibilities~~ ~~a. Provide guidelines for qualifications of contractor staff and primary care providers who will perform the enhanced primary care management functions.~~ ~~b. Provide written policy regarding care management.~~ ~~c. Provide written guidelines for an appeal process.~~ ~~d. Provide referrals for care management to the Medical Services contractor.~~ ~~e. Monitor the performance of the care management process.~~ ~~f. Approve care management edits and audits.~~ ~~6.2.3.2 Contractor Responsibilities~~ ~~a. Meet the objective to improve access to needed care and to reduce unnecessary and inappropriate utilization and costs.~~ ~~b. Maintain the following interfaces:~~ ~~1. Members referred for care management~~ ~~2. Case managers~~ ~~c. Accept referrals for care management upon request from the Department.~~ ~~d. Obtain additional information that is needed from the member's medical providers to determine the individual's need.~~

	~~e. Perform a prescreening assessment on each member referred for care management.~~ ~~f. Provide professional medical staff to perform the care management functions.~~ ~~g. Prepare care plans for each member receiving care management and maintain documentation.~~ ~~h. Notify members and the Department of the results of the prescreening assessment in a format determined by the Department.~~ ~~i. Respond to phone calls regarding members enrolled in care management.~~ ~~j. Survey members regarding satisfaction of care management activities.~~ ~~k. Identify outliers in cost, utilization and treatment patterns that could benefit from enhanced primary care management and provide recommendations to the Department.~~ ~~l. Submit reports in a format and frequency approved by the Department.~~ ~~1. Summary of care management activities and services authorized for members~~ ~~2. Comparison of services and funding prior to and after receiving care management~~ ~~3. Summary of satisfaction survey of members~~ ~~4. Length of time that members receive care management~~ ~~m. Participate in meetings and develop a plan to review claims data for foster care children to determine compliance with current EPSDT standards. When outliers are noted, the care management team would get involved to intervene as necessary. For psychotropic medications, the IME will transfer data to Magellan and request that they perform a review to determine that the right medications are being prescribed at the right intervals.~~ ~~6.2.3.3 Performance Standards~~ ~~a. Upon referral, complete initial member contact for care management services for 95 percent of the members within five business days.~~ ~~b. Maintain a minimum enrollment of 50 members.~~ ~~c. Send enrolled members a satisfaction survey within 10 business days of the member's sixth month of initial enrollment and annually on the anniversary of their enrollment.~~ ~~d. Contact 95 percent of the care-managed members within one business day following discharge from hospital.~~ ~~e. Demonstrate cost-avoidance through a decrease in emergency room visits annually for members enrolled for at least 11 of 12 months.~~ ~~f. Demonstrate cost-avoidance through a decrease in hospitalizations annually for members enrolled for at least 11 of 12 months.~~
6.2.4	~~**6.2.4**~~6.2.2 Children's Health Care Prevention and Well-Child-Care Promotion
6.2.4.1	~~6.2.4~~6.2.2.1 State Responsibilities
6.2.4.2	~~6.2.4~~6.2.2.2 Contractor Responsibilities
6.2.4.3	~~6.2.4~~6.2.2.3 Performance Standards
6.2.5	~~**6.2.5**~~6.2.3 Medical Prior Authorization
6.2.5.1	~~6.2.5~~6.2.3.1 State Responsibilities
6.2.5.2	~~6.2.5~~6.2.3.2 Contractor Responsibilities
6.2.5.2.c (now 6.2.3.2.c)	Provide professional medical staff to perform prior authorization on certain services, including a full-time, **on-site** medical director (an experienced managing physician who can be an MD or DO), nurses, and peer consultants (such as psychologists, dentists, therapists and other medical professionals) with recognized credentials in the service area being reviewed. These medical consultants must be licensed or otherwise legally able to practice in the state of Iowa and possess the professional credentials to provide expert witness testimony in hearings or appeals.

6.2.5.2.i (now 6.2.3.2.i)	Review all requests for prior authorizations that are required for services as well as prior authorization requests that providers submit when ambiguity exists as to whether a particular item or service is covered. ~~PA requests, d~~**D**etermine whether the service to be provided is medically necessary and appropriate and whether the service should be approved, denied or modified.
6.2.5.3	~~6.2.5~~6.2.3.3 Performance Standards
6.2.6	~~**6.2.6**~~6.2.4 Long-Term Care (LTC) Reviews
6.2.6.1	~~6.2.6~~6.2.4.1 State Responsibilities
6.2.6.2	~~6.2.6~~6.2.4.2 Contactor Responsibilities
6.2.6.3	~~6.2.6~~ 6.2.4.3 Performance Standards
6.2.7	~~6.2.7 Lock-in~~ ~~The contractor will coordinate the member health education program (MHEP) and lock in (LI) program. This includes the analysis of member surveillance and utilization reports, claim analysis, and referrals.~~ ~~The contractor will review medical utilization of members to identify overutilization, duplication of services, drug abuse, and possible drug interaction. The contractor will restrict members found to be misusing medical services to one physician, pharmacy, hospital, or combination of these providers.~~ ~~6.2.7.1 State Responsibilities~~ ~~a. Determine compliance with overall federal regulations and state laws.~~ ~~b. Establish policy regarding the administration of the member LI program.~~ ~~c. Define all parameters regarding utilization to be used by the contractor in administering the LI program.~~ ~~d. Approve the contractor's procedures for LI program administration.~~ ~~e. Monitor the contractor's performance of LI program activities.~~ ~~f. Conduct appeals and fair hearings related to LI decisions as needed.~~ ~~g. Respond to member inquiries regarding LI status and LI processes.~~ ~~6.2.7.2 Contractor Responsibilities~~ ~~a. Meet the following objectives:~~ ~~1. Improve care and health of members~~ ~~2. Reduce wasteful and duplicative services and therapies~~ ~~3. Program savings~~ ~~b. Review member utilization of medical services to identify misuse, drug abuse and duplicative services and secure medical providers to provide services to restricted members.~~ ~~c. Provide supportive professional and administrative services for appeals, prepare case summaries, and provide testimony regarding the review process during the administrative hearing.~~ ~~d. Using all available claims, enrollment and eligibility data in the MMIS and the DW/DS system, identify members for the LI program. The criteria for identifying candidates for the LI program will include, at a minimum:~~ ~~1. Number of physicians~~ ~~2. Number of pharmacies~~ ~~3. Number of prescriptions~~ ~~4. Controlled drugs~~ ~~5. Diagnoses~~ ~~6. Total cost~~ ~~e. For members identified for LI, set up a case in the workflow process and send a medical alert letter to the member notifying the member of the problem.~~

	~~f. Evaluate the member's utilization after one quarter to determine if utilization has been reduced. If no reduction in utilization has occurred, notify the member by letter requesting that the member choose a primary care provider and report to the Department.~~ ~~g. If the member chooses a primary care provider, prepare and send a letter to the chosen provider requesting the provider to become the primary care provider for the member. Contact the provider by telephone as a follow-up to the letter.~~ ~~h. If the member does not choose a primary care provider, identify a provider who is willing to serve as the primary care provider.~~ ~~i. Recruit providers who are willing to serve as primary care providers in all geographical areas of the state. If no providers in a specific area are willing to serve, notify the Department of the problem area.~~ ~~j. On approval of the provider, prepare and send a letter to the member notifying the member of the primary care provider and report to the Department.~~ ~~k. Set the LI indicator on the MMIS member database for each primary care provider for one year.~~ ~~l. No less frequently than every quarter, review the member's utilization to determine if the problems have been corrected. If utilization is still high, recommend a course of action and extend the restriction for one additional year. If the problems have been corrected, release the member from restriction. Prepare and send notification letters to the primary care provider and the member as approved by the Department and report to the Department.~~ ~~m. After a member has been released from the LI program restriction, review the member's utilization after two quarters to determine whether to reapply the LI, and notify the Department of the results of the review. Prepare and send letters to the primary care provider and the member as approved by the Department and report to the Department.~~ ~~n. Reassign a member to a primary care provider if a selected primary care provider requests the reassignment or can no longer serve as the primary care provider.~~ ~~o. Log all LI program activity in the workflow process, including the type of activity and the date the activity occurred.~~ ~~p. Provide information to the Department on LI activities when requested for use in appeals and fair hearings, including preparing case summaries and providing testimony regarding the review process during the administrative hearing.~~ ~~r. Meet monthly with Department staff to review restricted members, problems, and changes in review processes~~ ~~s. Assist the Department with communications to provider and member who have health care quality issues.~~ ~~t. Report the number of members on MHEP and on lock-in within 10 business days of the end of each quarter.~~ ~~6.2.7.3 Performance Standards~~ ~~a. On a quarterly basis, report the MHEP and LI program savings and a quarterly measurable growth rate from preenrollment to postenrollment for LI members. Outline the methodology for this analysis based on claims data to a level of detail that enables Department staff to substantiate the report's content.~~
6.2.8	~~6.2.8~~6.2.5 Quality of Care
6.2.8.1	~~6.2.8~~6.2.5.1 State Responsibilities
6.2.8.2	~~6.2.8~~6.2.5.2 Contractor Responsibilities
6.2.8.3	~~6.2.8~~6.2.5.3 Performance Standards
6.2.9	Removed Medicaid Value Management Program, which will be included in a separate RFP for a Program Integrity component.

	~~6.2.9 Medicaid Value Management Program~~ ~~The Medicaid Value Management (MVM) program was developed under the direction of the Iowa Medicaid Director to establish a more comprehensive approach for improving the quality and value of medical services to Iowa Medicaid members. MVM is an assessment and analysis of an array of information and data categories. Expert analysis of integrated information will allow for formulation of strategies centered on the objective of increasing the overall value of the Medicaid programs. The program objectives are to:~~ ~~a. Compare nationally recognized benchmarks and data on utilization of services, gaps in care and to evaluate the Medicaid program and services in Iowa.~~ ~~b. Conduct a periodic evaluation utilizing the various sources to identify opportunities to improve the balance of healthcare quality, service and cost for the Iowa Medicaid Program.~~ ~~c. Develop through analysis of data, recommendations to add value to programs and services for the Medicaid member.~~ ~~d. Utilize a predictive modeling tool in analyzing Iowa Medicaid utilization and trends including but not limited to identifying populations, programs or services for intervention to target disease/care management programs and make other programmatic recommendations to reduce costs and increase quality.~~ ~~The bidder will propose the type and number of projects to complete in the first year. The IME and the bidder will agree on the standards for these projects during contract negotiation.~~ ~~6.2.9.1 State Responsibilities~~ ~~a. Convene a monthly meeting with the MVM team to review and discuss status of the projects.~~ ~~b. Select projects that meet the objectives of the MVM program.~~ ~~c. Establish performance measures~~ ~~d. Review and take action on recommendations.~~ ~~6.2.9.2 Contractor Responsibilities~~ ~~a. The IME Medical Director leads the MVM team in the evaluation and analysis of program date and developing project goals.~~ ~~b. Convene and manage an MVM program team that includes Medical Services, policy staff, and other groups as necessary to perform MVM.~~ ~~c. The team shall include a professional with health care data analysis experience such as informatics, health economics or other health care data analysis experience.~~ ~~d. Identify nationally recognized benchmark measures of health care quality and utilization and perform analysis of Medicaid data to compare to the national benchmarks to identify overutilization and deficiencies in provision of service and evaluate Iowa Medicaid performance and make recommendations to the Department.~~ ~~e. Develop tools and analyze Medicaid expenditures and trends over time to identify areas for possible savings or targeted interventions.~~ ~~f. Prepare monthly reports that address the following:~~ ~~1. Evaluate the effectiveness of the projects selected for the MVM program.~~ ~~2. Analyze the effectiveness in meeting the MVM program goals.~~ ~~3. Conduct reviews that identify potential impact upon the MVM projects.~~ ~~4. Compare MVM results to industry standards and quality benchmark data.~~ ~~g. Identify projects to be included in MVM program that will benefit the IME with improving the quality of care, enhancing services, and cost savings for the Department. On a quarterly basis, recommend projects for Department review and approval.~~ ~~h. Conduct IME data systems searches that assist in the validation of project goals.~~ ~~i. Perform analysis of data and develop recommendations to add value to programs and~~

	~~services for the MVM program.~~ ~~j. Develop a comprehensive approach to improving quality and value for Iowa Medicaid members.~~ ~~k. Provide quarterly results to the Department from the review of the claims checklist, including Iowa Medicaid norms, industry standards, and quality indicators.~~ ~~l. Propose predictive modeling software for the Department's approval to be used in analyzing Iowa Medicaid utilization and trends to identify recommendations to reduce costs and increase quality for the Iowa Medicaid Program.~~ ~~m. Participate in monthly MVM meetings.~~ ~~n. Provide monthly reports prior to the monthly MVM meeting.~~ ~~o. Develop recommendations for project improvements.~~ ~~p. Identify trends that impact the operations or fiscal management.~~ ~~6.2.9.3 Performance Standards~~ ~~a. Achieve savings (through cost avoidance) of at least $1 million annually from the projects.~~ ~~b. Target a number of projects to complete per year.~~
new	**6.2.6 Health Information Technology** **The Department has begun development of a State Medicaid Health Information Technology (HIT) Plan. The document will describe the Department's strategic plan to align with the Iowa e-Health Project. The State Medicaid HIT plan will support the following objectives:** **Align with the Iowa HIE efforts** **Support provider adoption, including technical assistance and provider incentives** **Leverage the availability of clinical data for administrative efficiencies** **Provide quality reporting including population management for healthier Medicaid members and Iowans** **6.2.6.1 State Responsibilities** **a. Provide current policy, status and lines of communication regarding HIT plan.** **b. Set direction for contractor as plan matures.** **6.2.6.2 Contractor Responsibilities** **a. Participate in development of HIT plan as directed by the Department.** **b. Represent the Department in discussions with provider stakeholders.** **c. Protect the privacy of Medicaid members in all recommendations.** **d. Contribute to the definition of incentive payment strategies.** **e. Champion the plan within the Medical Services unit as the plan matures and features of the plan are enacted.** **f. Participate in planning and execution of statewide provider assessment as directed by the Department.**
6.5, new second paragraph	**The Member Services component also includes the activities related to monitoring member care: locking in members to particular providers when necessary and managing treatment for particular conditions. In addition, the Member Services contractor will conduct activities related to improving the outcomes of delivery of services to members, including but not limited to analysis of and intervention with high-cost populations.**
6.5, after new second paragraph	The Member Services component includes the following responsibilities: 6.5.1 Managed Health Care Enrollment Broker 6.5.2 Member Inquiry and Member Relations 6.5.3 Member Outreach and Education

	6.5.4 Member Quality Assurance 6.5.5 Medicare Part A and Part B Buy-In **6.5.6 Lock-In** **6.5.7 Disease Management** **6.5.8 Enhanced Primary Care Management**
6.5.3.1.e	**Review initiatives that the contractor proposes for member education.**
6.5.3.2.a.5	**Educate members in the appropriate use of the health care system.**
6.5.3.2.a.6	**Increase effective and preventive use of program services and decrease inappropriate use of program services.**
6.5.3.2.q	**Make recommendations to the Department for targeted education programs to member populations that are similar to standard screening, periodicity and treatment programs.**
6.5.3.2.r	**Implement the targeted member education programs upon receipt of Department approval.**
6.5.3.3.d	**Present at least six recommendations annually to the Department for targeted education programs for member populations.**
6.5.6	Moved with no changes from 6.2.7 **6.5.6 Lock-in** **The contractor will coordinate the member health education program (MHEP) and lock-in (LI) program. This includes the analysis of member surveillance and utilization reports, claim analysis, and referrals.** **The contractor will review medical utilization of members to identify overutilization, duplication of services, drug abuse, and possible drug interaction. The contractor will restrict members found to be misusing medical services to one physician, pharmacy, hospital, or combination of these providers.** **6.5.6.1 State Responsibilities** **a. Determine compliance with overall federal regulations and state laws.** **b. Establish policy regarding the administration of the member LI program.** **c. Define all parameters regarding utilization to be used by the contractor in administering the LI program.** **d. Approve the contractor's procedures for LI program administration.** **e. Monitor the contractor's performance of LI program activities.** **f. Conduct appeals and fair hearings related to LI decisions as needed.** **g. Respond to member inquiries regarding LI status and LI processes.** **6.5.6.2 Contractor Responsibilities** **a. Meet the following objectives:** **1. Improve care and health of members** **2. Reduce wasteful and duplicative services and therapies** **3. Program savings** **b. Review member utilization of medical services to identify misuse, drug abuse and duplicative services and secure medical providers to provide services to restricted members.** **c. Provide supportive professional and administrative services for appeals, prepare case summaries, and provide testimony regarding the review process during the administrative hearing.** **d. Using all available claims, enrollment and eligibility data in the MMIS and the DW/DS**

	system, identify members for the LI program. The criteria for identifying candidates for the LI program will include, at a minimum: **1. Number of physicians** **2. Number of pharmacies** **3. Number of prescriptions** **4. Controlled drugs** **5. Diagnoses** **6. Total cost** **e. For members identified for LI, set up a case in the workflow process and send a medical alert letter to the member notifying the member of the problem.** **f. Evaluate the member's utilization after one quarter to determine if utilization has been reduced. If no reduction in utilization has occurred, notify the member by letter requesting that the member choose a primary care provider and report to the Department.** **g. If the member chooses a primary care provider, prepare and send a letter to the chosen provider requesting the provider to become the primary care provider for the member. Contact the provider by telephone as a follow-up to the letter.** **h. If the member does not choose a primary care provider, identify a provider who is willing to serve as the primary care provider.** **i. Recruit providers who are willing to serve as primary care providers in all geographical areas of the state. If no providers in a specific area are willing to serve, notify the Department of the problem area.** **j. On approval of the provider, prepare and send a letter to the member notifying the member of the primary care provider and report to the Department.** **k. Set the LI indicator on the MMIS member database for each primary care provider for one year.** **l. No less frequently than every quarter, review the member's utilization to determine if the problems have been corrected. If utilization is still high, recommend a course of action and extend the restriction for one additional year. If the problems have been corrected, release the member from restriction. Prepare and send notification letters to the primary care provider and the member as approved by the Department and report to the Department.** **m. After a member has been released from the LI program restriction, review the member's utilization after two quarters to determine whether to reapply the LI, and notify the Department of the results of the review. Prepare and send letters to the primary care provider and the member as approved by the Department and report to the Department.** **n. Reassign a member to a primary care provider if a selected primary care provider requests the reassignment or can no longer serve as the primary care provider.** **o. Log all LI program activity in the workflow process, including the type of activity and the date the activity occurred.** **p. Provide information to the Department on LI activities when requested for use in appeals and fair hearings, including preparing case summaries and providing testimony regarding the review process during the administrative hearing.** **r. Meet monthly with Department staff to review restricted members, problems, and changes in review processes** **s. Assist the Department with communications to provider and member who have health care quality issues.** **t. Report the number of members on MHEP and on lock-in within 10 business days of the end of each quarter.** **u. Provide professional medical staff to perform Member Services services such as lock-in, disease management and enhanced primary care management as directed by the**

	Department, including a medical director (an experienced managing physician who can be an MD or DO), nurses, and peer consultants (such as psychologists, dentists, therapists and other medical professionals) with recognized credentials in the service area being reviewed. These medical consultants must be licensed or otherwise legally able to practice in the state of Iowa and possess the professional credentials to provide expert witness testimony in hearings or appeals. The Member Services contractor's medical director will coordinate with the Chief Medical Director in Medical Services as needed. **6.5.6.3 Performance Standards** **a. On a quarterly basis, report the MHEP and LI program savings and a quarterly measurable growth rate from preenrollment to postenrollment for LI members. Outline the methodology for this analysis based on claims data to a level of detail that enables Department staff to substantiate the report's content.**
6.5.7	Moved with no changes from 6.2.2 **6.5.7 Disease Management** **Disease management is an innovative intervention for improving care, outcomes, and costs for individuals with certain disease conditions. The use of quality indicators that reflect accepted guidelines for members with specified disease processes and address many of the disease-related objectives of Healthy People 2010 can improve the quality of care for members and use resources efficiently.** **Disease management is an organized, proactive approach to healthcare delivery that engages the member in self-management of their disease. Because many diseases are controlled primarily by the member living with the disease, an emphasis on self-management support is a means to change behaviors to improve disease control and health status.** **Key components of disease management are identification of the population with specified diseases, evaluation of candidates for disease management based on cost effectiveness guidelines, and use of recognized practice guidelines or performance standards for managing identified members. It is also imperative that the providers of service associated with members be involved with the education and intervention developed by the contractor.** **The contractor will be required to develop a limited disease management protocol for non-HMO members, for presentation and approval by the Department. The contractor may propose a risk-based provision that would allow the contractor to assume limited risk for the outcomes of the disease management population, in exchange for receiving a bonus for positive outcomes. Performance standards will be identified and agreed upon in the final contract based upon the disease management approach that the successful bidder proposes.** **The data sources for the Disease Management function are:** **a. Service utilization data from paid claims, encounters and Healthplan Employer Data and Information Set (HEDIS) findings** **b. Medical profile indicators from disease management protocols** **6.5.7.1 State Responsibilities** **a. Approve the clinical guidelines and requirements for enrollment in the disease management program.** **b. Review and approve the contractor's proposal for and any expansion to the disease management program.** **c. Monitor the activities of the contractor as they relate to the educational activities and clinical regimens developed and applied by the contractor.** **d. Require changes in the plan for management of individually identified members or the program parameters as a whole, based on review of contractor's activity.** **e. Supply access to the MMIS data Point of Sale (POS) data or enterprise data warehouse tools and data stored therein.**

	6.5.7.2 Contractor Responsibilities **a. Meet the following objectives:** **1. Improvement of health status for selected members with chronic conditions.** **2. Reductions in costs for high users of services who have specific medical maladies covered under the disease management program.** **3. Design of protocols for better management of chronic diseases.** **b. Maintain the following interfaces:** **1. MMIS and Data Warehouse/Decision Support (DW/DS) system for information on providers, members, services and costs** **2. Communication with providers participating in the disease management protocols** **3. Any contractor that may analyze data** **c. Obtain all data files necessary to accomplish the goals of the program.** **d. Use recognized guidelines to review disease classes that may be amenable to intervention. This universe will include, at a minimum, diabetes, congestive heart failure, asthma and juvenile asthma. The contractor may suggest other disease management initiatives and processes that might show significant positive health outcomes and subsequent reductions in overall cost to the Department, such as high-risk maternity, pharmacy case management, breast and cervical cancer, and other high-cost conditions.** **e. Undertake studies as directed by the Department.** **f. Prepare an annual proposal identifying potential diseases and/or individual members for development of a program in disease management and present the proposal to the Department. Include any criteria that the Department requests.** **g. Submit clinical guidelines and enrollment requirements to the Department for approval prior to enrolling members in the disease management program.** **h. Enroll members in the disease management program.** **i. Develop reports and other monitoring devices as requested by the Department to demonstrate the results of the program.** **j. Report on clinical outcomes experienced by the enrolled members on a proposed schedule approved by the Department. These reports would include self-assessments of health status and physician assessments of member health status.** **k. Obtain Department approval before undertaking outreach to members or providers of service regarding disease management programs. Report outcomes of the Department-approved outreach to the Department.** **l. Develop and obtain Department approval of the methodology to be used in reviewing Medicaid utilization data to identify new diseases to be added as disease management candidates.** **m. Report to the Department, annually, on the cost effectiveness of the disease management program, including base line service utilization data and overall health status, intervention during the year, new baseline health status and cost, plus changes in utilization and cost. Outline the methodology for this analysis based on claims data to a level of detail that enables Department staff to substantiate the report's content.** **n. Any enrolled member who has designated a primary care or primary medical provider will have that provider involved with the management of the member. This means that the active medical management of the member may only be done with the consultation and approval of the primary medical provider.** **o. Coordinate with the Iowa Plan for persons enrolled in the Iowa Plan with physical diseases that have a mental health or substance abuse issue or who are referred from the Iowa Plan due to physical issues'.** **p. Prepare a monthly report of member participation in disease management program,**

	their service utilization and cost. **q. Send enrolled members a satisfaction survey within 10 business days of the member's sixth and twelfth month of enrollment.** **6.5.7.3 Performance Standards** **a. Complete initial health status assessments for each member within 30 days of enrollment.** **b. Complete health status assessments on all members who have been enrolled for at least one year within 30 days of the anniversary date of the member's enrollment.** **c. Make recommendations for at least six studies that the Department agrees are valid.**
6.5.8	Moved with no changes from 6.2.3 **6.5.8 Enhanced Primary Care Management** **In addition to the MediPASS primary care case management program, the Department operates an enhanced primary care management program for members with high costs or high utilization of services. A primary care provider is responsible for providing or authorizing certain Medicaid services for these members. Medicaid members in the enhanced primary care management program receive all Medicaid services to which they are entitled. Iowa Medicaid State Plan services are included, except emergency services, transportation, family planning, mental health and substance abuse services; annual eye examinations, and school-based or well-child clinics. All optional services and other services not specifically mentioned above are not managed.** **The data sources for the enhanced primary care management function are:** **a. Interviews with member, family, service providers, current service workers, or case managers or other applicable sources** **b. Copies of medical records or previously accessed/authorized services plans** **c. Program policies for LTC eligibility** **d. Claim information** **e. Care management member satisfaction survey** **6.5.8.1 State Responsibilities** **a. Provide guidelines for qualifications of contractor staff and primary care providers who will perform the enhanced primary care management functions.** **b. Provide written policy regarding care management.** **c. Provide written guidelines for an appeal process.** **d. Provide referrals for care management to the contractor.** **e. Monitor the performance of the care management process.** **f. Approve care management edits and audits.** **6.5.8.2 Contractor Responsibilities** **a. Meet the objective to improve access to needed care and to reduce unnecessary and inappropriate utilization and costs.** **b. Maintain the following interfaces:** **1. Members referred for care management** **2. Case managers** **c. Accept referrals for care management upon request from the Department.** **d. Obtain additional information that is needed from the member's medical providers to determine the individual's need.** **e. Perform a prescreening assessment on each member referred for care management.** **f. Provide professional medical staff to perform the care management functions.**

	g. Prepare care plans for each member receiving care management and maintain documentation. **h. Notify members and the Department of the results of the prescreening assessment in a format determined by the Department.** **i. Respond to phone calls regarding members enrolled in care management.** **j. Survey members regarding satisfaction of care management activities.** **k. Identify outliers in cost, utilization and treatment patterns that could benefit from enhanced primary care management and provide recommendations to the Department.** **l. Submit reports in a format and frequency approved by the Department.** **1. Summary of care management activities and services authorized for members** **2. Comparison of services and funding prior to and after receiving care management** **3. Summary of satisfaction survey of members** **4. Length of time that members receive care management** **m. Participate in meetings and develop a plan to review claims data for foster care children to determine compliance with current EPSDT standards. When outliers are noted, the care management team would get involved to intervene as necessary. For psychotropic medications, the IME will transfer data to Magellan and request that they perform a review to determine that the right medications are being prescribed at the right intervals.** **6.5.8.3 Performance Standards** **a. Upon referral, complete initial member contact for care management services for 95 percent of the members within five business days.** **b. Maintain a minimum enrollment of 50 members.** **c. Send enrolled members a satisfaction survey within 10 business days of the member's sixth month of initial enrollment and annually on the anniversary of their enrollment.** **d. Contact 95 percent of the care-managed members within one business day following discharge from hospital.** **e. Demonstrate cost-avoidance through a decrease in emergency room visits annually for members enrolled for at least 11 of 12 months.** **f. Demonstrate cost-avoidance through a decrease in hospitalizations annually for members enrolled for at least 11 of 12 months.**
6.7	Removed SURS component, which will be included in a separate RFP for a Program Integrity component. That component also will include common analytical tools and associated analytical resources for use throughout the IME plus SURS and MARS services and system functions. ~~6.7 Surveillance and Utilization Review Services (SURS)~~ ~~The SURS contractor is generally responsible for all program integrity-related activities, except provider enrollment and member lock-in, as they pertain to the Iowa Medicaid Program. Program integrity, for the SURS contractor, encompasses postpayment provider claims reviews and preliminary and full investigations of providers.~~ ~~The SURS contractor will develop and update parameters for use in the production of SUR subsystem reports in the Core MMIS, conduct desk reviews of providers to identify potentially abusive patterns, and conduct provider field reviews to verify the findings of desk reviews if needed. The SURS contractor will also conduct reviews on a sample of providers for whom the SUR subsystem reports do not indicate potentially abusive practices. When the reviews indicate aberrant billing practices, the SURS contractor will identify overpayments and send a request to the provider for refunds of the overpayments. When reviews indicate suspect practices, the SURS contractor will refer the case to the Medicaid Fraud Control Unit (MFCU).~~ ~~The SURS function includes use of claims data for overall program management and use of statistics~~

	~~to establish norms of care in order to detect inappropriate or overutilization of services. The SUR subsystem is designed to provide statistical information on members and providers enrolled in the Iowa Medicaid Program. The SUR subsystem in the Iowa Medicaid Management Information System (MMIS) contains a parameter-controlled claim detail reporting module. The subsystem produces exception profiles for participating providers based on the number of standard deviations or user provided fixed limits. The subsystem can also accept percentiles as the upper limit in exception processing. The SURS contractor will perform other data mining activity through the use of the paid claims files in the data warehouse/decision support (DW/DS) system.~~ ~~The SUR subsystem produces comprehensive profiles of the delivery of services and supplies by Medicaid providers and the use of these services by Medicaid members. The current subsystem features algorithms for isolating potential inappropriate utilization. It also produces an integrated set of reports to provide the Department and its contractors with utilization data for analyzing medical care and service delivery. The SURS contractor will develop other algorithms for use in identifying aberrant provider billing practices.~~ ~~The SUR subsystem also provides extensive capabilities for data management, exception processing, and report content and format. The Department and its contractors use the data to support several utilization management functions. The SURS function also includes a review of the delivery and utilization of medical care on a case basis to identify possible aberrant medical practice. The data sources for the SURS function are:~~ ~~a. SUR subsystem reports produced by the Core MMIS contractor~~ ~~b. MMIS paid claims data and any other provider or program statistics maintained by the Department~~ ~~c. Medical record data collected during field reviews~~ ~~6.7.1 State Responsibilities~~ ~~a. Approve all policy including the criteria used for utilization review and edit resolution.~~ ~~b. Initiate and interpret all policy and make administrative decisions regarding utilization review.~~ ~~c. Advise SURS contractor of providers to be placed on prepayment review or whose participation privileges are suspended or revoked.~~ ~~d. Make provider referrals to peer review committees.~~ ~~e. Provide instructions to the contractor concerning suspended providers and providers to whom payment is suspended.~~ ~~f. Make determinations on questionable practice of providers.~~ ~~g. Determine services requiring preauthorization or postpayment review.~~ ~~h. Determine which SUR subsystem reports are necessary.~~ ~~i. Determine the frequency of reports.~~ ~~j. Approve parameters of SUR subsystem reports.~~ ~~6.7.2 Contractor Responsibilities~~ ~~a. Maintain the following interfaces:~~ ~~1. Providers for reviews~~ ~~2. MFCU for referrals of SURS cases~~ ~~b. Update operational procedure manuals within 10 business days of the implementation of a change.~~ ~~6.7.2.1 Profiling and Data Mining~~ ~~a. Provide a profile of health care providers and members through which the quality, quantity, and/or timeliness of services can be identified and assessed.~~ ~~b. Provide continuous interrelated statistics in concert with the Management and Administrative Reporting (MAR) function to show how the total health care delivery system and its individual parts are meeting program objectives.~~

	~~c. Aid management in the process of ensuring that only medically necessary covered services and items including prescribed drugs are provided in the appropriate setting at the lowest cost.~~ ~~d. Create a comprehensive profile of health care delivery and utilization patterns established, in all categories of services including prescribed drugs, under the Iowa Medicaid Program.~~ ~~e. Develop and coordinate the update of the parameters file on the MMIS to classify providers into peer groups using criteria such as category of service, provider type, specialty, type of practice or organization, enrollment status, facility type, geographic region, billing versus performing provider, and size for the purpose of developing statistical profiles by the end of each quarter, assuring that all provider types are reviewed in a one-year period.~~ ~~f. Develop and update parameters file to classify treatment into peer groups, by diagnosis or range of diagnosis codes, level of care, or other methodology for the purpose of developing statistical profiles.~~ ~~g. Develop and update the SUR subsystem parameter file with data needed to apply weighting and ranking to exception report items to facilitate the identification of those with the highest exception ranking.~~ ~~h. Compile provider profiles.~~ ~~i. Maintain a process to evaluate the statistical profiles of all individual providers within each peer group against the matching exception criteria established for each peer group.~~ ~~j. Identify providers who exhibit aberrant practice or utilization patterns, as determined by an exception process, comparing the individuals' profiles to the limits established for their respective peer groups, reviewing each provider type scheduled in that quarter.~~ ~~k. Review SUR subsystem reports generated by the Core MMIS contractor to identify providers who exceed calculated norms based on the SUR subsystem parameters identified and input to the SUR subsystem parameter file.~~ ~~l. Perform analysis of service and billing practices to detect utilization and billing problems, including but not limited to incidental or mutually exclusive procedures, unbundling of procedure codes and bill splitting.~~ ~~m. Receive referrals on potential provider fraud and abuse from all the other Iowa Medicaid Enterprise (IME) units for a preliminary investigation and coordinate IME-related referrals to the MFCU of suspected cases of provider fraud.~~ ~~n. Analyze and propose cost avoidance initiatives and regular self-review requests to providers, including credit balance reviews for hospitals and other institutional providers.~~ ~~6.7.2.2 Reviewing~~ ~~a. Provide a basis for conducting medical reviews to verify that covered health care services have been documented and that payments have been made in accordance with state and federal policies, regulations, and statutes.~~ ~~b. Protect Medicaid participants against the occurrence of overutilization and underutilization of health care services by providing support for the following processes:~~ ~~1. Referring providers, whose practices are suspect, to the appropriate medical component for review~~ ~~2. Initiating administrative actions to curtail aberrant behavior~~ ~~3. Referring suspect cases to an investigative agency~~ ~~c. Conduct review of providers (including nursing facility (NF) and intermediate care facility for the mentally retarded (ICF/MR) facilities) based on SURS exception criteria.~~ ~~d. Perform the provider reviews pursuant to the Department's requirements.~~ ~~e. Perform all provider review activities and recovery activities for erroneous provider payments~~ ~~f. Conduct field reviews on request, including managed care activities and reviews of health maintenance organization (HMO) and Medicaid managed behavioral care encounters.~~ ~~g. Perform the analysis of provider practice patterns and review of medical records on-site in~~

	~~provider offices.~~ ~~h. Perform preliminary and full investigations on all cases opened from referrals.~~ ~~i. Monitor compliance with any new federal or state laws that are related to mandatory provider documentation as a part of a preliminary investigation.~~ ~~j. Annually review claims for all provider types. Reviews selected will be based on outlier status, any additional information that indicates potential billing abnormalities, or both. The reviews will involve performing both in-house and field audits (annual and cumulative).~~ ~~6.7.2.3 Case Follow-Up and Reporting~~ ~~a. Provide management with information to assist in overall program direction and supervision.~~ ~~b. Have written procedures for all SURS activities, including review criteria for all provider groups.~~ ~~c. Report findings from medical record reviews to the Department on a quarterly basis.~~ ~~d. Meet periodically with the Department SURS staff to discuss individual cases reviewed and determine action to be taken.~~ ~~e. Refer providers requiring sanctions to be imposed against them to the Department in accordance with current Iowa Administrative Code rules on sanctions.~~ ~~f. Initiate appropriate action to recover erroneous provider payments.~~ ~~1. Notify the Core MMIS and Provider Services contractors of requested actions on providers, including requests to recover payment through the use of the credit and adjustment procedure in the case of erroneous payments, such as wrong provider, incorrect amount, wrong procedure, etc.~~ ~~2. Under the direction of the Department, direct the Core MMIS contractor to process refunds to providers who have been identified as having been underpaid.~~ ~~g. Meet all the federal certification standards for operation of surveillance and utilization review functions.~~ ~~h. Follow up by sending findings letters and collecting overpayments or processing refunds for underpayments resulting from Payment Error Rate Measurement (PERM) errors in those years that Iowa participates in the PERM project.~~ ~~i. Receive and review Explanations of Medical Benefits (EOMBs) and follow up as needed.~~ ~~j. Adjust claims to recover inappropriate provider payments that result from optical character recognition (OCR) scanning errors.~~ ~~k. Coordinate referrals of cases with and between the MFCU according to the following criteria.~~ ~~1. Refer all cases of suspected provider fraud to the MFCU~~ ~~2. Promptly comply with a request from the MFCU for the following:~~ ~~i. Access to, and free copies of, any records or information kept by the Department or its contractors~~ ~~ii. Computerized data stored by the Department or its contractors. These data must be supplied without charge and in the form requested by the MFCU~~ ~~iii. Access to any information kept by providers to which the Department is authorized access by section 1902(a)(27) of the Social Security Act and section 42 CFR 431.107 of the federal regulations and protection of the privacy rights of Medicaid members.~~ ~~3. On referral from the MFCU, initiate any available administrative or judicial action to recover improper payments to a provider.~~ ~~l. Follow up on overpayments identified by the CMS Medicaid Integrity contractors (MICs).~~ ~~m. Record payments received in the IME accounts receivable system for GAAP reporting and bank account reconciliation purposes.~~ ~~n. Upon request, assist the Department with policy related items, such as updates to the state plan, Iowa Administrative Rules, Iowa Code, and provider manuals.~~

	~~o. Maintain and update operational procedures as necessary and in a format designated by the Department.~~ ~~p. Log and prepare all payments to be deposited in the state-owned Title XIX recovery bank account according to RFP Section 6.1.8 Banking Policies.~~ ~~q. Meet the following reporting requirements.~~ ~~1. Produce and submit monthly to the Department a report summarizing provider review activity, including the following information in the report at a minimum:~~ ~~i. Names of providers reviewed~~ ~~ii. Dates of each review~~ ~~iii. Review findings~~ ~~iv. Actions taken~~ ~~v. Outcome of referral authorization review~~ ~~vi. Educational letters sent~~ ~~2. Produce a quarterly identification of the medical services for which overutilization is most prevalent.~~ ~~6.7.2.4 Appeals~~ ~~a. Prepare documents and assist in appeal hearings for all SURS cases that result in an appeal by the provider.~~ ~~6.7.3 Performance Standards~~ ~~a. In each contract year, recover no less that 350% of the total state cost of SURS and provider review activities including the following:~~ ~~1. Measurable and quantifiable recoveries, which are actual recoupments made and money received~~ ~~2. Avoided costs, which are those expenses eliminated or reduced as reducing future costs of the Medicaid program (such as identifying a new MMIS edit that will reduce costs of Medicaid claims)~~ ~~3. Enhanced revenues that are additional recoveries that the SURS staff identified, including those funds that are included in pending appeal hearings at any point in time~~ ~~b. Annually review a random minimum sample of .5 percent of paid claims.~~ ~~1. The reviews will involve performing both in-house and field reviews.~~ ~~2. Review cases must include providers who exceed calculated norms and a random sample of providers who do not exceed norms.~~ ~~c. Open a minimum of 60 cases for provider reviews during each quarter according to the following criteria.~~ ~~1. All cases referred from the Department must be opened in the quarter referred.~~ ~~2. Review cases must include both providers who exceed calculated norms, and a random sample of providers who do not exceed norms.~~ ~~3. The contractor must describe in its proposal the percentage of cases to be opened for providers who exceed the norm and the percentage of cases for the random sample.~~ ~~d. On average for all cases, complete reviews within 90 days when all documentation required necessary to perform the review has been obtained.~~ ~~e. Proposals for cost avoidance measures submitted by SURS staff members or other entities will be analyzed and addressed with a response for proposed action (including the option of closure) within 30 days of the date the proposal was submitted.~~ ~~f. Proposals for cost avoidance measures that have been approved for follow-up action to be implemented by the SURS unit will be addressed with the identified follow-up action within 45 days of the date that the proposal was approved by the SURS contract director.~~

6.8	~~6.8~~6.7 Provider Cost Audits and Rate Setting
6.8	~~6.8.1~~ 6.7.1 Rate Setting, Cost Settlements, and Cost Audits ~~6.8.2~~ 6.7.2 State Maximum Allowable Cost Program Rate Setting ~~6.8.3~~ 6.7.3 Rebasing and Diagnosis Related Group and Ambulatory Payment Classification Recalibration ~~6.8.4~~ 6.7.4 Reimbursement Technical Assistance and Support ~~6.8.5~~ 6.7.5 IowaCare
6.8.1	~~**6.8**~~ 6.7.1 Rate Setting, Cost Settlements, and Cost Audits
6.8.1.1	~~6.8~~ 6.7.1.1 State Responsibilities
6.8.1.2	~~6.8~~ 6.7.1.2 Contractor Responsibilities
6.8.1.2.l	Perform the provider audit or desk review, the cost settlement, and the rate determination function, when applicable, for the provider types listed in RFP Section ~~6.8.1.2~~ 6.7.1.2 Contractor Responsibilities. Cost settlements entail a mix of retrospective and prospective methodologies. The contractor shall notify each provider in writing of any corrections made as a result of a desk review. Ensure the thoroughness and mathematical accuracy of submitted reports and ensure conformance to the requirements for allowance of costs as stated in the Code of Federal Regulations (CFR) and Iowa Administrative Code (IAC).
6.8.1.2.n	Perform on-site audits for providers identified by the Department on request. Audits shall be sufficiently detailed to enable contractor to express an opinion on total costs and statistical data provided by the cost report. The protocol for and selection of providers subject to on-site audits (for provider types listed under RFP Section ~~6.8.1.2~~ 6.7.1.2 Contractor Responsibilities) will be based on criteria developed by the contractor and will be subject to approval by the Department.
6.8.1.3	~~6.8.1.3~~ 6.7.1.3 Performance Standards
6.8.1.3.b	In SFY 2011, Iowa shall realize state savings through collection of overpayments or avoidance of overpayments by the Provider Cost Audits and Rate Setting contractor of no less than $850,000. These savings are expected to result from the more intense scrutiny provided by the cost and payment audit activity described in the RFP. In SFY 2012 and thereafter, the amount of the state savings shall be increased by 10 percent a year over the previous year's state savings. ~~Should the activities described in this subsection cause the state to realize state savings in any year in excess of the savings specified above, the excess (but not any deficit) shall be credited toward the state savings for the succeeding year.~~
6.8.2	~~**6.8**~~ 6.7.2 State Maximum Allowable Cost Program Rate Setting
6.8.2.1	~~6.8~~ 6.7.2.1 State Responsibilities
6.8.2.2	~~6.8.2.2~~ 6.7.2.2 Contractor Responsibilities The following subsections list the contractor responsibilities for the SMAC program: ~~6.8.2.2.1~~ 6.7.2.2.1 General Responsibilities ~~6.8.2.2.2~~ 6.7.2.2.2 State Maximum Allowable Cost Program and Rate Schedule Maintenance ~~6.8.2.2.3~~ 6.7.2.2.3 Program Monitoring, Product and Rate Review and Adjustments ~~6.8.2.2.4~~ 6.7.2.2.4 State Maximum Allowable Cost Program Administrative Support and Assistance to the Department ~~6.8.2.2.5~~ 6.7.2.2.5 Support for Prescribing Providers and Pharmacies ~~6.8.2.2.6~~ 6.7.2.2.6 Technical Support, Pharmacological Expertise, and Evaluation Services
6.8.2.2.1	~~**6.8.2.2.1**~~ 6.7.2.2.1 General Responsibilities
6.8.2.2.2	~~**6.8.2.2.2**~~ 6.7.2.2.2 State Maximum Allowable Cost Program and Rate Schedule Maintenance

6.8.2.2.3	**~~6.8.2.2.3~~** 6.7.2.2.3 Program Monitoring, Product and Rate Review and Adjustments
6.8.2.2.4	**~~6.8.2.2.4~~** 6.7.2.2.4 State Maximum Allowable Cost Program Administrative Support and Assistance to the Department
6.8.2.2.5	**~~6.8.2.2.5~~** 6.7.2.2.5 Support for Prescribing Providers and Pharmacies
6.8.2.2.6	**~~6.8.2.2.6~~** 6.7.2.2.6 Technical Support, Pharmacological Expertise and Evaluation Services
6.8.2.3	~~6.8.2.3~~ 6.7.2.3 Performance Standards
6.8.3	**~~6.8.3~~** 6.7.3 Rebasing and Diagnosis Related Group and Ambulatory Payment Classification Recalibration
6.8.3.1	~~6.8.3.1~~ 6.7.3.1 State Responsibilities
6.8.3.2	~~6.8.3.2~~ 6.7.3.2 Contractor Responsibilities
6.8.3.3	~~6.8.3.3~~ 6.7.3.3 Performance Standards
6.8.4	**~~6.8.4~~** 6.7.4 Reimbursement Technical Assistance and Support
6.8.4.1	~~6.8.4.1~~ 6.7.4.1 State Responsibilities
6.8.4.2	~~6.8.4.2~~ 6.7.4.2 Contractor Responsibilities The following topics list the contractor responsibilities for this function: ~~6.8.4.2.1~~ 6.7.4.2.1 General Responsibilities ~~6.8.4.2.2~~ 6.7.4.2.2 Upper Payment Limit Tests ~~6.8.4.2.3~~ 6.7.4.2.3 Other Technical Assistance and Monitoring ~~6.8.4.2.4~~ 6.7.4.2.4 Reporting
6.8.4.2.1	**~~6.8.4.2.1~~** 6.7.4.2.1 General Responsibilities
6.8.4.2.2	**~~6.8.4.2.2~~** 6.7.4.2.2 Upper Payment Limit Tests
6.8.4.2.3	**~~6.8.4.2.3~~** 6.7.4.2.3 Other Technical Assistance and Monitoring
6.8.4.2.4	**~~6.8.4.2.4~~** 6.7.4.2.4 Reporting
6.8.4.3	~~6.8.4.3~~ 6.7.4.3 Performance Standards
6.8.5	**~~6.8.5~~** 6.7.5 IowaCare
6.8.5.1	~~6.8.5.1~~ 6.7.5.1 State Responsibilities
6.8.5.2	~~6.8.5.2~~ 6.7.5.2 Contractor Responsibilities
6.8.5.3	~~6.8.5.3~~ 6.7.5.3 Performance Standards
6.9	~~6.9~~ 6.8 Estate Recovery Services
6.9	The Estate Recovery Services component includes the requirements listed in the following sections: ~~6.9.1~~ 6.8.1 Recoverable Assets ~~6.9.2~~ 6.8.2 Criteria for Exemptions and Delays ~~6.9.3~~ 6.8.3 Estate Recovery ~~6.9.4~~ 6.8.4 Medical Assistance Income Trusts and Special Needs Trust Recovery
6.9.1	**~~6.9.1~~** 6.8.1 Recoverable Assets
6.9.2	**~~6.9.2~~** 6.8.2 Criteria for Exemptions and Delays
6.9.3	**~~6.9.3~~** 6.8.3 Estate Recovery

6.9.3.1	~~6.9.3.1~~ 6.8.3.1State Responsibilities
6.9.3.2	~~6.9.3.2~~ 6.8.3.2 Contractor Responsibilities
6.9.3.3	~~6.9.3.3~~ 6.8.3.3 Performance Standards
6.9.4	~~**6.9.4**~~ 6.8.4 Medical Assistance Income Trust and Special Needs Trust Recovery
6.9.4.1	~~6.9.4.1~~ 6.8.4.1 State Responsibilities
6.9.4.2	~~6.9.4.2~~ 6.8.4.2 Contractor Responsibilities
6.9.4.3	~~6.9.4.3~~ 6.8.4.3 Performance Standards
7.1.d.4	Removed SURS component, which will be included in a separate RFP for a Program Integrity component. That component also will include common analytical tools and associated analytical resources for use throughout the IME plus SURS and MARS services and system functions. RFP component for which the bid proposal is being submitted for consideration: i. Medical Services ii. Pharmacy Medical Services iii. Provider Services iv. Member Services v. Revenue Collections ~~vi. Surveillance and Utilization Review Services (SURS)~~ ~~vii.~~vi. Provider Cost Audits and Rate Setting ~~viii.~~vii. Estate Recovery Services

1 PROCUREMENT OVERVIEW

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

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

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

1.1 Procurement Background

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

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

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

- Medical Services
- Pharmacy Medical Services
- Provider Services
- Member Services
- Revenue Collections
- Provider Cost Audits and Rate Setting

- Estate Recovery Services

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

1.2 RFP Purpose

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

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

Vendors may offer bid proposals on any or all components, but each individual component proposal must be self-contained and self-sufficient. The resultant winners of the contract awards are expected to perform all contractor responsibilities of the respective professional services components, as defined by this RFP and its supporting documentation, throughout the duration of the contract as specified in the sample contract in RFP Attachment O Sample Contract.

1.3 Authority

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

1.4 RFP Summary

The Department's objective for this procurement is to maintain the current business model of the cohesive IME with "best-of-breed" contractors located with state staff at a common facility. The IME is not unlike the conceptual view of the operation of a managed care organization (MCO) or health maintenance organization (HMO). This

strategy allows the state to retain greater responsibility for the operation and direction of healthcare delivery to Medicaid members in Iowa.

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

- The Iowa MMIS that the Core MMIS contractor operates and maintains
- The OnBase workflow process management system that the Core MMIS contractor operates and maintains
- The Data Warehouse/Decision Support (DW/DS) system that the state operates and maintains
- The replacement for the Siemens Hi-Path ProCenter v7.0 contact management (call center) and reporting tool that is in place today, which the Department will describe in RFP Section 5 Operating Environment when information is available

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

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

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

Since this procurement has the potential of resulting in contracts with multiple vendors, the identification and explanation of all interfaces and inputs that the bidder's solution requires from other components is an important evaluation criterion. As such, the work plan for each component must also identify the required interfaces to other key data sources. During the transition, it is essential that each contractor specify any contractor interface-related decision support requirements or capabilities that the data warehouse / decision support team can develop to streamline business processes for the IME.

Bidders who are awarded components will be required to work with the Core MMIS contractor and state technical staff to support integration of the respective work plans into the overall project plan for the IME. RFP Section 2.1 Procurement Timetable identifies the timeframe that bidders who have been awarded components will have after contract award in which to complete all transition-related tasks.

1.5 RFP Organization

This RFP contains the following primary sections:

- Section 1: Procurement Overview
- Section 2: Procurement Process
- Section 3: Program Description
- Section 4: Project Management
- Section 5: Operating Environment
- Section 6: Professional Services Requirements
- Section 7: Proposal Format and Content
- Section 8: Evaluation Process
- Section 9: Attachments

2 PROCUREMENT PROCESS

This section includes the following topics:

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

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

2.1 Procurement Timetable

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

Figure 1: IME Professional Services Procurement Timetable

Key Procurement Task	Date
Notice of intent to issue RFP	June 18, 2009
RFP issue	September 17, 2009
Bidders' conference	October 7, 2009
Bidders' questions due	October 21, 2009
Letters of intent to bid requested	October 21, 2009
Written responses to bidders' questions	November 12, 2009
Closing date for receipt of bid proposals and amendments	December 10, 2009
Oral presentations	January 19 through 27, 2010
Request for best and final offers (if any)	January 19 through 27, 2010
Best and final offers due (as requested)	January 26 through February 3, 2010
Notice of intent to award to successful bidders	February 16, 2010
Completion of contract negotiations and execution of the contract	February 24, 2010
CMS contract approval	April 24, 2010
Execution of contracts	April 24 through 30, 2010
Transition phase of contracts	May 3, 2010
Operations phase of contracts	July 1, 2010

2.2 Issuing Officer

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

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

2.3 Communication Restrictions

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

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

2.4 RFP Amendments

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

2.5 RFP Intent

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

2.6 Resource Library

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

2.7 Bidders' Conference

A bidders' conference will be held on the date listed in RFP Section 2.1 Procurement Timetable at 10:00 a.m., Central Time in the auditorium at the Wallace Building, which is a state office building located at 502 E 9th Street in Des Moines, Iowa, 50309. Although attendance at the bidders' conference is not a mandatory requirement for submission of a proposal, the Department strongly encourages bidders to attend.

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

2.8 Letter of Intent to Bid

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

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

The Department will not accept electronic mail and faxed letters of intent to bid. The Department asks bidders who plan to submit bid proposals for multiple RFP components to submit separate letters of intent to bid for each component on which they intend to bid. The Department's receipt of a letter of intent ensures the sender's receipt of written responses to bidders' questions in the formal question-and-answer process, comments, and any amendments to the RFP.

2.9 Questions and Clarification Requests

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

Bidders must submit questions and comments to the issuing officer by mail or electronic mail and not via fax. For questions via electronic mail, bidders should use the following e-mail address: *medicaidrfp@dhs.state.ia.us*.

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

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

2.10 Proposal Amendments and Withdrawals

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

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

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

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

2.11 Proposal Submission

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

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

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

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

2.12 Proposal Opening

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

2.13 Proposal Preparation Costs

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

2.14 Proposal Rejection

The Department reserves the right to reject any or all bid proposals in response to this RFP, in whole or in part, and to cancel this RFP at any time prior to the execution of a written contract. Issuance of this RFP in no way constitutes a commitment by the Department to award a contract.

2.15 Disqualification

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

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

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

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

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

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

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

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

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

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

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

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

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

m. The bidder provides misleading or inaccurate responses.

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

2.16 Material and Nonmaterial Variances

The Department reserves the right to waive or permit cure of nonmaterial variances in the bid proposal if the Department determines it to be in the best interest of the Department to do so. Nonmaterial variances include minor informalities that do not affect responsiveness, that are merely a matter of form or format, that do not change the relative standing or otherwise prejudice other bidders, that do not change the meaning or scope of the RFP or that do not reflect a material change in the services.

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

2.17 Reference Checks

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

2.18 Information from Other Sources

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

2.19 Proposal Content Verification

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

2.20 Proposal Clarification

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

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

2.21 Proposal Disposition

All bid proposals become the property of the Department. The Department will not return them to the bidder. At the conclusion of the selection process, the contents of all bid proposals will be in the public domain and be open to inspection by interested parties subject to exceptions provided in Iowa Code Chapter 22 or other applicable law.

2.22 Public Records and Requests for Confidential Treatment

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

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

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

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

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

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

2.23 Copyrights

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

2.24 Release of Claims

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

2.25 Oral Presentations

The Department will request bidder finalists to make an oral presentation of the bid proposal. The Department will ask bidders that are finalists for more than one RFP component to present all component presentations together. RFP Section 8 Evaluation Process provides additional information on the oral presentations process and the subsequent best and final offer process.

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

2.26 Proposal Evaluation

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

2.27 Financial Viability Review

For each of the components, the compliant bidder whose bid proposal receives the most points in accordance with the evaluation criteria is subject to a review for financial

viability. The Department may designate a third party to conduct a review of financial statements, financial references, and any other financial information that the compliant bidder provides in the Company Financial Information section of the bid proposal.

2.28 Notice of Intent to Award

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

2.29 Acceptance Period

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

2.30 Review of Award Decision

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

2.31 Definition of Contract

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

2.32 Choice of Law and Forum

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

2.33 Restrictions on Gifts and Activities

Iowa Code Chapter 68B restricts gifts which may be given or received by state employees and requires certain individuals to disclose information concerning their activities with state government. Bidders are responsible to determine the applicability of

this chapter to their activities and to comply with the requirements. In addition, pursuant to Iowa Code Section 722.1, it is a felony offense to bribe or attempt to bribe a public official.

2.34 No Minimum Guaranteed

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

3 PROGRAM DESCRIPTION

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

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

3.1 Medicaid Program Administration

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

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

3.1.1 Iowa Department of Human Services

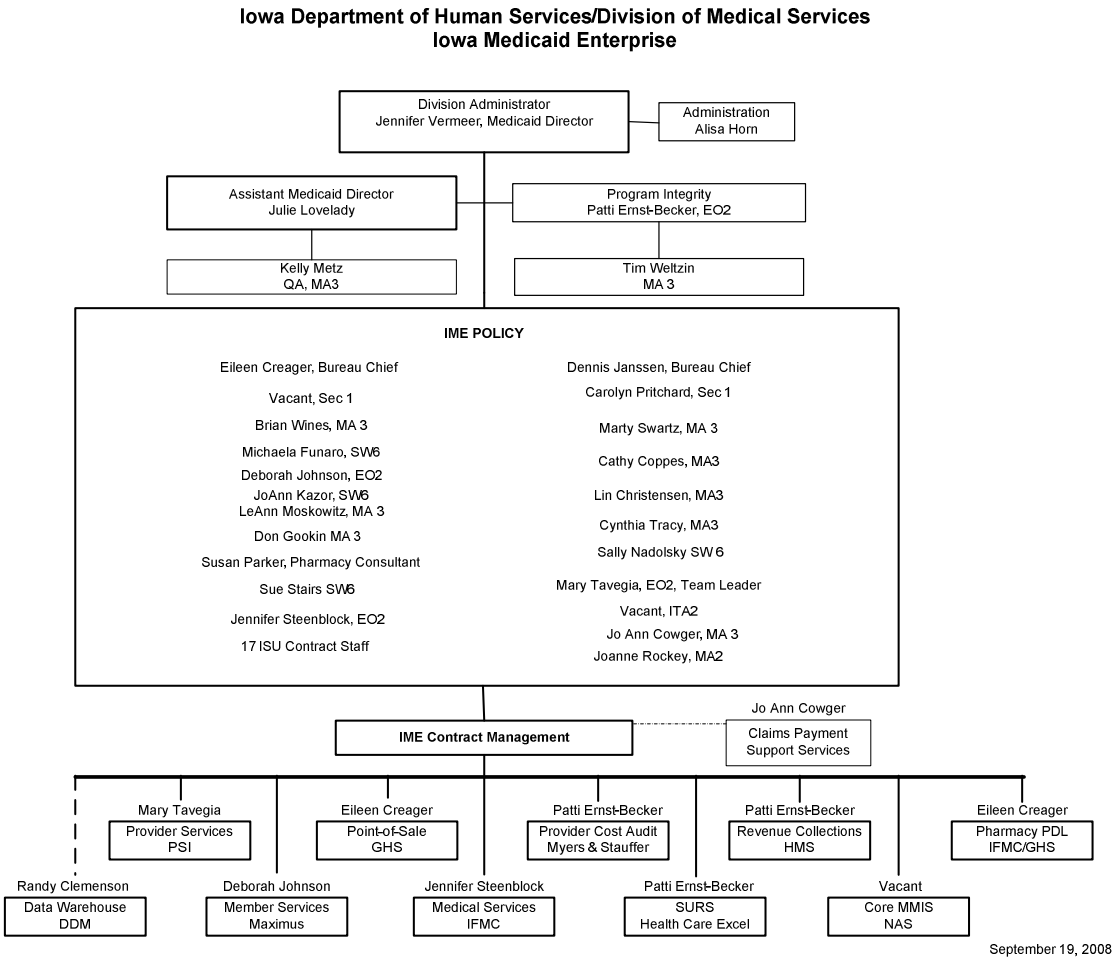
The Iowa Department of Human Services (DHS) is the single state agency responsible for the administration of the Iowa Medicaid Program. The Department has seven divisions, eight field services area offices, and nine state facilities that serve developmentally disabled, mentally ill or juvenile clients.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

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

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

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

Figure 2: IME Organizational Structure



3.1.2 US Department of Health and Human Services

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

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

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

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

3.2 Overview of Present Operation

This section includes the following topics:

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

3.2.1 Systems Responsibilities

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

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

3.2.2 Current MMIS Interfaces

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

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

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

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

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

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

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

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

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

i. Medicare Provider Number File – On request, the Medicare intermediary furnishes to the Core MMIS contractor a file containing Medicare provider numbers. This file is used by the Core MMIS contractor to verify Medicare provider numbers during the Medicaid enrollment process. The file is also used to investigate crossover claim cross-referencing problems.

j. Monthly paid claims file – The Core MMIS contractor provides a monthly paid claims file to other contractors including but not limited to the current Revenue Collections contractor.

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

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

3.2.3 Eligibility

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

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

This section includes the following topics:

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

3.2.3.1 Mandatory Title XIX Eligible Groups

The following groups are covered under the mandatory eligibility category:

a. Supplemental Security Income (SSI) recipients

b. Mandatory state supplementary assistance (SSA) recipients

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

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

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

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

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

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

i. FMAP recipients

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

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

l. Newborn children of Medicaid-eligible mothers

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

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

o. Foster care Medicaid under Title IV-E

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

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

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

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

3.2.3.2 Optional Title XIX Eligible Groups

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

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

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

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

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

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

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

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

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

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

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

k. Medicaid for Employed People with Disabilities (MEPD)

l. Non IV-E foster care Medicaid

m. Non IV-E subsidized adoption Medicaid

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

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

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

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

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

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

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

3.2.3.3 IowaCare

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

3.2.3.4 Children’s Health Insurance Program (CHIP)

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

3.2.4 Providers

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

3.2.5 Covered Services

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

3.2.6 Provider Reimbursement

This section includes the following topics:

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

3.2.6.1 Institutional Provider Reimbursement

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

3.2.6.2 Noninstitutional Provider Reimbursement

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

3.2.6.3 Specific Provider Categories and Basis of Reimbursement

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

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

Figure 3: Provider Reimbursement Categories

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

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

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

3.2.6.4 Restrictions on Reimbursement

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

3.2.6.4.1 Copayments

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

a. Services provided to members under age 21

b. Family planning services or supplies

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

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

d. Services provided to pregnant women

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

f. Emergency services (as determined by the Department)

3.2.6.4.2 Preadmission Review

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

3.2.6.4.3 Transplant and Preprocedure Review

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

3.2.6.4.4 Prior Authorization (PA) Requirements

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

3.3 Summary of Program Responsibilities

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

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

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

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

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

3.3.1 Determine Eligibility

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

3.3.2 Enroll Member

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

3.3.3 Disenroll Member

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

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

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

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

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

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

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

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

3.3.4 Inquire Member Eligibility

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

3.3.5 Manage Applicant and Member Communication

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

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

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

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

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

3.3.6 Manage Member Complaint and Appeal

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

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

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

3.3.7 Manage Member Information

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

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

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

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

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

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

3.3.8 Perform Population and Member Outreach

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

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

b. New initiatives from Program Administration

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

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

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

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

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

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

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

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

3.3.9 Enroll Provider

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

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

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

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

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

        i. Education and training/board certification

        ii. License to practice

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

        iv. Medicare/Medicaid sanctions

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

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

        vii. Verifying SSN or EIN and other business information

        viii. State/national accreditation

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

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

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

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

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

g. Performing scheduled user-requested:

   1. Credentialing reverification.
   2. Sanction monitoring.

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

3.3.10 Disenroll Provider

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

a. Processing of disenrollment

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

      i. Provider fails enumeration or credentialing verification

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

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

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

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

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

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

   1. The Capitation and Premium Payment Area

   2. The Prepare Provider EFT/Check process

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

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

3.3.11 Inquire Provider Information

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

3.3.12 Manage Provider Communication

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

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

3.3.13 Manage Provider Complaint, Grievance and Appeal

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

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

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

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

3.3.14 Manage Provider Information

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

3.3.15 Perform Provider Outreach

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

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

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

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

3.3.16 Produce Administrative or Health Services RFP

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

3.3.17 Award Administrative or Health Services Contract

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

3.3.18 Manage Administrative or Health Services Contract

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

3.3.19 Close-out Administrative or Health Services Contract

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

NOTE: The contract may end with no succession.

3.3.20 Manage Contractor Information

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

3.3.21 Manage Contractor Communication

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

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

Other examples of communications include:

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

b. Incentives to improve encounter data quality and submission rates

3.3.22 Perform Contractor Outreach

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

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

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

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

3.3.23 Support Contractor Grievance and Appeal

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

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

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

3.3.24 Inquire Contractor Information

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

3.3.25 Authorize Referral

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

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

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

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

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

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

3.3.26 Authorize Service

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

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

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

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

3.3.27 Authorize Treatment Plan

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

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

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

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

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

3.3.28 Apply Claim Attachment

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

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

3.3.29 Apply Mass Adjustment

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

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

3.3.30 Edit Claim

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

a. Determines its submission status

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

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

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

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

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

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

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

3.3.31 Audit Claim

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

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

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

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

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

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

3.3.32 Price Claim-Value Encounter

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

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

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

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

3.3.33 Prepare Remittance Advice-Encounter Report

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

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

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

3.3.34 Prepare Provider EFT/Check

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

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

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

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

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

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

f. Support frequency of payments

3.3.35 Prepare Coordination of Benefits (COB)/TPL

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

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

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

3.3.36 Prepare Explanation of Benefits (EOB)

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

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

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

3.3.37 Prepare HCBS Payment

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

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

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

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

3.3.38 Prepare Premium Capitation EFT/Check

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

a. Calculation of:

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

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

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

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

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

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

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

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

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

g. Support frequency of payments

3.3.39 Prepare Capitation Premium Payment

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

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

3.3.40 Prepare Health Insurance Premium Payments (HIPP)

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

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

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

3.3.41 Prepare Medicare Premium Payments

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

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

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

3.3.42 Inquire Payment Status

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

3.3.43 Manage Payment Information

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

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

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

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

3.3.44 Calculate Spend-Down Amount

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

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

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

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

3.3.45 Prepare Member Premium Invoice

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

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

NOTE: This process is limited to IowaCare and MEPD.

3.3.46 Manage Drug Rebate

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

3.3.47 Manage Estate Recovery

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

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

3.3.48 Manage Recoupment

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

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

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

3.3.49 Manage Cost Settlement

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

3.3.50 Manage TPL Recoveries

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

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

3.3.51 Designate Approved Services and Drug List

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

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

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

3.3.52 Develop & Maintain Benefit Package

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

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

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

a. Determination of scope of coverage

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

c. Identification of impacted members and trading partners.

3.3.53 Manage Rate Setting

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

3.3.54 Develop Agency Goals and Objectives

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

3.3.55 Develop and Maintain Program Policy

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

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

3.3.56 Maintain State Plan

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

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

3.3.57 Formulate Budget

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

3.3.58 Manage Federal Financial Participation (FFP) for MMIS

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

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

3.3.59 Manage Federal Medical Assistance Percentages (F-MAP)

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

3.3.60 Manage State Funds

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

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

3.3.61 Manage 1099s

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

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

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

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

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

3.3.62 Generate Financial & Program Analysis Report

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

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

3.3.63 Maintain Benefits/Reference Information

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

3.3.64 Manage Program Information

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

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

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

3.3.65 Perform Accounting Functions

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

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

b. Assign account coding to transactions processed in MMIS

c. Process accounts payable invoices created in the MMIS.

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

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

f. Manage cancelled/voided/stale dated checks

g. Perform payroll activities

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

i. Manage cash receipting process

j. Manage payment offset process to collect receivables

k. Develops and maintain cost allocation plans

l. Manages draws on letters of credit

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

n. Respond to inquiries concerning accounting activities

3.3.66 Develop and Manage Performance Measures and Reporting

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

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

3.3.67 Monitor Performance and Business Activity

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

3.3.68 Draw and Report FFP

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

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

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

3.3.69 Manage FFP for Services

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

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

a. Family planning services for which FFP is 90 percent

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

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

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

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

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

g. Refugee Medical Services-100 percent FFP

h. Money follows the person-special enhanced FFP

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

3.3.70 Manage Legislative Communication

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

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

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

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

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

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

3.3.71 Establish Business Relationship

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

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

3.3.72 Manage Business Relationship

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

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

3.3.73 Terminate Business Relationship

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

3.3.74 Manage Business Relationship Communication

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

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

3.3.75 Identify Candidate Case

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

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

Candidate cases may be identified by:

a. Provider utilization review

b. Provider Inquiry

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

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

3.3.76 Manage Program Integrity Case

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

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

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

j. Quality review

k. Performance review

l. Erroneous payment

m. Contract review

n. Audit Review

o. Other state work plan review (SURS)

p. Other

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

3.3.77 Establish Case

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

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

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

b. Disease management

c. EPSDT

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

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

3.3.78 Manage Care Management Case

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

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

a. Medicaid Waiver program case management

b. HCBS waiver program

c. Other agency programs

d. Disease management

e. Catastrophic cases

f. EPSDT

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

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

a Service planning and coordination with the member

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

c. Facilitating/Advocating for the member

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

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

3.3.79 Manage Medicaid Population Health

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

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

4 PROJECT MANAGEMENT

This section includes the following topics:

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

4.1 Procurement Approach

The Department is interested in obtaining all the services required in this Request for Proposal (RFP) by making a contract award for each respective professional services component. The RFP provides a complete description of the requirements for each requested component in Section 6. Bidders may offer proposals on any or all components.

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

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

4.2 Regulatory Compliance

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

4.3 Contract Phases

The activities resulting from the professional services contracts will occur in the phases described in the following topics:

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

Each phase has specific objectives, tasks and deliverables, all of which are directed toward continual support of the Medicaid program as described in this RFP (irrespective of changes in contractors). Because of the disparity in complexity of individual components, the Department anticipates that the task details in the components will vary also.

4.3.1 Transition Phase

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

The Department recognizes significant differences in the scope and complexity of the professional services contractors' responsibilities. The detail in the transition activities for the respective contractors should reflect this level of complexity.

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

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

4.3.1.1 Planning Task

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

4.3.1.1.1 Activities

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

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

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

4.3.1.1.2 State Responsibilities

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

a. Approve key personnel.

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

c. Provide responses to policy questions.

d. Review and approve contract deliverables.

e. Review and approve all plans.

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

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

4.3.1.1.3 Contractor Responsibilities

Contractor responsibilities for the planning task will be as follows:

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

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

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

d. Review the turnover plan from the current contractor.

4.3.1.1.4 Deliverables

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

a. Transition Project Plan

b. Transition Staffing Plan

c. Operations Staffing Plan

d. Operational Procedures Sign-Off

4.3.1.2 Operational Prereadiness Task

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

a. Staffing

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

b. Staff training

1. Data and telephone systems
2. Workflow process management
3. Operational procedures
4. Iowa Medicaid policy

c. Updated operations documentation

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

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

4.3.1.2.1 Activities

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

a. Prepare and complete an operational readiness checklist.

b. Assess operational readiness.

c. Implement corrective action plan as necessary.

e. Prepare weekly progress report.

f. Monitor operational readiness preparations.

4.3.1.2.2 State Responsibilities

The Department’s responsibilities for this task are:

a. Review and approve all operational readiness checklists.

b. Respond to contractor inquiries related to program policy.

c. Assure provision of training in data and phone systems as appropriate for all contractors.

d. Review the weekly progress reports.

e. Approve corrective action plans developed by the contractors.

4.3.1.2.3 Contractor Responsibilities

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

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

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

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

d. Conduct training for its staff.

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

4.3.1.2.4 Deliverables

The professional services contractors must provide the following deliverables, as appropriate to their responsibilities, for the Department's review and approval:

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

b. Completed checklist matrix for all training activities.

c. Completed checklist matrix for all interface operations.

d. Completed weekly status report.

e. Updated operational procedures documents as appropriate.

4.3.1.3 Operational Readiness Task

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

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

4.3.1.3.1 Activities

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

a. Finalize operations documentation.

b. Finalize interfaces.

c. Occupy permanent space in IME facilities.

d. Execute operational readiness checklist.

e. Implement corrective action plan for any problems identified.

f. Monitor operational readiness preparations.

4.3.1.3.2 State Responsibilities

For operational readiness, the Department's responsibilities are:

a. Respond to contractor inquiries related to program policy.

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

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

d. Approve training completion.

4.3.1.3.3 Contractor Responsibilities

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

a. Produce and update all operations documentation.

b. Establish interfaces, as necessary, to other component contractors and the Department.

c. Develop and obtain Department approval of operations schedule.

d. Complete all training.

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

4.3.1.3.4 Deliverables

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

a. Completed operational readiness checklist

b. Final documentation and operational procedures

4.3.2 Operations Phase

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

4.3.3 Turnover Phase

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

5 OPERATING ENVIRONMENT

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

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

5.1 Iowa MMIS

This overview of the Iowa MMIS includes the following topics:

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

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

5.1.1 Claims Processing Function

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.1.2 Recipient Function

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

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

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

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

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

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

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

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

5.1.3 Provider Function

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.1.4 Reference Function

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

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

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

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

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

The MMIS reference subsystem supports the following files:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.1.5 Medically Needy Function

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

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

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

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

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

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

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

g. Generate notification documents.

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

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

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

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

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

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

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

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

5.1.6 Management and Administrative Reporting (MAR) Function

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

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

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

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

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

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

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

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

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

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

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

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

d. Extensive internal program documentation

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

f. Thorough backup and restart capability that minimizes hardware use

5.1.7 Surveillance and Utilization Review (SUR) Function

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

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

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

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

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

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

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

5.1.8 Third-Party Liability (TPL) Function

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

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

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

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

a. Identify third party resources available to Medicaid members.

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

c. Avoid state costs for these services.

d. Recover third-party funds.

e. Report and account for related information.

5.1.9 Prior Authorization Function

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

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

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

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

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

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

5.2 Eligibility Verification Information System

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

a. Recipient eligibility request and response

b. Claims status request and response

c. Provider summary request and response

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

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

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

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

5.4 Workflow Process Management System

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

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

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

5.5 Call Center Management System

The Department is in the process of obtaining a replacement for the current call center system. The Department will update this section with a description of the new product when the information is available. Until that time, the RFP provides a description of the product currently in use.

Siemens HiPath® ProCenter® Enterprise v7.0 system (call center) is an integrated multimedia contact center solution featuring advanced skills-based routing for the mid-to-large contact center, with up to 750 active agents on a single site. Multiple HiPath ProCenter servers can be networked across sites for increased scalability to over 2,000 agents. Whether inbound or outbound interactions, single-site or multi-site, or integrated with your existing CRM systems, HiPath ProCenter Enterprise provides the key capabilities for enterprise contact centers.

The HiPath ProCenter Enterprise Manager desktop provides a unified and easy-to-use interface for all contact center management tasks. It is a highly visual and easily customizable console organized into "work centers" dedicated to the key contact center management tasks:

a. Designing intelligent multimedia and multi-site routing strategies and queue processing flows

b. Defining and viewing real-time monitoring and historical reporting across all media

c. Administering users and resources

d. Creating wallboard views and streaming "ticker tape" content for agent desktops

Design Center provides managers with a visual, workflow-style tool, the Design Editor, for defining multimedia routing strategies, multi-site networking and queue processing flows. To streamline the creation of flows, it offers a library of configurable and reusable routing, queue processing and networking components. Managers can create and edit flows using a drag-and-drop interface, where strategies are automatically checked and validated for completeness as they are created.

Call Director is a fully integrated, optional Interactive Voice Response (IVR) system. It allows the gathering of caller requirements, for example by prompting callers with interactive navigation menus. Managers can use Design Center's convenient drag-and-drop interface to integrate components into routing and queue processing flows. Call Director components are easily combined with other Design Center components, for example to read from and write to external databases. This facilitates basic transactional or self-service applications that previously may have required a more complex and expensive external IVR integration.

HiPath ProCenter Enterprise is built on a patented, industry-leading skills-based routing engine that matches incoming contacts with the best qualified agent on a contact-by-

contact basis. This allows managers to optimize the use of their most valuable resource, their agents. It will also help to raise First-Contact Resolution rates by optimally matching agent skills and customer requirements regardless of contact channel.

The HiPath ProCenter Enterprise Report Center runs on a customizable, visual reporting engine. It facilitates defining and viewing a virtually unlimited number of real-time, cumulative and historical reports for all media. The flexible interface makes tailoring specific reports or formats easy, without requiring an external report writer. Report Center provides insight into contact center operations, allowing for better operational monitoring, more effective decision making, and the ability to proactively spot patterns and respond – before they become problems.

Broadcast Center offers a fully integrated interface for defining rules-based streaming statistics for wallboards as well as "ticker- tape" views for the agent desktop or external plasma displays. Managers can configure rules-based thresholds for wallboard as well as broadcaster views, to alert agents visually of changes in the operational conditions of the contact center.

5.6 Iowa Automated Benefit Calculation (IABC) System

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

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

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

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

5.7 Individual Services Information System (ISIS)

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

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

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

5.8 Title XIX

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

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

5.9 Medicaid Quality Utilization and Improvement Data System (MQUIDS)

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

5.10 Iowa Medicaid Electronic Records System (I-MERS)

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

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

5.11 IMEServices.org

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

a. NPI verification

b. Provider enrollment renewal

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

d. Provider registration to view electronic remittance advice statements.

5.12 Provider Incident Reporting (Iowa Medicaid Provider Access)

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

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

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

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

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

This application will be in place by December 2009.

5.13 Medicaid IowaCare Premium System (MIPS)

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

5.14 Social Security Buy-In (SSBI)

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

5.15 Pharmacy Point-of-Sale (POS) System

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

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

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

- Claims processing for pharmacy claims
- Reference (formulary file)
- Prospective drug utilization review (ProDUR)
- Drug rebates
- Verification of provider and client eligibility
- Cost avoidance edits for third-party liability including private insurance and Medicare
- Price determination utilizing all pricing sources required
- Copayment calculation and tracking in accordance with state regulations
- Dispensing fees requirements
- Standard ProDUR and customized ProDUR interventions
- Customized messaging
- Acceptance of prior authorization data from multiple sources
- Preferred drug list and recommend drug list support

- Support for additional programs such as Medicare Part B and Medicare Transitional Assistance when they are initiated
- Customized override functionality
- Ability to implement smart PA edits using patient profiles and therapeutic classes
- Administration of federal and supplemental rebates
- Patient restrictions or lock-ins
- Physician exemptions from certain edits

6 PROFESSIONAL SERVICES REQUIREMENTS

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

- 6.1 General Requirements for All Components
- 6.2 Medical Services
- 6.3 Pharmacy Medical Services
- 6.4 Provider Services
- 6.5 Member Services
- 6.6 Revenue Collections
- 6.7 Provider Cost Audits and Rate Setting (PCA)
- 6.8 Estate Recovery Services

6.1 General Requirements for All Components

Following are the high-level general requirements for all components.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.1.1 Staffing

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

6.1.1.1 Named Key Personnel

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

for the contractor's approach to the RFP requirements. The following named positions for the professional services contractors require identified personnel and current resumes:

a. Account manager

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

c. Medical director (only for the Medical Services and Member Services contractors)

d. Operations managers (minimum of two key positions for the Medical Services contractor)

6.1.1.1.1 Key Personnel Requirements

General requirements for key personnel are as follows:

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

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

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

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

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

Figure 4: Key Personnel for Professional Services Components

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

Transition manager	Required: Three years of account management or major supervisory role for government or private sector healthcare payer or provider; bachelor's degree or equivalent relevant experience to the transition manager position.	Contract signing date	May also serve as account or operations manager. Must be 100 percent dedicated to Iowa Medicaid project until operations begin under new contract.
Medical director (Medical Services and Member Services units only)	Required: MD or DO with four years experience as medical director or senior manager for HMO, PRO or other administrative health care operation in a program of equivalent scope to Iowa. Medical Services contractor's medical director will be the Chief Medical Director for the IME.	30 days before operations phase	May not serve in any other capacity. Medical Services Medical Director must be on site and 100 percent dedicated to the Iowa Medicaid project.
Operations managers (minimum of two key positions for the Medical Services contractor)	Required: Minimum four years experience managing a major component of a health care operation in an environment similar in scope and volume to the Iowa Medicaid Program. The experience could be in claims management, eligibility, financial controls, utilization review, managed care enrollment, call center management or provider services. Desired: Bachelor's degree and four years' experience in managing health care operations.	30 days before operations phase	May not serve in any other capacity. Must be 100 percent dedicated to the Iowa Medicaid project.

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

6.1.1.1.2 Key Personnel Resumes

Resumes must include the following information:

a. Employment history for all relevant and related experience

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

c. All educational institutions attended and degrees obtained

d. All professional certifications and affiliations

6.1.1.1.3 Key Personnel References

References for key personnel must meet the following requirements:

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

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

c. For any client contact listed as a reference, must also include the agency's or company's full name and street address with the current telephone number and e-

mail address of the client's responsible project administrator or service official who is directly familiar with the key person's performance.

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

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

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

6.1.1.1.4 Department Approval of Key Personnel

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

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

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

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

6.1.1.1.5 Changes to Contractor's Key Personnel

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

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

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

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

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

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

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

3. Upon request, the project director or contract administration will have an opportunity to meet the proposed replacement key personnel in Des Moines, Iowa, within the ten-day period.
4. The project director or contract administration will not reject proposed replacement key personnel without reasonable cause.
5. The project director or contract administration may waive the 15-day notice requirement when replacement is due to termination, death or resignation of a key employee.

6.1.1.2 Special Staffing Needs

All contractors must meet the following special staffing needs:

a. All professional medical staff assigned to this account and working in Iowa must be licensed or certified for practice in the State of Iowa. In addition, professional medical staff must carry appropriate insurance.
b. The Revenue Collections and Estate Recovery Services contractors must provide a fidelity bond as specified in RFP Attachment O Sample Contract to protect against loss or theft for all staff that handle or have access to checks in the contractor's performance of its functions.
c. The contractor will develop and maintain a plan for job rotation and cross-training of staff to ensure that all functions can be adequately performed during the absence of staff for vacation and other absences.
d. The contractor will designate staff who are trained and able to perform the functions of sensitive positions when the primary staff member is absent.

6.1.2 Facilities

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

6.1.2.1 Permanent Facilities

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

6.1.2.1.1 State Responsibilities

a. At no cost to the vendor, the Department will provide the following:
    1. Office space for all IME staff (except Medical Services field staff)
    2. Desks, chairs, and cubicles (except Medical Services field staff)
    3. Network infrastructure and network connections

4. Personal computers
5. Telephones and facsimile (fax) machines (except Medical Services field staff, who receive a voice mailbox)
6. Photocopiers and copier paper (except Medical Services field staff)
7. Network printers (except Medical Services field staff)
8. Licenses for contractor staff using the MMIS, OnBase, replacement for Siemens HiPath ProCenter v7.0 to be named when information is available, Pharmacy POS, and DW/DS applications; standard Microsoft Office packages; and other standard software packages (such as Visio or MS Project) as necessary for individual jobs that require them

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

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

6.1.2.1.2 Contractor Responsibilities

The Department expects contractors to provide the following equipment:

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

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

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

d. Any special needs equipment for ergonomic or other purposes

6.1.2.2 Courier Service

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

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

   1. For large-volume mailings, the Department will identify the most cost-effective way to print and mail.
   2. The contractor generating the mailing will be responsible for providing a print-ready copy of the documents to the printer the Department selects (such as the state print shop or a commercial print shop).

3. The Core MMIS contractor will be responsible for the small-volume mailings, and the Department will identify the mailing entity for large-volume mailings.
4. The Department will pay all postage and external entity mailing costs for IME operational costs.

6.1.3 Contract Management

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

6.1.3.1 Performance Reporting and Quality Assurance

a. The contracts awarded through this RFP will contain performance standards that reflect the performance requirements in this RFP.
    1. The standards will include timeliness, accuracy and completeness for performance of or reporting about operational functions.
    2. These performance standards must be quantifiable and reported using as much automation as possible.
    3. The Department will select a subset of the standards for the contractors to include in a quarterly public report.
b. Meeting the performance standard in the selected indicators will represent average performance.
    1. The Department and the contractors will finalize specific performance reporting and measurements during the first year of operations as listed in RFP Section 6.1.3.1.a.
    2. After the first full year of operations, liquidated damages can result from failure to meet the standards.
    3. The liquidated damages will comprise 1.5 percent of the monthly operations fee if a single performance measure or the total score falls more than five points below the acceptable standard for more than three months in a six-month period.
c. In addition, the professional services contractors are responsible for internal quality assurance activities. The scope of these activities include the following functions:
    1. Identify deficiencies and improvement opportunities within the professional services contractor's area of responsibility.
    2. Provide the Department with a corrective action plan within ten business days of discovery of a problem found through the internal quality control reviews.
    3. Agree upon timeframes for corrective actions.
    4. Meet all corrective action commitments within the agreed upon timeframes.

6.1.3.2 State Responsibilities

a. The Department's contract administration for the IME is the principal contact with the professional services contractors and coordinates interaction between the Department and the professional services contractors. Contract administration includes the Contract Administration Office (CAO) and the Department's designated unit manager for each component. The Department's contract administration is responsible for the following activities:

   1. Monitor the contract performance and compliance with contract terms and conditions.
   2. Serve as a liaison between the professional services contractors and other state users.
   3. Initiate or approve system change orders and operational procedures changes.
   4. Assess and invoke damages for contractor noncompliance.
   5. Monitor the development and implementation of enhancements and modifications to the MMIS, DS/DW, workflow management, Pharmacy POS, and call center systems and inform the professional services contractors of the operational impact and scheduling of the system enhancements and modifications.
   6. Review and approve completion of the contractor's documentation as required by the Department.
   7. With participation from each professional services contractor, develop the report of that contractor's compliance with the performance standards, negotiate reporting requirements and measure compliance for the contractor's responsibilities.
   8. Review and approve professional services contractors' invoices and supporting documentation for payment of services.
   9. Coordinate state and federal reviews and assessments.
   10. Consult with the contractor on quality improvement measures and determination of areas to be reviewed.
   11. Monitor the contractor's performance of all contractor responsibilities.
   12. Review and approve proposed corrective actions taken by the contractor.
   13. Monitor corrective actions taken by the contractor.
   14. Communicate and monitor facilities concerns.

6.1.3.3 Contractor Responsibilities

The components contractors are responsible for the following contract management activities:

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

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

c. Provide to the Department reports regarding components contractors' activities. Individual professional services contractors are to propose and negotiate the content of these reports with the Department. The intent of the reports is to provide the Department and the component contractors with better information for management of the contractors' activities and the Medicaid program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.1.3.4 Performance Standards

The following performance standards apply to all contractors for all components unless specified differently.

6.1.3.4.1 Reporting Deadline

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

6.1.3.4.2 Documentation

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

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

c. Maintain Department-approved documentation of the methodology used to measure and report on all completed contract requirements and all performance standards. State the sources of the data and include enough detail to enable Department staff or others to replicate the stated results.

6.1.3.4.3 Annual Performance Reporting

a. The following performance standards are in addition to any performance standards required for individual components. Those individual requirements (if any) appear in the subsections of RFP Section 6 Professional Services Requirements for the individual components.

b. The contractor will provide annual performance reporting no later than October 15 of each contract base and option year for the state fiscal year (SFY) that ended in the prior month of June. (Example: Provide data by October 15, 2009, for the state fiscal year that ended on June 30, 2009.) The contractor will present the required data in Department-approved format and content for the following annually reported performance standards. DHS will publish the annual measurements by the following February 15.

6.1.3.4.3.1 Medical Services

a. Services performed by the Medical Services contractor that are included in annually reported performance standards are care management, prior authorization (except pharmacy prior authorization), long term care assessments, and reduction in the use of emergency room care, together with the identification and promotion of best practices for acute, long term and preventive health care under the direction of the medical director. The Medical Services contractor's performance will result in measurable state savings (including cost avoidance) as follows:

    1. $10 million in SFY 2011
    2. In every subsequent base and option year, an increase of 7 percent more than the SFY 2011 state savings or an increase of 7 percent more than the highest overall state savings in any year after SFY 2011, whichever is higher

b. The Medical Services contractor shall:

    1. Report annually to DHS, to the extent practical, on the health status of Medicaid Members grouped into cohorts by factors such as age, income, disability and optional eligibility.
    2. Report on a quarterly basis to DHS the per-member-per-month cost and total cost of all services and of each service for each cohort.
    3. Report annually to DHS on the most prevalent medical problems for which each cohort receives treatment paid for by Medicaid and the associated treatment and the treatment costs of each.
    4. Report annually to DHS, to the extent practical, on the reason for changes in medical service utilization rates for each cohort.

6.1.3.4.3.2 Pharmacy Medical Services

a. The Pharmacy Medical Services contractor will provide state savings as follows:

    1. $12.5 million in state savings in SFY 2011 (2009 number increased by 7 percent for 2010 and again for 2011)
    2. In every subsequent base and option year, an increase of 7 percent more than the SFY 2011 state savings or an increase of 7 percent more than the highest overall state savings in any year after SFY 2011, whichever is higher

b. The state savings shall be realized from the preferred drug list, improvements in rebate billing and collections not connected with increases in rebate rates, and any other new and quantifiable pharmacy cost recovery or pharmacy cost avoidance strategies (not connected with rebate changes or any rate changes) implemented by the contractor that do not conflict with or require changes in Iowa law.

c. Using the SFY 2010 statistically valid survey as a baseline, the Pharmacy Medical Services contractor shall demonstrate the satisfaction rate of Medicaid pharmacy services and achieve the following results:

    1. An overall satisfaction rating of 3.85 (on a 5-point scale) in SFY 2011

2. In every subsequent base and option year, an increase of 2 percent more than the SFY 2011 rating or an increase of 2 percent more than the highest overall rating in any year after SFY 2011, whichever is higher

d. The Pharmacy Medical Services contractor will use a Department-approved, consistent survey instrument and methodology. The Department will pay 50 percent of the cost of conducting each survey.

6.1.3.4.3.3 Provider Services

a. The Provider Services contractor will demonstrate provider satisfaction using as a baseline the SFY 2010 statistically valid survey of Iowa Medicaid providers (except pharmacy prescribers and providers). The Provider Services contractor shall demonstrate the satisfaction rate as follows:

    1. An overall satisfaction rating of at least 3.85 (on a 5-point scale) in SFY 2011
    2. In every subsequent base and option year, an increase of 2 percent more than the SFY 2011 rating or an increase of 2 percent more than the highest overall rating in any year after SFY 2011, whichever is higher

b. The Provider Services contractor will use a Department-approved, consistent survey instrument and methodology. The Department will pay 50 percent of the cost of conducting each survey.

c. Using DHS-approved contractor internal control, 99 percent of all information and responses to Medicaid providers by the contractor must be consistent regarding accuracy and content.

d. The Provider Services contractor shall demonstrate that the Iowa Medicaid provider network is sufficient to provide the same access to medical services as that available to members of the public who have comprehensive health insurance coverage.

6.1.3.4.3.4 Member Services

a. The Member Services contractor will demonstrate member satisfaction with administrative services and awareness of Member Services functions using as a baseline the SFY 2010 statistically valid survey of Iowa Medicaid members. The Member Services contractor shall demonstrate the satisfaction rate as follows:

    1. An overall satisfaction rating of at least 3.85 (on a 5-point scale) and awareness rating of at least 3.85 (on a 5-point scale) in SFY 2011
    2. In every subsequent base and option year, an increase of 2 percent more than the SFY 2011 rating or an increase of 2 percent more than the highest overall rating in any year after SFY 2011, whichever is higher

b. The Member Services contractor will use a Department-approved, consistent survey instrument and methodology. The Department will pay 50 percent of the cost of conducting each survey.

c. Using DHS-approved contractor internal control, 99 percent of all information and responses to Medicaid members by the contractor must be consistent regarding accuracy and content.

d. Services performed by the Member Services contractor that are included in annually reported performance standards are lock-in and member health education program (MHEP), disease management, and enhanced primary care management. The Member Services contractor's performance will result in measurable state savings (including cost avoidance) as follows:

   1. $15 million in SFY 2011, $16 million in SFY 2012 and $17 million in SFY 2013
   2. In every subsequent option year, an increase of 7 percent more than the SFY 2013 state savings or an increase of 7 percent more than the highest overall state savings in any year after SFY 2011, whichever is higher

6.1.3.4.3.5 Revenue Collections

a. The Revenue Collections contractor will demonstrate state savings resulting from state funds collected and state costs avoided (minus the costs of revenue collections activities and not including Medicare cost avoidance) as follows:

   1. $102.4 million in state savings in SFY 2011 (2009 number increased by 15 percent for 2010 and again for 2011)
   2. In every subsequent base and option year, an increase of 15 percent more than the SFY 2011 state savings or an increase of 15 percent more than the highest overall state savings in any year after SFY 2011, whichever is higher

6.1.3.4.3.6 Provider Cost Audit and Rate Setting

a. The Provider Cost Audit and Rate Setting contractor will provide state savings through collection of overpayments or avoidance of overpayments as follows:

   1. $20.4 million in state savings in SFY 2011 (2009 number increased by 10 percent for 2010 and again for 2011)
   2. In every subsequent base and option year, an increase of 10 percent more than the SFY 2011 state savings or an increase of 10 percent more than the highest overall state savings in any year after SFY 2011, whichever is higher

b. The Provider Cost Audit and Rate Setting contractor will provide state savings through state maximum allowable cost (SMAC) rate setting activities as follows:

   1. $7.8 million in state savings in SFY 2011 (2009 number increased by 7 percent for 2010 and again for 2011)
   2. In every subsequent base and option year, an increase of 7 percent more than the SFY 2011 state savings or an increase of 7 percent more than the highest overall state savings in any year after SFY 2011, whichever is higher

6.1.3.4.3.7 Estate Recovery Services

a. The Estate Recovery Services contractor will demonstrate state savings resulting from state funds collected and state costs avoided (minus the costs of estate recovery activities) as follows:

   1. $23.4 million in state savings in SFY 2011 (2009 number increased by 15 percent for 2010 and again for 2011)

2. In every subsequent base and option year, an increase of 15 percent more than the SFY 2011 state savings or an increase of 15 percent more than the highest overall state savings in any year after SFY 2011, whichever is higher

6.1.4 Training

All contractor staff will receive appropriate training in the systems functions that they will use. The Department will require that the Core MMIS contractor provide MMIS and workflow process management training. The Department will arrange contact management (call center) and tracking system training for all professional services contractor staff members who interface with these systems. Likewise, the Department will provide DS/DW system training to all professional services contractor staff members who will use the system.

a. Each contractor will be responsible for training its staff in the system and operational procedures required to perform the contractor's functions under the contract.

b. Each contractor will designate a trainer for its component who will train the professional services contractor's staff.

c. Each professional services contractor will provide initial and ongoing training to its staff in its operational procedures. The training will occur when:

   1. New staff or replacement staff are hired
   2. New policies or procedures are implemented
   3. Changes to policies or procedures are implemented

6.1.5 Operational Procedures Documentation

a. The professional services contractors must maintain operational procedures in the Department-prescribed format documenting the processes and procedures used in the performance of their IME functions. RFP Section 4 Project Management provides further detail on the expected deliverables.

b. The contractor will document all changes within 10 business days of the change in the format prescribed by the Department. The contractor will provide to the Department updated documentation within 10 business days of the date changes are installed. The contractor must use version control to identify current documentation.

c. All documentation must be provided in electronic form and made available online.

d. The contractor will maintain standard naming conventions in the documentation. The contractor will not reference the contractor's corporate name in any of the documentation.

6.1.6 Security and Confidentiality

a. When not occupying state space, the contractor must provide physical site and data security sufficient to safeguard the operation and integrity of the IME. The contractor

must comply with the Federal Information Processing Standards (FIPS) outlined in the following publications, as they apply to the specific contractor's work:

1. Automatic Data Processing Physical Security and Risk Management (FIPS PUB.31)
2. Computer Security Guidelines for Implementing the Privacy Act of 1974 (FIPS PUB.41)

b. In all locations, the contractor must safeguard data and records from alteration, loss, theft, destruction, or breach of confidentiality in accordance with both state and federal statutes and regulations, including but not limited to Health Insurance Portability and Accountability Act (HIPAA) requirements. All activity covered by this RFP must be fully secured and protected.

c. Safeguards designed to assure the integrity of system hardware, software, records, and files include:

1. Orienting new employees to security policies and procedures
2. Conducting periodic review sessions on security procedures
3. Developing lists of personnel to be contacted in the event of a security breach
4. Maintaining entry logs for limited access areas
5. Maintaining an inventory of Department-controlled IME assets, not including any financial assets
6. Limiting physical access to systems hardware, software, and libraries
7. Maintaining confidential and critical materials in limited access, secured areas.

d. The Department will have the right to establish backup security for data and to keep backup data files in its possession if it so chooses. Exercise by the Department of this option will in no way relieve the contractor of its responsibilities.

6.1.7 Accounting

a. The contractor will maintain accounting and financial records (such as books, records, documents, and other evidence documenting the cost and expenses of the contract) to such an extent and in such detail as will properly reflect all direct and indirect costs and expenses for labor, materials, equipment, supplies, services, etc., for which payment is made under the contract. These accounting records will be maintained in accordance with generally accepted accounting principles (GAAP). Furthermore, the records will be maintained separate and independent of other accounting records of the contractor.

b. Financial records pertaining to the contract will be maintained for five years following the date of final payment for the contract.

6.1.8 Banking Policies

Professional services contractors in the IME may receive checks or money orders related to the work that they perform. These checks and money orders may be for

refunds, recoveries, cost settlements, premiums, or drug rebates. All professional services contractors are to meet the following requirements for checks or money orders.

a. Any unit that receives checks or money orders will log and prepare all payments for deposit on the day of receipt and deliver them to the Revenue Collections contractor's designated point of contact for daily deposits.

b. Any unit that receives checks or money orders will assist in the maintenance and updating of the existing check classification code schematic, as necessary.

c. Any unit that receives checks or money orders will provide assistance to the Department, Division of Fiscal Management, in the reconciliation of the monthly Title XIX Recovery bank account if requested to do so.

Only the Revenue Collections contractor will make the deposits, as listed in RFP requirement 6.6.1.2.d.

6.1.9 Payment Error Rate Measurement (PERM) Project

a. Pursuant to the Improper Payments Information Act (IPIA) of 2002 and federal regulations at 42 CFR Parts 431 and 457, all states are required to participate in the measurement of improper payments in the Medicaid and CHIP programs. Iowa's participation began in federal fiscal year 2008 (October 1, 2007, through September 30, 2008) and is scheduled to continue every three years. The PERM Project measures the following aspects of the Medicaid and CHIP programs:

    1. Eligibility – the eligibility of the Member for the program and, if applicable, enrollment in a managed care plan.

    2. Medical Review – the medical necessity and appropriate medical classification of the service that was provided.

    3. Data Processing Review – the appropriate processing of the paid claim in the claims processing system, taking into account all necessary edits. This includes verifying the appropriate rate cell and payment for managed care (capitation) payments.

b. The Centers for Medicare and Medicaid Services (CMS) manage the PERM Project for all states, in which they contract certain aspects of the work. Required state involvement includes work that is performed by the IME and its contractors. During the course of the PERM Project, IME policy staff and contractors are responsible for the following:

    1. Department Program Integrity Director and Manager (Department Policy) – Project coordination between all IME units and overall project management for IME-related work

    2. DW/DS – Submission of paid claims data, including details associated with the claims that are selected for review

    3. Provider Services – Issuance of general project notifications, assistance with ensuring that providers submit their documentation timely, and provision of copies of licenses or other enrollment documents upon request.

4. Provider Cost Audits and Rate Setting – Assistance with repricing claims in cases of potential findings of overpayments or underpayments and consultation related to reimbursement methodologies and pricing of claims
5. Medical Services – Re-review of providers' documentation related to potential medical review errors and recommendation as to potential disputes
6. Core – Claims processing and MMIS expertise and consultation related to pricing and payment of claims
7. SURS – All follow-up provider recovery or repayment actions associated with findings of overpayments or underpayments

6.1.10 Subcontractors

a. Subcontractors must comply with all requirements of this RFP for all work related to the performance of the contract.

6.1.11 Regulatory Compliance

a. All professional services components acquired through this procurement are expected to be fully compliant with state and federal requirements (including HIPAA requirements) in effect as of the date of release for the RFP and with any changes that subsequently occur unless otherwise noted.

b. Bidders are responsible for describing how their proposed solution meets and will remain in compliance with state and federal requirements (including HIPAA requirements for transactions and code sets, national provider identifiers (NPI), privacy and security).

6.1.12 Audit Support

a. All contractors are expected to support and provide assistance with any state and federal audits and certifications as the Department requests. Examples include but are not limited to the annual audit that the state auditor's office conducts, the Medicaid Integrity Group (MIG) review and the Office of the Inspector General (OIG) audits.

6.1.13 No Legislative Conflicts of Interest

a. In the event that the bidder (prior to contract award) or contractor (after contract award) is directly involved with or otherwise supports legislation impacting the Medicaid program but outside the role as the IME contractor, notification to the Department is necessary.

b. If this situation exists prior to proposal delivery, the bidder should reflect this status in the response to the requirements in this section. If it exists prior to contract award, the bidder must notify the issuing officer in writing. If it exists after contract award, the contractor must notify contract administration prior to the next legislative session.

c. At all times, the bidder or contractor must ensure that the legislation does not pose a conflict of interest to IME work in their proposal and contract. If a conflict exists, the bidder or contractor must do one of these things: withdraw their support of the

legislation; or withdraw from consideration for contract award (while a bidder) or terminate contract according to termination requirements in the contract (while a contractor). This ongoing restriction applies throughout all phases of the contract.

d. At no time will the contractor use its position as a contractor with the Department or any information obtained from performance of this contract to pursue directly or indirectly any legislation or rules that are intended to provide a competitive advantage to the contractor by limiting fair and open competition in the award of this contract upon its expiration or to provide advantage the contractor during the term of the contract resulting from this RFP.

6.1.14 No Provider Conflicts of Interest

a. The contractor warrants that it has no interest and agrees that it shall not acquire any interest in a provider that would conflict, or appear to conflict, in any manner or degree with the contractor's obligations and performance of services under this contract.

b. The contractor will meet the following specifications to preclude participation in prohibited activities:

   1. The contractor will subcontract with another firm to conduct any desk reviews or on-site audits of a provider if the provider is a client of the contractor and the provider also provides services for the Department. However, the subcontractor will not conduct desk review or on-site audit of provider if provider is a client of either the contractor or subcontractor when said entity also provides services for the Department.

   2. The contractor will not use any information obtained by virtue of its performance of this contract and its relationship with the Department to provide what would be "inside information" to the contractor's clients who are providers of medical, social or rehabilitative treatment and supportive services on behalf of the Department or to the organizations that represent such providers.

   3. The contractor will disclose its membership on any and all boards. The contractor will not use any information obtained by virtue of its contractual relationship with the Department to its advantage by voting, speaking to, or attempting to influence board members in the performance of services by that board's organization.

   4. The contractor will not have ownership in any provider or provider organization that contracts with the Department or is approved by the Department to provide medical, social or rehabilitative treatment and supportive services on behalf of the Department.

6.2 Medical Services

Medical Services includes an array of professional and medical activities to support claims adjudication, program evaluation and quality assessment including the following functions: general medical and professional support; prevention and promotion, which includes early and periodic screening, diagnosis and treatment (EPSDT) support; prior authorization for medical and professional services (excluding pharmacy prior authorizations), quality of care evaluation for managed care and long-term care (LTC) participants, and LTC reviews. The following topics describe the functions associated with the Medical Services component:

- 6.2.1 Medical Support
- 6.2.2 Children's Health Care Prevention and Well-Child-Care Promotion
- 6.2.3 Medical Prior Authorization
- 6.2.4 Long-Term Care (LTC) Reviews
- 6.2.5 Quality of Care
- 6.2.6 Health Information Technology

6.2.1 Medical Support

The medical support function includes policy development and consulting for specific service areas on behalf of the Department. The Medical Services contractor needs appropriately skilled medical and professional staff to respond to Department requests. These requests require professional advice on individual service requests for all areas of the program as well as recommendations on potential additions or changes to the existing coverage array for Medicaid. Data sources for the medical support function include the Department policy and provider manuals for Medicaid and procedure codes, prior authorization (PA) requirements and pricing files, all residing on the Iowa Medicaid Enterprise (IME) data systems.

6.2.1.1 State Responsibilities

a. Approve all policy for covered services under the Medicaid program.

b. Ensure that policy updates are made available to all affected contractors in a timely manner.

c. Schedule and provide administrative support for provider appeal hearings.

d. Make decisions regarding policy recommendations that the contractor suggests.

6.2.1.2 Contractor Responsibilities

a. Meet the following objectives:

   1. Assure the Department that Iowa Medicaid policy reflects current medical practice.

2. Provide the Department with appropriate medical and professional expertise to evaluate any requests for new or unusual services or treatment modalities and their impact on current coverage policy.
3. Assure the Department that adequate medical or professional expertise is available to support administrative or court challenges to coverage decisions.
4. Assure the Department that decisions on individual service claims reflects current Iowa Medicaid policy.

b. Maintain the following interfaces:
   1. MMIS for entering individual claims decisions, updating IME data systems and making Department-requested updates to provider records with new procedure codes or provider types or prior approval indicators to reflect policy changes
   2. Contact with individual providers regarding medical policy questions and decisions on individual claims
   3. Formal policy clarifications or updates to selected provider groups on behalf of the Department

c. Provide written instructions for the management of medical codes for claims processing.

d. Provide professional consultation services to the Department on requested changes to Medicaid services, whether from the Department, providers or other stakeholders. This responsibility includes drafting proposed policy clarifications or new policy regarding services covered under the Medicaid program.

e. Assist the Department in responding to appeals, provide written statements to support decisions and participate in appeal hearings as requested by the Department. Provide administrative support in preparing for appeals.

f. Review individual service requests for policy exceptions. Provide a written request to the provider for any needed additional information. Provide recommendation to the Department.

g. Provide professional and technical support to the Department in responding to program reviews and audits.

h. Perform the functions of a CMS-designated Quality Improvement Organization (QIO) or CMS-designated QIO-like organization on behalf of the Iowa Medicaid Program in accordance with 42 CFR 431.630.

i. Provide professional support to Medicaid providers regarding policy, prior authorization or billing requirements. This support may be in the form of oral instruction or written communication and must be documented in IME data systems.

j. Retain (on staff or in a consulting capacity) medical and social service professionals and other fields as deemed necessary by the Department. The consultants must be knowledgeable about the Iowa Medicaid Program's policies and procedures regarding coverage and limitations. These consultants provide consultation in the following areas at a minimum:
   1. Anesthesiology
   2. Audiology
   3. Cardiovascular, vascular, and thoracic surgery

4. Child psychiatry
5. Chiropractic services
6. Dentistry
7. Disability services
8. Geriatrics
9. Family practice
10. Hematology
11. Medical supplies and equipment
12. Neurology
13. Obstetrics/gynecology
14. Occupational therapy
15. Oncology
16. Ophthalmology
17. Optical
18. Optometry
19. Organ transplant services
20. Orthodontics
21. Pathology
22. Pediatrics
23. Physical medicine
24. Plastic surgery
25. Podiatry
26. Psychiatry
27. Psychology
28. Radiology and nuclear medicine
29. Rehabilitation (physical therapy, occupational therapy and speech therapy)
30. Speech pathology
31. Developmental disability services (such as autism, Asperger disorder, brain injury and similar conditions)

k. Use the medical and professional staff and consultants to support the Department in responding to appeals on prior authorizations or other denials of coverage including claims inquiries, requests for exceptions to policy related to coverage of services, or other medical issues. The medical and professional staff or consultants, as appropriate, are required to attend appeal hearings and provide expert testimony in respect to their decisions on prior authorizations or other medical necessity cases. Medical and professional staff and consultants will also attend meetings with providers or other stakeholder groups in support of the Department programs and as requested by the Department. The Medical Services contractor's medical director will be the ultimate authority for medical decisions and will coordinate with the medical director of the Member Services contractor.

l. Certify new outpatient hospital programs for appropriateness of Medicaid coverage and make recommendations to the Department regarding appropriateness of new programs; determine criteria to be used regarding coverage for new programs.

m. Review all claims relating to hysterectomies, abortions, and sterilization.

n. Review orthodontia claims that suspend for discrepancy between the PA and claim.

o. Review other claims that suspend for review of documentation or pricing.

p. Review a statistically valid random sample of paid claims for private duty nursing and personal care for each quarter. Each home health agency's services should be reviewed at least once annually. Request the medical documentation, review and provide written feedback to provider.

q. Prepare for Department approval the CMS 64.96 Quarterly Report of Abortions, Hysterectomies and Sterilization, including supplemental worksheets relating to abortions and qualifications for federal funding.

r. Perform a monthly analysis of Medicare policy changes and provide report to Department policy staff of changes that may affect Medicaid.

s. When appropriate, request from providers, medical records, operative reports, and documentation of medical necessity, invoices, or other information necessary for proper resolution of claims.

t. Track communication with providers or other stakeholders over policy requests, billing procedures and appeals

u. Conduct monthly home health retrospective reviews on a statistically valid random sample of paid home health claims. Request home health agency documentation to determine medical necessity of reimbursement paid. Complete recoupment process if appropriate. Develop quarterly reports of issues resulting from the reviews.

v. Conduct retrospective reviews of acute care retrospective nonoutlier, acute retrospective outlier, hospital outpatient program, ambulatory payment classifications (APCs), and outpatient emergency department/observation status.

w. Provide technical assistance, reporting and monitoring of the nursing facility pay-for-performance program.

x. Provide support and technical assistance for any updates to the Minimum Data Set (MDS).

y. Provide medical support, coordination and facilitation for the clinical advisory committee (CAC). The committee members will represent all medical services providers. The committee will meet at a minimum quarterly and consist of seven to nine medical services providers. The IME medical services medical director will chair the CAC. Payment for pass-through costs shall be made as expenses are incurred as requested by the Department, which include but are not limited to quarterly meeting costs and ad hoc committee meetings for clinical advisory committee member attendance

z. Provide the following reports:

    1. Quarterly report of all appeal hearings, including status, disposition of case and recommendations for policy changes identified from appeals

    2. Monthly report of exception to policy requests, including requestor, status disposition of request and recommendations for policy changes identified from requests

    3. Retrospective review reports, in a format as determined by the Department

    4. An annual report summarizing activities of the CAC. The report shall be provided within 90 days of the state fiscal year end.

5. Prevalence reports for the CAC

aa. Manually review claims requiring the determination of medical necessity or appropriateness and take appropriate action to adjudicate the claims.

bb. Consult with Provider Cost Audits and Rate Setting contractor when medical judgment is needed for manual pricing of claims when no current fee or payment exists for the service.

cc. Provide support for the Payment Error Rate Measurement (PERM) Project by following up on all provider medical findings of overpayments and underpayments related to the PERM Project.

6.2.1.3 Performance Standards

a. Notify the provider within five business days of receipt of a claims inquiry with missing or incomplete information.

b. Send the final determination letter on a claims inquiry to the provider within 10 business days of receipt of complete documentation.

c. Provide recommendations for exceptions to policy within eight business days of receipt unless additional information is requested. If additional information is needed, request it within two business days of receipt.

6.2.2 Children’s Health Care Prevention and Well-Child-Care Promotion

Children’s Health Care Prevention and Well-Child-Care Promotion, which includes Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program benefits, is a proactive medical services program for members under the age of 21. Its goal is to prevent illness, complications, and the need for long-term treatment by screening and detecting health problems in their early stages. The EPSDT function supports the Department in the timely initiation and delivery of these services. The data sources for this function are:

a. Eligibility, claims, encounter and PA data from the Core MMIS

b. Input from the interdisciplinary team for the private duty nursing and personal care services provided to the special needs children under the EPSDT program

6.2.2.1 State Responsibilities

a. Provide policy interpretation and administrative decisions regarding EPSDT.

b. On a monthly basis, produce and print face sheet of notification letters for new eligibles and those due for a screen based on the periodicity schedule.

c. Follow up on foster care and medically needy with spend-down members who have requested service but who are not included on monthly summary reports as having service provided. The data should identify the children in these two categories that providers have referred for treatment. The information is reported by the Medical Services contractor to the Department and Iowa Department of Public Health (IDPH) for the non-HMO population.

6.2.2.2 Contractor Responsibilities

a. Maintain the following objectives:

   1. Satisfy all the Department requirements for member EPSDT notification, services tracking, and reporting.
   2. Perform tracking and monitoring of member screening and follow-up treatment, and provide linking of costs to specific conditions.
   3. Report all screenings and referrals, and track the treatments that result from the screening referrals.
   4. Produce extensive detail and summary reports, and case documentation necessary for the state to monitor the program as well as satisfy all federal reporting requirements. Documentation for the federal reports must be received by March 10 for Department review. It must use both claims and encounter data for the report. The information must be provided on a county and payment (fee for service/HMO) basis in addition to the statewide CMS 416 report. Produce the CMS 416 and expanded reports electronically and on paper.

b. Maintain the following interfaces:

   1. Iowa Department of Public Health (IDPH) to provide a monthly report on paid claims for the non-HMO population
   2. Interdisciplinary team for the private duty nursing and personal care services provided to the special needs children under the EPSDT program
   3. Iowa Department of Education
   4. Case managers to provide alerts on expiring PAs and members turning 21
   5. Child Health Specialty Clinic (CHSC) to provide a monthly electronic PA summary, including PAs on file for the next 6 months of authorized services for their clients

c. Assist the Department in determining the appropriateness of EPSDT services.

d. Process requests from providers or the public for services under the EPSDT program that are outside the coverage for the Medicaid program and make a determination of medical necessity within 10 days from receipt of the request.

e. Assemble and coordinate the service care planning and interdisciplinary team for the private duty nursing and personal care services provided to the special needs children under the EPSDT program.

f. Process prior authorization requests for private duty nursing services and personal care services for EPSDT special needs children.

g. For special needs children, notify case managers within 60 days of the due date that a PA is due. Provide reminders as necessary, if PA is not received four weeks prior to expiration date. Provide a monthly PA summary electronically to CHSCs for their clients. This summary needs to show authorizations forward for up to six months. If there is a change to the service request, the child's case manager can request a conference telephone call to review the PA decision with the team [case manager,

CHSC (if applicable), family, and provider]. If the decision on the PA request is not modified, no call is necessary.

h. Upon receipt of PA and all supporting information, immediately process new requests for private duty nursing and personal care services with the case manager (using Individualized Service Information System (ISIS) to identify case manager for some members) and process all other new requests within the standards required by the Department. Send a Notice of Decision (NOD) for modifications and denials.

i. Approve procedures (including prior authorization services) for private duty nursing of EPSDT special needs children and facilitate coordination of the service care plan for these individuals.

j. Provide to the Department, a service breakdown of the various procedures that have occurred during the course of a private duty nursing member's service.

k. Provide an alert to the case manager (using ISIS to identify the case manager for some members) 60 days prior to the end date of a PA and to the case manager 12 months prior to a member turning 21.

l. Recommend improvements to the EPSDT functionality.

6.2.2.3 Performance Standards

a. Process 95 percent of requests from providers or the public for services under the EPSDT program that are outside the coverage for the regular Medicaid program within 10 business days of receipt of complete information. Process 100 percent within 25 business days.

b. Notify case managers that a PA is due within 60 business days of the due date.

c. Complete 95 percent of PA requests not requiring physician review within 10 business days of receipt of completed PA and supporting documentation. Complete 100 percent within 20 business days.

d. Complete 95 percent of requests for private duty nurse and personal care services, when notified that the member is being discharged from the hospital within one business day of receipt of PA request. Complete 100 percent within three business days.

e. Complete 95 percent of PA requests requiring a physician review within 15 business days of receipt of completed PA and supporting documentation. Complete 100 percent within 30 business days.

f. Provide an alert to case manager 95 percent of the time 12 months prior to the member turning 21 years of age. Complete 100 percent six months prior to the member turning 21 years of age.

6.2.3 Medical Prior Authorization

Prior authorization (PA) of health services is a way of managing certain services and equipment provided to program members. The PA process includes several components:

a. Developing policy for services requiring prior authorization

b. Building the file structure to identify those services, usually through procedure codes, requiring authorization prior to payment and performing the file maintenance to keep the list current

c. Adjudicating the actual requests for authorization

d. Using file interfaces to upload the authorization to the claims payment system

The Iowa MMIS includes a prior authorization file containing the procedure codes requiring prior authorization. The system supports the entry and processing of PAs that are pending, approved, or denied. Pending authorizations may be entered and later updated based on the outcome of the review of these requests. Updates to the file are processed by the Medical Services contractor when received and are updated either through file updates or through online updates by staff. The PA system supports the business operations of the Medical Services contractor related to prior authorizations, which includes processing prior authorization requests for those services specified by the Department including medical and dental.

The Medical Services contractor is responsible for providing qualified staff whose duties include verification of the medical necessity of specified services prior to provision of these services and other processes required to authorize payment for specified services. Inputs to the prior authorization function include hardcopy, telephone, facsimile, and electronic prior authorization requests.

6.2.3.1 State Responsibilities

a. Determine specific services requiring prior authorization and provide a listing to the Core MMIS contractor and the Medical Services contractor.

b. Provide written guidelines for prior authorization processing, including criteria for specific edits in the MMIS.

c. Monitor the Medical Services contractor's performance of the prior authorization function.

d. Contract with a CMS-designated QIO **or CMS-designated QIO-like organization** to perform prior authorization and preadmission review of selected services.

6.2.3.2 Contractor Responsibilities

a. Meet the following objectives:

   1. Monitor services requiring prior authorization.

   2. Control utilization of targeted services by providing a deterrent to inappropriate use.

   3. Provide data to support management of services requiring prior authorization.

   4. Process prior authorization requests, including pended, approved, modified, and denied.

b. The Medical Services contractor is responsible for processing the prior authorizations for the following types of services. Currently, this includes private duty nursing (EPSDT), personal care (EPSDT), certain dental services, DME, hearing aids, eyeglasses, certain medical services and psychological services. Information

on specific procedures requiring prior authorization and volume of requests is available in the bidder's library.

c. Provide professional medical staff to perform prior authorization on certain services, including a full-time, on-site medical director (an experienced managing physician who can be an MD or DO), nurses, and peer consultants (such as psychologists, dentists, therapists and other medical professionals) with recognized credentials in the service area being reviewed. These medical consultants must be licensed or otherwise legally able to practice in the state of Iowa and possess the professional credentials to provide expert witness testimony in hearings or appeals.

d. Staff, maintain and respond to the toll-free telephone line that providers (including LTC providers) call to determine the status of their PA request and handle all routine inquiries and correspondence regarding PAs. When a service requires PA, the provider submits the request to the Medical Services contractor's medical and professional staff. The Medical Services contractor staff reviews all requests for PA to determine whether the service to be provided is medically necessary and appropriate, determines whether the service should be approved or denied based on Department guidelines, and (if approved) determines an approved duration as required. When necessary, the medical and professional staff must attempt to obtain from providers additional information that is needed to adjudicate the PA requests.

e. Medical Services contractor staff may approve but can not deny a PA request without first referring it to a peer consultant.

f. Accept PA requests on paper, by facsimile or electronically, in formats approved by the Department.

g. Accept PA requests from participating Medicaid providers, Department staff, or other sources determined by the Department.

h. Maintain PA requests and supporting documentation in the workflow management system that the Department provides. Hardcopy requests and documentation will be imaged by the Core MMIS contractor and be made available to the Medical Services contractor electronically.

i. Review all requests for prior authorizations that are required for services as well as prior authorization requests that providers submit when ambiguity exists as to whether a particular item or service is covered. Determine whether the service to be provided is medically necessary and appropriate and whether the service should be approved, denied or modified.

j. When necessary, attempt to obtain from providers additional information that is needed to adjudicate the PA requests.

k. Provide PA decisions through online updates to the MMIS by Medical Services staff.

l. Produce and send adverse action notices (NODs) on PA to the member indicating the reason and the circumstances for the adverse action, the appropriate section of the Iowa Administrative Code, information as to the specific reason for the denial that members would understand as the basis for denial and the right to appeal.

m. Send a copy of the Request for Prior Authorization form 470-0829 to the provider with the review decision. Do not list the identity of the consultant on the notice.

n. Produce and mail a decision notice to the member for denied ambulance claims.

o. Ensure timely review of all requests and subsequent notifications to providers, pursuant to the Department performance standards. Automatically approve any PA request not acted on within 60 days of receipt (per the Iowa Administrative Code).

p. Represent the Department in appeals on modified and denied PAs. Attend appeal hearings to support the decision unless excused by the Department. Provide written appeal summary to support the PA decision.

q. Obtain Department approval to support any request for review resulting from a decision reversed on appeal and involve Department policy staff as needed.

r. Provide a monthly report of all PAs, exceptions, appeals, count of overturned decisions, reasons for overturned decisions and recommendations on a monthly basis.

s. Develop and recommend criteria to be used for PA.

t. Communicate in writing to the Department any recommendations to amend or clarify PAs based on provider questions and communication. This would include tracking of issues presented by providers relative to PA.

u. Meet the PA file maintenance requirements identified below. File maintenance will be coordinated with the MMIS and could be delegated to the respective system contractors, depending upon the Department and contractor preferences.

   1. Assist the Department in identifying when and for which procedures, PA or preprocedure review should be required.

   2. Change the scope of services authorized at any time and extend or limit the effective dates of authorization.

   3. Accept and process electronic PA requests (ANSI X12 278 Request for Authorization).

   4. Maintain detailed audit trail reports of all changes to PA records.

   5. Indicate date of last change, ID of the person making the change, and information changed for each PA record.

   6. Maintain a PA data set, which at a minimum, must include the following information:

      i. Unique PA number

      ii. Iowa Medicaid provider number and NPI, plusunique provider identification number (UPIN) if applicable

      iii. Member ID

      iv. Status of the PA request, including pending, denied, authorized, or modified

      v. Multiple line items for requested and authorized services by procedure code and range of procedure codes or specification of multiple, distinct procedure codes

      vi. Diagnosis code and range of diagnosis codes or specification of multiple distinct diagnosis codes

      vii. Type of service codes

viii. Units of service billed and authorized

ix. Dollar amount billed

x. Line-item approval/denial indicator

xi. Beginning and ending effective dates of the PA

xii. ID of authorizing person

xiii. Date of PA request

xiv. Date of request for additional information

xv. Date of PA determination

xvi. Date PA notice sent

7. Include the most specific description possible in the reason for denial field on the PA.

v. Maintain a free-form text area on the PA record for special considerations, along with a flag to allow the system to identify authorizations with special considerations. Provide separate text area that will be printed on the PA notice, using predefined messages as well as unique messages.

w. Maintain provider-specific prior authorizations. PAs for Department-specified services can be transferred without the PA process beginning again.

x. Edit PAs online, including:

1. Validation of provider ID and eligibility
2. Validation of member ID
3. Validation of procedure and diagnosis codes
4. Duplicate authorization check to previously authorized or previously adjudicated services (including denials) and duplicate requests in process

6.2.3.3 Performance Standards

a. Complete 95 percent of PA requests not requiring physician review, enter into system, and send appropriate notice within 10 business days of initial receipt. Complete 100 percent within 15 business days of initial receipt.

b. Complete 95 percent of PA requests requiring physician review, enter into system and send appropriate notice within 15 business days of initial receipt. Complete 100 percent within 20 business days of initial receipt.

c. For PA requests for which additional information has been requested and not received, process 95 percent of them no earlier than 45 days from initial receipt (to allow time for receipt of the requested information) and no later than 60 days of initial receipt. Complete 100 percent within 60 business days of initial receipt.

6.2.4 Long-Term Care (LTC) Reviews

The contractor will perform prescreening, admission, continued stay, quality and utilization reviews (URs) for identified LTC services. Various reviews will be conducted

for LTC programs including but not limited to nursing facility, intermediate care facilities for individuals with mental retardation (ICF/MR), home and community-based services (HCBS) waiver programs, remedial services, habilitation services, Psychiatric Medical Institution for Children (PMIC), Mental Health Institute (MHI), hospitals, out-of-state placements, and Program for All-inclusive Care for the Elderly (PACE) programs. The various reviews provide an objective and accurate evaluation of the individual's needs and are used to determine medical necessity and appropriateness of admissions to LTC services. The contractor will perform LTC reviews for members based on the Department guidelines.

6.2.4.1 State Responsibilities

a. Provide guidelines for staff qualifications of contractor staff conducting the assessment reviews.

b. Provide policy regarding the prescreening, admission, continued stay reviews, quality reviews and UR processes according to specific program guidelines.

c. Provide guidelines for an appeal process.

d. Monitor the performance of the LTC review processes.

e. Approve all LTC review edits and audits.

f. Approve all policies for covered services.

6.2.4.2 Contactor Responsibilities

a. Meet the following objectives:

    1. Provide timely and objective functional eligibility decisions for LTC services.

    2. Determine medical necessity and appropriateness of admissions to LTC services.

    3. Provide information to members and families as directed by the Department.

    4. Determine continued medical necessity and appropriateness for LTC services.

b. Provide professional medical staff to perform the LTC reviews on all members who apply for LTC services. The type and qualifications of the staff must be approved by the Department.

c. Conduct level of care determinations (initial and continued stay reviews) in accordance with all state and federal requirements for applicants requesting Medicaid funding for facility services (nursing facility, ICF MR, PMIC) or review-based services (HCBS waivers, PACE) and other services as requested by the Department.

d. Conduct Preadmission Screening and Resident Review (PASRR) Level 1 screenings for all nursing facilities' admissions, regardless of pay source, in accordance with all state and federal requirements.

e. When necessary, attempt to obtain additional information that is needed to determine the member's need.

f. Maintain documentation for all reviews completed.

g. Conduct quality reviews in accordance with all state or federal requirements of all Iowa Medicaid certified facilities including but not limited to NFs, ICFs/MR, habilitation, HCBS waiver programs, and targeted case management (TCM) as approved by the Department and other services as requested. Coordinate the reviews with other contractors and state staff. The quality reviews evaluate level of care needs, medical necessity, person-centered care planning, effective services delivered timely, and discharge plans. The results of these reviews need to be at a satisfactory level as evidenced by:

   1. Services are individualized and reflect member's preferences and needs.
   2. Services are implemented as planned and produce the desired results.
   3. Members are safe and secure.
   4. Members are free to exercise their rights.
   5. Services strive to improve quality outcomes for members.

h. Conduct UR activity in accordance with 42 CFR Part 456.

   1. For ICF/MR, NFMI, PMIC and MHI, the purpose of the annual on-site review is to evaluate the appropriateness of placement and that services are meeting the treatment needs of the members.
   2. For hospitals, conduct a desk review every three years of each hospital's utilization control processes to assess their comprehensiveness and verify their completion.

i. Notify providers of the results of the LTC reviews:

   1. Notice of decision for remedial services
   2. URs for ICF/MR, NFMI, PMIC, MHI, and hospitals
   3. Quality reviews for HCBS, habilitation and remedial services, and TCM
   4. A report on the MDS validation review to the facility within 30 days of the last date of the on-site review

j Update IME data systems with the results of the LTC reviews within the timeframes specified in the performance standards.

k. Respond to phone calls from members on the questions or status of admission and continued stay reviews within two business days.

l. Conduct annual on-site MDS validation reviews on 25 percent of Medicaid-eligible residents in each of Iowa's certified NFs. The review will ensure a minimum inter-rater reliability of 95 percent.

   1. The sample shall include a representative from each RUG category, with a minimum of 40 percent of the sample being residents identified in the physical function reduced case mix category.
   2. The on-site validation review will utilize all pertinent information, including the MDS, the member's medical record, interviews with facility staff and observation of the resident.

3. Conduct exit conference with the NF administrative staff to identify inconsistencies found in the MDS fields utilized for RUGs III classifications. The exit conference shall include MDS assessment with patterns of errors, areas that need improvement, staff education and training needs, and notice of when the final report will be sent to the facility.
4. Provide formal written report of the MDS validation process.
5. If a facility has an error rate greater than 25 percent, the review shall be increased to include an additional 25 percent of the Medicaid members. Notify the Department if a nursing facility's error rate is greater than the established threshold or questionable patterns of coding or transmission are noticed.
6. Provide qualified and trained staff to perform the MDS validation reviews. The Department must approve the guidelines for the type and experience level of proposed staff.

m. For habilitation services, complete determination of need initial assessments, annual reviews and approve service plans.

n. Operate a quality assurance and compliance monitoring plan for the PACE providers in accordance with 42 CFR, Part 460.

1. In cooperation with CMS and the Department for newly established PACE programs, provide adequate staff to complete the initial technical assistance review.
2. Conduct at least one unscheduled quality review on site annually utilizing the quality review process developed by CMS.
3. In cooperation with CMS and the Department, participate with adequate staff in the annual reviews of the PACE organization during the three-year trial period and biannually thereafter.
4. Write reports utilizing CMS format.
5. Monitor and follow up to ensure corrective actions will be implemented.
6. Submit reports to the Department within 30 business days.

o. Select a statistically valid random sample of remedial service progress notes each quarter. Each provider must be reviewed annually.

1. Review the notes for compliance with documentation standards.
2. Send feedback to the provider regarding findings of the review.
3. Calculate overpayment and follow the Department's appeal procedures.
4. Participate in provider appeals of the findings and any disallowance.
5. Complete within 20 business days of the end of the quarter.

p. For remedial services, provide to Department monthly activity reports and quarterly progress reports as specified in RFP Section 6.1 General Requirements for All Components.

q. Prepare and submit to the Department the following:

1. Report on the members approved and denied for LTC services based on assessments and reassessments using Department-approved criteria
2. Reports of appeal activity with fiscal year-to-date totals with trending and recommendations for improvements
3. Monthly activity and quarterly progress reports for remedial services with trending and recommendations for improvements
4. Quarterly report of MDS validation review activity and findings

r. Provide reports to the Department as identified in a Department-approved format within 30 business days of completion of the on-site quality reviews and URs. Forward to the Department of Inspections and Appeals (DIA) upon receipt of Department approval.

s. Provide a written report to the provider that includes the evaluation of the ICF/MR, NF/MI, PMIC, MHI and hospital UR plan compliance and recommendations for enhancements, corrective action or both within 30 business days of completion of the on-site visit.

t. Provide written report on the findings of the quality assurance and compliance monitoring of PACE providers and recommendations, corrective action or both within 30 days of completion of the review.

6.2.4.3 Performance Standards

a. Complete 95 percent of level-of-care (LOC) determinations for admissions within two business days of receipt of complete information. Complete 100 percent within five business days.

b. Complete 95 percent of LOC determinations for continued stay reviews within five business days of receipt of complete information. Complete 100 percent within ten business days.

c. Conduct annual on-site UR visits between months 10 and 12 following the prior year visit to ICF/MR, nursing facility for the mentally ill (NF/MI), PMIC and MHI facilities.

e. For habilitation services, complete the following:

1. Complete determination of need initial assessment within two business days of notification in IME data systems.
2. Complete determination of need review within five business days of notification in IME data systems.
3. Approve service plan within two business days of notification in IME data systems.

f. For remedial services, complete the following*:*

1. Complete initial plan review within two days of receipt of information
2. Complete continuing review within five days of receipt of information
3. Complete quality improvement reviews within 30 days of receipt of information

6.2.5 Quality of Care

The quality of care (QOC) function is designed to monitor the care provided to Iowa Medicaid members. The Medical Services contractor is expected to focus on the three managed care programs as the basis for this quality function. The managed care programs include MediPASS (a primary care case management system), the HMO network (if any) and the Iowa Plan for behavioral health. The contractor will use monitoring programs in place in the Medicaid program today as a base but will be expected to design a comprehensive report card that looks at quality of care across all managed care programs under Medicaid.

The primary data source will be claims and encounter data from the data warehouse. The MMIS will provide information on capitation payments and providers. The managed care providers will provide information on provider panels and access.

6.2.5.1 State Responsibilities

a. Provide current policy requirements for member access and quality standards, to the extent available.

b. Provide quality and access requirements for HMO, MediPASS and Iowa Plan contracts.

c. Facilitate access to HMO, MediPASS and Iowa Plan contractors.

d. Provide policy direction to contractor in defining components of federally approved quality plan.

6.2.5.2 Contractor Responsibilities

a. Meet the following objectives:

    1. Determine the status of Medicaid program contract providers' compliance with service agreements.

    2. Determine health status of Medicaid members, to the extent information is available through assessment tools such as HEDIS.

    3. Design a process for measuring overall health status of Medicaid members.

b. Perform technical analyses, data collection and reporting on the performance of the HMOs (if any) in the Iowa Medicaid Program. This responsibility includes:

    1. Ensuring that federal requirements for managed health care contracting are met

    2. Assisting the Department in the preparation of any managed health care waivers necessary to operate the program

    3. Ensuring the HMOs' provider panel adequacy
    The Department will provide the Medical Services contractor with a quarterly report of the HMOs and their enrolled providers. The Medical Services contractor will perform a quarterly review of the HMO provider panel data to assure each HMO is adequately serving the number of enrollees based on the number and type of providers enrolled with the HMO. The findings are reported to the Department.

4. Participating in any federal reviews, as necessary.
5. Conducting and reporting on appointment surveys
6. Performing call center and quality assurance/utilization review (QA/UR) functions
7. Providing medical expertise for review of appeals that occur subsequent to an adverse action by the health plans
8. Ensuring that providers are adequately trained and understand all QA/UR systems, grievance procedures and grievance resolution
9. Collecting and analyzing data to ensure adequate system entry and data integrity of all encounter-based data
10. Sponsoring and participating in biweekly meetings with the Department and the HMOs
11. Providing meeting minutes for approval to the Department

c. Perform UR, quality assurance, grievance resolution, data collection, technical analysis, and reporting for the HMOs and MediPASS providers. Specific data to be collected and analysis performed will be negotiated between the contractor and the Department. Report all analysis outcomes, including but not limited to MediPass access issues, providers not making enough referrals or providing services, and member-reported quality of care issues.

d. Evaluate adequacy of provider panels for the contracted Managed Care Organizations (MCOs)

e. Verify compliance by MediPASS providers with requirements for 24-hour coverage for assigned Medicaid members.

f. Perform quality assurance, UR, and grievance resolution for the Iowa Plan participants, which include:

1. Ensuring that federal requirements for managed health care contracting are met
2. Assisting the Department in the preparation of any managed health care waivers necessary to operate the program
3. Ensuring the Iowa Plan's provider panel adequacy. The Department will provide the Medical Services contractor with a quarterly report of the Iowa Plan enrolled providers. The Medical Services contractor will perform a quarterly review of the provider panel data to assure the Iowa Plan is adequately serving Medicaid members. The findings are reported to the Department.
4. Participating in any federal reviews, as necessary
5. Conducting and reporting on appointment surveys
6. Performing call center and QA/UR functions
7. Providing medical expertise for review of appeals that occur subsequent to an adverse action by the health plans
8. Ensuring that providers are adequately trained and understand all QA/UR systems, grievance procedures, and grievance resolution

9. Collecting and analyzing data to ensure adequate system entry and data integrity of all encounter-based data

g. Design, in conjunction with the Department, a report card to provide a qualitative assessment of the MCOs in the Iowa Medicaid Program. The contractor must have a test version of such an instrument ready for use by the beginning of the second year of operation.

h. Collaborate with and provide requested data and other information requested by the External Quality Review (EQR) contractor on behalf of the IME.

i. Accept referrals from other IME units regarding continuity of care issues from managed care enrollees. With referral, begin the special authorization process.

j. Complete EQR report as required by CMS following each on-site MCO audit. Perform EQR audits to comply with CMS-mandated regulations and protocols requiring external evaluations of the quality and utilization processes for MCO systems. These reviews are performed for the MCOs contracted as Medicaid providers in Iowa.

j. Provide quarterly quality assurance and UR reports to MediPASS providers.

k. Provide quarterly paid claims audits of MediPASS enrollees.

l. Use the Department's data warehouse as the primary source for claims and encounter data. The Medical Services contractor will also need to obtain HEDIS information from the EQR contractor, and may need performance measures from HMO contractors, either from Department staff or through the claims processing contractor.

m. Provide recommendations to the Department for further investigation.

6.2.5.3 Performance Standards

a. Provide quarterly reports within 10 business days of the end of the reporting quarter.

b. Submit EQR report to the Department within 45 business days of the on-site audit of a managed care organization.

6.2.6 Health Information Technology

The Department has begun development of a State Medicaid Health Information Technology (HIT) Plan. The document will describe the Department's strategic plan to align with the Iowa e-Health Project. The State Medicaid HIT plan will support the following objectives:

- Align with the Iowa HIE efforts
- Support provider adoption, including technical assistance and provider incentives
- Leverage the availability of clinical data for administrative efficiencies
- Provide quality reporting including population management for healthier Medicaid members and Iowans

6.2.6.1 State Responsibilities

a. Provide current policy, status and lines of communication regarding HIT plan.

b. Set direction for contractor as plan matures.

6.2.6.2 Contractor Responsibilities

a. Participate in development of HIT plan as directed by the Department.

b. Represent the Department in discussions with provider stakeholders.

c. Protect the privacy of Medicaid members in all recommendations.

d. Contribute to the definition of incentive payment strategies.

e. Champion the plan within the Medical Services unit as the plan matures and features of the plan are enacted.

f. Participate in planning and execution of statewide provider assessment as directed by the Department.

6.3 Pharmacy Medical Services

Pharmacy Medical Services functions include retrospective drug utilization review (RetroDUR), review and approval of prior authorization (PA) requests for prescription drugs, maintenance of the preferred drug list (PDL), and the supplemental rebate program. This section includes the following topics related to these functions:

- 6.3.1 RetroDUR
- 6.3.2 Pharmacy Prior Authorization
- 6.3.3 Preferred Drug List (PDL) and Supplemental Rebate Program

6.3.1 RetroDUR

RetroDUR is a federal requirement that provides an opportunity for the state to look at patterns of drug prescription among physicians and identify drug classes, individual drugs and individual physicians for education and intervention. The RetroDUR process includes state staff, contractor resources, a review committee of practicing pharmacists and physicians, and a data system that allows the committee to evaluate drug utilization and test assumptions on interventions. Currently, the staff support is provided through the contractor for Pharmacy Medical Services. The drug utilization review (DUR) committee is confirmed by the Department.

6.3.1.1 State Responsibilities

a. Approve the DUR commission consistent with federal and state requirements.

b. Provide the DUR commission with the Department policy guidelines for prescription drug coverage and any changes to overall policy for reimbursement of drugs in the Medicaid program.

c. Approve education letters generated by the commission.

d. Designate a staff liaison for contractor to DUR commission and participate in the DUR commission meetings.

e. Monitor the activities of the DUR commission and contractor.

6.3.1.2 Contractor Responsibilities

a. Establish a DUR commission comprised of four Iowa-licensed physicians, four Iowa-licensed pharmacists, one member of the Department, and one full-time dedicated registered pharmacist as the project coordinator, all of whom the Department must confirm.

    1. Secure the services of a professional staff to serve on the DUR Commission. Appointments to the Commission shall be made after input from the Department.

    2. Enforce term limits as mandated by the Department for members of the commission.

    3. Convene six meetings each year of the DUR commission as necessary to assure that the commission meets its purpose to review individual patient medication

profiles, recommend intervention action, establish drug review policy, conduct educational outreach activities, conduct retrospective drug utilization review, apply drug use standards, implement ongoing interventions, and review predetermined standards for prospective drug review from the Department or the pharmacy point-of-sale (POS) system contractor prior to application in prospective drug review.

4. Include in the review of predetermined standards of prospective drug review any recommendations to the Department on the therapeutic validity of the standards as well as the appropriateness of implementation of the standards for use in claim denials as requested.
5. Meeting packet, including 30 properly prepared patient medication profiles per commissioner for review, must be mailed to commission members at least three weeks prior to the meeting date.
6. Convene meetings of any DUR subcommittees (such as the mental health advisory group) as necessary to perform specified function. This includes securing the professional staff to serve voluntarily on these subcommittees.
7. Follow and maintain the DUR commission policy and procedure manual updating annually at a minimum.
8. Document and maintain procedures for making member appointments to the commission in writing in the policy and procedure manual.
9. Use all relevant data and reports from the Department to assist the commission in performing their functions.

b. Secure the services of experienced, properly trained administrative staff to provide all administrative support to the DUR commission including but not limited to:

1. Ensure that meetings of the DUR commission are conducted in accordance with Chapter 21 of the Code of Iowa (regarding open meetings). Also provide notice pursuant to Department standards of the time, date and place of each meeting and its tentative agenda by publication in the news media, by appropriate posting of the notice. This includes e-mailing this information upon request to organizations or associations whose membership consists of persons who have an interest in the activities of the DUR commission.
2. Schedule the meetings including arrangement of the meeting location. This includes scheduling and conducting orientation of new members in coordination with the Department pharmacy consultant.
3. Provide an orderly mechanism for interested persons to speak at meetings of the DUR commission regarding issues coming before the commission including public comment participation by interested parties, according to the policy established by the DUR commission.
4. Maintain a Department-approved website on the DUR commission that contains at a minimum the meeting schedule and location, agenda, minutes, newsletters, members and other pertinent information and activities, as well as an e-mail address for questions.
5. Develop the agenda and meeting packet and provide to the Department for review and approval no less than 30 days prior to the meeting date. Patient

medication profiles in a Department-approved format must be included in the packet. Mail the packet to the DUR commission members three weeks prior to the meeting. At the same time, post all non-confidential information to the web site for public review.

6. Present a minimum of two new initiatives based on Iowa Medicaid trend monitoring at each meeting that will improve the effectiveness of the Iowa Medicaid program. Before presenting, each initiative must account for all collateral issues including programming capabilities and costs and impact to the PA and/or POS units as well as Medical Services.
7. Must generate letters to providers based on patient-focused profile reviews for a minimum of 65 percent of the profiles reviewed.
8. Must generate letters to providers based on problem-focused studies for 100 percent of members that meet the selected criteria.
9. Record open and closed minutes of the DUR commission meetings for approval by the DUR commission and distribute the minutes as approved. Minutes must include a summary of the events that took place, including attendees, action items and outcomes, and follow-ups for subsequent meetings at a minimum.
10. Provide and collect required forms from commission members (including but not limited to conflict of interest disclosures, confidentiality forms, travel and meeting reimbursement forms), and provide copies as required to the Department. Contractor staff is responsible for providing all commission member reimbursement associated with the meetings.
11. Provide lunch during the meeting for commission members and other staff in attendance.
12. Provide information and staff support to the DUR commission as needed to ensure the commission completes all requirements.
13. Provide the Department with a written report of the DUR commission's recommendations within three business days of the conclusion of the meeting for review and final approval by the Department.
14. Assure drug utilization review is completed for no less than 1,800 Medicaid members annually. Appointments to the commission shall be made after input from the Department. While each commission member reviews 30 medication profiles each per meeting, during any orientation of new members, absences or vacancies on the commission, contractor staff is responsible for completing the remainder of the reviews.
15. Secure outside expertise and information when necessary from professionals such as pharmacologists, clinical pharmacists, attorneys, specialist physicians and consultant pharmacists to answer questions. The services of these experts may also be required to update the criteria used in the data analysis system, which identifies profiles that are exceptions to standards established by the DUR commissioners.
16. Assimilate the findings of the DUR commission or other review entities resulting from data evaluation activities and execute the follow-up educational recommendations of the reviewers to the physicians and pharmacists involved in

the care of the patients. Include direct informational correspondence to providers and indirect information through periodic newsletters to providers. Additional educational measures may include face-to-face meetings with providers if determined necessary.

17. Use Department-approved evaluation criteria to measure the effects and outcomes of the drug utilization review process.
18. Coordinate communications with other state professional associations representing provider groups with an interest in drug utilization in the Medicaid program. This responsibility includes seeking input from these organizations prior to making final criteria recommendations to the Department.
19. Maintain at least one full-time dedicated Iowa-licensed pharmacist available to the Department to discuss DUR-related questions and issues during the hours of 8:00 a.m. to 4:00 p.m. Monday through Friday. This pharmacist will be considered the project coordinator and will conduct all meetings in coordination with the chair and vice chair of the commission.
20. Collaborate with the Iowa Plan (for managed mental health and substance abuse treatment) regarding prescription utilization as requested by the Department.
21. Complete required reports accurately and timely. Unless otherwise indicated, monthly reports are due five business days following the end of the month, quarterly reports are due five business days following the end of the quarter, and annual reports are due the tenth business day following the end of the federal fiscal year, state fiscal year or other annual reporting period.
22. Provide appropriate follow-up reporting and measurement of success of DUR activities. Specific reports are to be generated by the contractor and provided to the Department.
    a. Annual state report within 90 business days of the state fiscal year end. Include in this report:
        1. Focused study activities performed
        2. The cost impact tabulated by month, resulting from the initial patient profile review, intervention, and re-review process
        3. Annual savings in total outlays for prescription drugs as a result of retroDUR activities including an explanation of the Department-approved methodology for calculating savings
    b. An annual DUR report as required by the Centers for Medicare and Medicaid (CMS) following the federal fiscal year end, containing the CMS-specified items and submitted within CMS guidelines

c. Data Analytics

1. Provide data analytics that aggregate multiple sources of evidence-based medical information pertinent to the review of member utilization of services (such as laboratory, pharmacy, clinical, physician office, mental health and other selected high cost services) and provide analysis of resource utilization.

2. Provide reviews that evaluate member drug utilization based on both the quality of care provided according to evidence-based standards and the appropriate level of resources expended.
3. The contractor must be able to:
    a. Identify patterns of inappropriate health care using evidence-based rules and by assessing resource utilization, including for high-cost and high-risk Medicaid beneficiaries;
    b. Perform in-depth analysis of the utilization of high-cost and high-risk Medicaid beneficiaries, many with co-morbidities and receiving mental health and substance abuse services;
    c. Build individual provider and member utilization history files and profiles reflecting evidence-based rules and resource utilization;
    d. Identify deficiencies in the level of care or quality of service by providers and their treatment protocols;
    e. Provide documentation of excessive Medicaid program payments due to inappropriate utilization;
    f. Identify providers who may benefit from education or other intervention concerning more appropriate service utilization
4. Conduct utilization analysis of Medicaid claims within 30 days of receipt of an accurate data file to allow for the following:
    a. Improving the quality of care of individual enrollees
    b. Timely identification of inappropriate provider practices
    c. Timely modification of treatment protocols

d. Have computer hardware and software capabilities to select patient-specific profiles and to produce prevalence reports as specified below:
    1. Patient Specific Profile – The system shall be able to select from the entire Iowa Medicaid population those patients at greatest risk for potential problems with drug therapy. The program shall assess data on drugs using predetermined standards consistent with the following compendia: United States Pharmacopeia Drug Information, American Hospital Formulary Service Drug Information, DRUGDEX Drug Evaluations, and peer-reviewed medical literature.
    2. The system shall assign a utilization index to each Medicaid member. This index is determined by the application of weighted criteria which include the number of pharmacies dispensing prescriptions, the number of physicians prescribing medications, the total number of claims submitted, and the total dollars paid for claims.
    3. The system shall provide a therapeutic exception screen involving at least 30 major therapeutic categories of the prescription drugs most frequently dispensed in the Medicaid program. The process shall include, at a minimum, drug-drug interactions, drug-disease contraindications, patient-drug considerations, dose limit exceptions, and drug-laboratory considerations.

4. The system shall have the capability to select a number of patient profiles by passing each patient's six-month medication claims history through the therapeutic screen until the appropriate number of profiles have been selected. This process shall begin with the patient with the highest utilization index and continue until the specified number of profiles have been selected.
5. These profiles shall be printed in a format showing the patients' most recent six-month prescription claims data. Specific information included on a profile shall include patient ID number, age, sex, race, county of residence, dates of service, drug name and strength, quantity dispensed, days supply, new/refill indicator, prescription number, pharmacy identification number, physician identification number, total charge, and claim amount paid. Multiple copies of the patient profiles shall be printed according to the number of different providers identified on the profile.
6. Prior to meetings, the system shall select profiles six times each year for a period of nine months and sequester those profiles selected for the initial review. After this nine-month period, the system shall access the holding file and automatically reselect the sequestered profiles. These reselected profiles shall then be evaluated to determine the extent of improvement in drug therapy as a result of DUR intervention. The contractor shall report the data obtained in the annual report.
7. The contractor shall perform the report data processing using the two-year paid claims history file plus monthly updates maintained by the POS contractor for the Department.
8. Prevalence Reporting – The system shall produce reports that identify the prevalence of certain factors within the Medicaid drug program. Prevalence reports shall include, at a minimum, utilization based on age and sex, utilization based on age, pharmacy activity report, prescription claims analysis, prescription claims analysis by pharmacy, physician activity report, quarterly drug category analysis, top 100 prescribers by number of prescriptions written, top 100 prescribers by total dollar amount, therapeutic class ranking by total dollar amount and therapeutic class ranking by total number of prescriptions. These reports shall be produced six times each year. The reports shall be provided to the members of the DUR commission in an easily interpreted report format.

e. Evaluation, Intervention, and Follow-Up: The DUR commission shall provide for the evaluation of individual patient profiles by a qualified professional group of Iowa physicians and pharmacists.

1. These professionals shall have expertise in the clinically appropriate prescribing of covered outpatient drugs, the clinically appropriate dispensing and monitoring of outpatient drugs, drug use review, evaluation and intervention, and medical quality assurance.
2. Members of this group shall also have the knowledge, ability, and expertise to target and analyze therapeutic appropriateness, inappropriate long-term use of medication, overuse/underuse/abuse/polypharmacy, lack of generic use, drug-drug interactions, drug-disease contraindications, therapeutic duplication, drug cost versus, therapeutic benefit issues, and use of cost-effective drug strengths and dosage forms.

3. Members of this group, based on profile reviews, may refer members to the member health education program (MHEP) or the lock-in program.
4. Members of this group shall collaborate with the Iowa Plan (managed mental health and substance abuse treatment) regarding prescription utilization as requested by the Department.

f. Intervention: The DUR commission shall include a process of provider intervention that promotes quality assurance of care, patient safety, provider education, cost effectiveness, and positive provider relations. The methods used for communication and intervention among physician and pharmacy providers shall include:

1. Letters to providers generated as a result of the professional evaluation process that identify concerns about medication regimens of specific patients. These letters shall be informational in nature and not accusatory and threatening. These letters are to be generated at the Iowa Medicaid Enterprise (IME) by the administrative staff to allow for timely retrieval by the Department and physician and pharmacist reviewers.
2. At least one IME-located Iowa-licensed pharmacist available to perform the following functions:
   a. Reply in writing to questions submitted by providers regarding provider correspondence
   b. Communicate by telephone with providers as necessary
   c. Coordinate face-to-face interventions as determined by the DUR commission
3. Production of an electronic provider newsletter at least three times per year to communicate prevalence information, drug therapy information, and appropriate medication use to Iowa Medicaid physicians and pharmacy providers. These newsletters will be posted on the IME web site.
4. The administrative staff must track and provide a written report prior to the next meeting of:
   a. All communications sent to providers and other entities.
   b. Profile intervention tracking including but not limited to issue addressed in communication, person to whom the issue was communicated, dates for communication and responses, outcome and any additional follow-up or intervention, including any referrals to member health education or lock-in programs.

f. Prior Authorization: The DUR commission shall advise the Department regarding criteria development and professional standards for drug prior authorization.

1. On request of the Department, the DUR commission shall review drug products and make recommendations for prior authorization.
2. The DUR commission shall, at a minimum, annually conduct reviews of drug prior authorization criteria and make recommendations to the Department on criteria that should be retained, revised or removed.

6.3.1.3 Performance Standards

a. Cases from profile review must be completely resolved in an average of 90 days from the meeting date at which the profile was discussed.

6.3.2 Pharmacy Prior Authorization

Pharmacy prior authorization (PA) involves obtaining approval for dispensing a drug before providing it to a member as a condition for provider reimbursement. PA is requested at the prescriber level. The PA process includes several components:

a. Prescriber PA fax-only system using the forms provided by the IME

b. Adjudicating the actual requests for authorization

c. File interfaces to upload the authorization to the point of sale system

6.3.2.1 State Responsibilities

a. Determine specific drugs or drug categories requiring prior authorization and provide a listing to the pharmacy POS contractor.

b. Provide written guidelines for prior authorization processing, including criteria for specific edits in the pharmacy POS system.

c. Monitor the Pharmacy Medical Services contractor's performance of the PA function.

6.3.2.2 Contractor Responsibilities

a. Monitor toll-free telephone line and facsimile access and respond to contacts from providers regarding drug PA 24 hours a day, seven days a week.

b. Ensure qualified personnel respond to PA requests and handle all routine inquiries and correspondence regarding PAs; have the capacity to handle all telephone calls and facsimiles at all times and have upgrade ability to handle additional call or facsimile volumes.

c. Assist in the development and recommendation of PA criteria for drugs in conjunction with the Department, the DUR commission, and the pharmaceutical and therapeutics (P&T) committee using CMS-approved reference books as well as current medical literature.

d. Ensure that PA review criteria is easily understood and widely available to providers, Medicaid members, and identified stakeholders through various media, including listing on the web site and updated through informational letter releases.

e. Continue the administration of pharmacy PA services, which requires the prescriber to submit all PA documents for drugs.

    1. Provide PA services for prescriptions written for non-preferred drugs and for preferred drugs with conditions to achieve the objective of compliance with the PDL without unduly disrupting access to care or increasing provider costs.

    2. Pretest the PA procedure with select prescribers and pharmacists prior to implementation to ensure the process is working as designed.

3. Provide prior authorization review by a licensed pharmacist to ensure that all predetermined clinically appropriate criteria have been met before approving or denying the drug PA.
4. Ensure sufficient clarity of PA criteria so that all staff understand it.
5. Subject to Department approval, develop and implement a staffing plan to reflect anticipated PA volume, broken down by skill set and how the contractor will revise this staffing plan when necessary.
6. Ensure that all PAs meet the required service and quality standards.
7. Revise current and develop new PA forms, subject to Department approval, for prescriber PA submission.
8. Obtain Department approval for the PA process flow.
9. Update the pharmacy PA manual within three business days of state approval of a change or state request for a change.
10. Comply with all federal and state laws on PA, protocols and standards regarding responsiveness, timeliness and availability of appropriate clinical staff 100 percent of the time.
11. Respond to 100 percent of pharmacy prior authorization requests within 24 hours of receipt.
12. If an automated voice response system is used as an initial response to inquiries, include an option that allows the caller to speak directly with an operator.
13. Return all call line inquiries that require a call back, including general inquiries, within one business day of receipt 100 percent of the time.
14. Assist the Department with:
    a. The appeals process by writing and providing the Department-approved appeal summary and attend the appeal hearings to support the decision made on PA requests.
    b. The exception to policy process by evaluating the request and writing the medical review and upon request, the exception to policy letter of response.
    c. Reviewing and writing the response to judicial proceedings and any other clarifying inquiry at the request of the Department.
15. Collaborate with the Pharmacy POS contractor to provide an automated approval process for PA based on the member's specific drug history with an emphasis on reduction of transactions and manual interventions.
16. Submit monthly reports in a Department-approved format summarizing all PA activities including but not limited to, approvals and denials by PA criteria defined categories, to the Department. Provide tracking on PAs logged as incomplete including the final outcome. Include recommendations for changes to decrease the number of incomplete PAs in each area.
17. Submit an annual state fiscal year report in a Department-approved format summarizing all PA activities including but not limited to, approvals and denials by PA criteria defined categories to the Department. Provide tracking on PAs

logged as incomplete including the final outcome. Include recommendations for changes to decrease the number of incomplete PAs in each area.

18. Submit quarterly reports in a Department-approved format on monitoring parameters for PA staff quality assurance to the Department.
19. Submit quarterly reports in a Department-approved format on trend reporting for exception to policy and appeal requests to the Department.
20. Complete required reports accurately and timely. Unless otherwise indicated, monthly reports are due five business days following the end of the month, quarterly reports are due five business days following the end of the quarter, and annual reports are due the tenth business day following the end of the federal fiscal year, state fiscal year or other annual reporting period.

6.3.2.3 Performance Standards

1. Provide sufficient staff such that 95 percent of all call line inquiry attempts are answered. The total number of abandoned calls shall not exceed five percent in any calendar month.
2. Provide sufficient staff such that average wait time on hold per calendar month shall not be in excess of 30 seconds.
3. Zero percent of appeal decisions overturned due to nonspecific prior authorization criteria.

6.3.3 Preferred Drug List (PDL) and Supplemental Rebate Program

The preferred drug list (PDL) is a comprehensive list of all Iowa Medicaid-payable drugs, considering clinical efficacy, safety, and cost effectiveness. Within therapeutic categories of medications where little therapeutic variation occurs within the class, the list will designate the most cost-effective drug as the preferred drug for Iowa Medicaid. Nonpreferred drugs require PA for Medicaid payment. The list specifies the conditions for PA of all nonpreferred drugs and conditions for coverage of preferred drugs.

The preferred drug list is developed and recommended to the Department by the governor-appointed P&T committee. The Department posts the approved list to the IME web site.

The Department has the authority to negotiate supplemental rebates from drug manufacturers and labelers for the Medicaid program over and above those required under federal regulations, which would affect the determination of cost-effectiveness. Coverage of nonprescription drugs may also be expanded if nonprescription drugs are found to be cost effective.

The contractor will support the Department in the administration and maintenance of a PDL program for the Iowa Medicaid pharmacy benefits. In addition, the contractor will support the P&T committee, including explaining the clinical and economic considerations in developing the PDL. The contractor shall assist the Department in the supplemental rebate process with pharmaceutical manufacturers. The Department participates in the Sovereign States Drug Consortium (SSDC). The SSDC is a state-run

purchasing pool that contracts with a vendor for negotiation of supplemental rebates on behalf of the pool states.

6.3.3.1 State Responsibilities

a. Initiate and interpret all policy and make administrative decisions regarding the PDL and supplemental rebate.

b. Review and approve the contractor's proposal and work plan for the PDL and supplemental rebate.

c. Provide guidelines and approve staff qualifications of contractor staff.

d. Provide guidelines and approve reporting requirements to the Department.

e. Review and approve any communications prior to release.

f. Monitor all activities of the contractor.

g. Designate a staff liaison for contractor to P&T committee and participate in P&T committee meetings.

6.3.3.2 Contractor Responsibilities

a. Within 10 business days of signing the contract provide the Department with a PDL base line analysis.

b. Use pharmaco-economic modeling to formulate recommendations for preferred drugs in each class to the Department.

c. With the Department approval, incorporate therapeutic reviews at subsequent P&T committee meetings and respond to questions from the committee. The contractor shall provide drug monographs, supplemental rebate negotiation information, and savings information for each therapeutic class. The contractor shall provide supplemental rebate information in a format agreed to by the Department. In addition, the contractor shall perform and include documentation of benchmark analyses for financial and clinical outcomes to monitor trends and shall provide program recommendations to improve clinical and financial outcomes.

d. When two or more drugs within a therapeutic class have equal effectiveness and therapeutic value, review the drugs on a cost basis to formulate recommendations to the Department.

e. Develop a strategy to collaborate with the supplemental drug rebate negotiation vendor to incorporate the rebate information into analyses and P&T meetings.

f. Consider expanding coverage of nonprescription drugs and including on the PDL as preferred agents when they are determined to be cost-effective. This responsibility includes establishing the reimbursement rate as set forth in state law.

g. Include on the PDL those preferred drugs recommended by the P&T committee and confirmed by the Department.

h. Subject to Department approval, establish written criteria and a prior authorization process for obtaining the nonpreferred drugs.

i. Ensure that the PDL program includes provisions for:

1. The dispensing of a 72-hour emergency supply and/or a 30-day supply of the prescribed drug and a dispensing fee to be paid to the pharmacy for such a supply in accordance with policies established by the Department
2. Responses by telephone or other telecommunications device within 24 hours of a request for prior authorization
3. Consumer and provider education, which shall include informational letters and web site access to information

j. Ensure that Medicaid providers have accurate, timely and complete information about all drugs on the PDL. The contractor shall make this information available through various sources, such as written materials and on the web site. The minimum notification to providers is 30 days prior to implementation.

k. Receive claims files (on a schedule to be determined) from the appropriate IME contractors to support evaluation and management of the PDL program.

l. Support the management and coordination of all activities related to the maintenance of the PDL, including presentation of ongoing efforts to the Department and the P&T committee as appropriate. Activities include but are not limited to the following:

1. Clinical review of new brand drugs for clinical safety and efficacy including a cost analysis.
2. Clinical review of new generic drugs or clinical safety and efficacy including a cost analysis.
3. Clinical review and cost analysis of existing drugs for new indications, changes to indications and/or safety issues.
4. Review of new products forms and strengths and associated cost analysis.
5. Development of and changes to PDL criteria based on new information.

m. Perform ongoing analysis and clinical reviews of Iowa Medicaid pharmacy claims and conduct a review and cost analysis of each therapeutic class at least one time per calendar year.

n. Represent the Department in public relations matters and coordinate with other agencies, groups, boards and individuals regarding the program at the request of the Department, including but not limited to the following activities:

1. Preparing draft written responses or assisting the Department in responding to inquiries from providers and other interested parties concerning the PDL
2. Orally presenting the PDL process or otherwise informing various Department personnel and designees including but not limited to the legislature, provider groups or associations, other state agencies, or any other interested parties about the PDL and supplemental rebate process
3. Providing education materials, communication strategies, and/or providing training for groups that may be impacted by the PDL process

o. Provide stakeholder support and include a Department-approved method of communication for manufacturers to receive assistance with questions related to the PDL.

p. Provide a Department-approved web site that is available to all the public. The web site must include but is not limited to the following:
    1. Preferred drug list
    2. Prior authorization criteria and forms
    3. P&T committee meetings, agendas and minutes
    4. Communication and education as determined in collaboration with the IME Member Services and Provider Services contractors
    5. Manufacturer-specific directions for the supplemental rebate process
    6. A link to a Department-provided mailbox for submission of questions, which must be monitored regularly and responded to within a timeframe specified by the Department
    7. A link to a Department-provided mailbox for submission of public comment which must be monitored regularly and posted to the web site within a timeframe specified by the Department
    8. All communications to members and providers
    9. Any other documents deemed necessary by the Department

q. Provide administrative support to the P&T committee to administer and maintain the PDL and prior authorization services.
    1. Ensure that meetings of the P&T committee are conducted in accordance with Chapter 21 of the Code of Iowa (open meetings). In accordance with Chapter 21, notice shall be given of the time, date, and place of each meeting and its tentative agenda by publication in the news media and by appropriate posting of the notice. Notice shall be e-mailed on request to organizations or associations whose membership consists of persons who have an interest in the activities of the P&T committee.
    2. Schedule the meetings, including arrangement of the meeting location. This responsibility includes scheduling and conducting orientation of new members in coordination with the Department pharmacy consultant.
    3. Provide and collect required forms from commission members (including but not limited to conflict of interest disclosures, confidentiality forms, travel and meeting reimbursement forms), and provide copies as required to the Department. Contractor staff is responsible for coordinating all commission member reimbursement associated with the meetings.
    4. Convene meetings of any P&T subcommittees as necessary to perform specified function. This responsibility includes securing the professional staff to serve voluntarily on these subcommittees.
    5. Provide an orderly mechanism for interested persons to speak at meetings of the P&T Committee regarding issues coming before the committee, including public comment participation by interested parties, according to the policy established by the P&T committee and provide public notice of the meetings.

6. Maintain a web site listing the P&T committee meeting schedule, agendas, committee members, minutes of the meetings and other information deemed necessary by the Department.
7. Formulate information packets, including at a minimum the preparation of the agenda, meeting minutes for committee's review and approval, and therapeutic class reviews (including drug monographs) for Department review and approval at least 45 days prior to each meeting. Mail to the P&T committee at least 30 days prior to each meeting. At the same time, post all information to the web site for public review.
8. Record the open and closed minutes of the P&T committee meetings for approval by the committee and distribute the minutes as approved. Minutes must include a summary of the events that took place including attendees, action items and outcome, and follow-ups for subsequent meetings at a minimum.
9. Provide information and staff support to the P&T committee as needed to ensure timely on-going maintenance of the PDL and prior authorization programs.
10. Facilitate the review of all therapeutic classes by the P&T committee before and after implementation of the program.
11. Provide P&T committee support by providing reviews of all medications in a therapeutic class for comparative efficacy, side effects, dosing, prescribing trends, and other clinical indications. The therapeutic class reviews should include at a minimum a description of products scheduled for review at the meeting and clinical, safety and cost-effectiveness information for each drug class. The information must be accurate, reflect recent cost and clinical outcomes information, and be based on acceptable clinical review protocols and nationally peer-reviewed, evidence-based research.
12. Develop and maintain a predictive pricing methodology that incorporates rebate and administration costs to estimate the net cost to the Department associated with individual PDL decisions. This information must be provided to the Department and the P&T committee for specific drugs reviewed by the P&T committee.
13. Provide the Department with a written report of the P&T committee's PDL recommendations within three business days of the conclusion of the meeting for review and final approval by the Department. This report must be accompanied by a contractor analysis in cases where the P&T committee made modifications to the original recommendations.
14. Facilitate the P&T committee's use of clinical subject matter experts in reviewing various classes of drugs or individual drugs if such expertise is needed and is not represented among the P&T committee members.
15. Develop and facilitate a process for the Department to act on or deviate from the recommendations by the P&T.

r. Provide the following supplemental drug rebate services:

1. Assist the Department during analysis and negotiation of state supplemental rebate agreements with pharmaceutical manufacturers annually and as needed.

2. Establish a method for communication between the contractor and manufacturers as approved by the Department.
3. Accept and handle all contract discussions and inquiries from manufacturers, consulting with the Department as needed.
4. Maintain all the original agreements and provide the Department with access to all supplemental rebate agreements and related documentation within 24 hours of request. The Contractor must maintain electronic copies of all executed supplemental rebate agreements.
5. Ensure that supplemental rebates are over and above the federal rebates and in compliance with federal law.
6. Maintain the terms of the supplemental rebate agreement with each pharmaceutical manufacturer as confidential, separate from any of the contractor's other clients and undisclosed except to the Department or its designee.
7. Provide supplemental drug rebate billing data quarterly in a Department-approved format in accordance with timelines established by the Department. Ensure system interface with the IME pharmacy POS system for the receipt of data to track and invoice the supplemental rebates.
8. Establish and operate a process for accurate reporting and monitoring of negotiated supplemental rebates.
9. Provide to the Department reports on the performance and savings associated with the PDL and supplemental rebates. Deliver reports to the Department in a format and on a schedule approved by the Department.
10. Provide supplemental rebate projection reports. Deliver reports to the Department in a format and on a schedule approved by the Department.
11. Provide rebate analysis and suggestions for enhancing rebates and/or lowering net pharmacy costs. This responsibility includes review and analysis of utilization data for performance under PDL drug classes and areas for improvement for both clinical impact and cost effectiveness of PDL classes. Deliver reports to the Department in a format and on a schedule approved by the Department.
12. Provide by December 15 of each calendar year a list by therapeutic category of all drugs for which a supplemental rebate has been accepted, including but not limited to the drugs, NDCs, types of offer, tiers of drugs, manufacturers or labelers and durations of contracts. This report must be continually updated and provided quarterly and one month prior to the annual SSDC pool meeting.
13. Ensure 100 percent of supplemental rebate contracts are sent to the manufacturer or labeler following Department confirmation within 30 days following the annual P&T meeting.
14. Ensure <u>100 percent of all</u> supplemental rebate contracts are returned from the manufacturer or labeler by the end of the first quarter of the calendar year and sent to the Department for signature.
15. Provide access to the Department of tracking on status of all supplemental rebate agreements within 24 hours of request.

s. Provide the following education services:
   1. Subject to Department approval, design, develop and implement an ongoing, broad-based education effort to ensure that providers and members are provided with timely and accurate information regarding the PDL and prior authorization.
   2. Begin the education effort immediately upon contract award and continue on an ongoing basis.
   3. At a minimum, include provider manual changes and updates, direct mailings of written materials and web-based information.
   4. Ensure that the web site is accessible upon contract award and continue on an ongoing basis.
   5. Obtain Department approval for the web site information and keep the web site accurate with regular updates as determined necessary by the Department.
   6. Include the following topics at a minimum:
      i. Program Intent
      ii. Process to develop PDL
      iii. Prior authorization criteria and process
      iv. Appeal process
      v. Informational Letters and Updates
      vi. FAQ

t. Assist the Department in developing communication strategies for Medicaid members, Medicaid providers, pharmaceutical manufacturers, advocacy groups, Department staff, IME staff and others with an interest in the PDL and prior authorization programs. No program materials may be distributed unless approved by the Department. The communication strategies include, but are not limited to:
   1. Assist the Provider Services unit in training of providers to educate them.
   2. Assist the Members Services unit in providing information to the members
   3. Maintain direct involvement with constituent groups to facilitate their understanding of the program and the processes that will be followed.
   4. Provide a combination of telephone support and web-based information.
   5. Monitor and report on outcomes of the educational efforts.
   6. Recommend to the Department education and notification processes and methods that minimize transition disruptions.
   7. Design and implement targeted educational efforts approved by the Department to improve compliance among outlier providers in order to maximize the effectiveness of the PDL.

u. Develop and implement a Department-approved procedure for communicating system changes to all affected IME contractors and State agencies.

v. No later than 10 business days after Department approval of the PDL, transmit the PDL and PA criteria to the IME POS contractor. The contractor will design, develop,

test and implement an electronic interface with the IME pharmacy POS system to assure timely transmission and uploading. The contractor must ensure computer system capability and interface between the contractor and the IME pharmacy POS system for accurate acceptance of the information that the contractor provides.

1. The contractor shall electronically transmit to the IME pharmacy POS contractor the list of drugs requiring prior authorization due to the level of participation on the PDL in a format approved by the Department.
2. The contractor's project work plan should include detailed data integration requirements and the steps the contractor will take to ensure successful integration.

w. Complete required reports accurately and timely. Unless otherwise indicated, monthly reports are due five business days following the end of the month, quarterly reports are due five business days following the end of the quarter, and annual reports are due the tenth business day following the end of the federal fiscal year, state fiscal year or other annual reporting period.

6.3.3.3 Performance Standards

a. Be able to demonstrate annual savings in the total outlay for prescription drugs (including an explanation of the Department-approved methodology for calculating savings). [$9.3 million in State Savings in SFY 2008 over a SFY 2004 base]

6.4 Provider Services

The Provider Services component encompasses the functions necessary to encourage and support provider participation in the Iowa medical assistance programs, enroll providers and maintain provider data, and provide training and assistance to providers who participate. In addition, this component encompasses the activities required to educate providers and respond to provider inquiries. These functions are primarily the responsibility of the Provider Services contractor and follow Department policies.

The Provider Services function includes those processes required to maintain a repository of provider information. The provider master file (PMF), which resides in the Medicaid Management Information System (MMIS), includes all active and inactive providers for use in claims processing, management reporting, surveillance and utilization review, managed care, and other program systems and operations. The provider subsystem supports the Provider Services contractor's business operations, which include the following functions:

- 6.4.1 Provider Enrollment
- 6.4.2 Provider Inquiry and Provider Relations
- 6.4.3 Stale-Dated Checks
- 6.4.4 Provider Outreach and Education
- 6.4.5 Provider Training
- 6.4.6 IME Support Services
- 6.4.7 ISIS Help Desk and Quality Assurance

6.4.1 Provider Enrollment

The functions for provider enrollment include the following categories:

6.4.1.1 General Requirements

6.4.1.2 Criminal Background Checks

6.4.1.1 General Requirements

a. The provider enrollment function consists of enrolling eligible new providers in the Iowa Medicaid Program according to state and federal regulations for participation, periodic reverification of provider licensure, certification or other enrollment requirements and updating of the provider file maintained in MMIS with changes to provider data. This function also includes encouraging eligible providers to enroll in Iowa Medicaid through an outreach program.

b. The data sources for this function are:

   1. Provider application forms
   2. Provider information update forms
   3. Provider change information from the Department

4. Provider inquiries regarding enrollment
5. State and federal licensing and certification documentation
6. Medicare provider number listing
7. Provider sanction listings
8. Provider correspondence
9. Telephone logs
10. MMIS
11. Individualized Service Information System (ISIS)

c. The Provider Services contractor is responsible for enrolling providers of medical and other services in the Medicaid program by using a formal procedure to enroll, certify, maintain and reverify eligibility for all participating providers. This process includes ensuring that providers are qualified to participate in the Medicaid program through verification of state licensure and appropriate state and federal certifications prior to enrollment as Medicaid providers. The Provider Services contractor collects, controls and processes provider enrollment and status information and also provides telephone support for provider enrollment inquiries.

d. The Provider Services contractor performs the administrative functions related to provider enrollment. These functions include obtaining provider agreements for all providers enrolling in the program and screening providers to ensure that state licensure, certification or other enrollment requirements are met. The Provider Services contractor may deny participation in the Medicaid program for certain providers based on a decision provided by the Department.

e. Medical and other providers wishing to participate in the Medicaid program must complete an application and a provider agreement. The Provider Services contractor reviews the applications, verifies licensure (where appropriate) through state licensure boards, initiates background checks when appropriate, approves the application if all requirements for participation have been met and assigns a unique internal Medicaid provider number. After approving the application, the Provider Services contractor updates the PMF through the web portal with the new information.

f. Meet the following objectives:

   1. Enroll providers of medical services in the Medicaid program by utilizing a formal procedure to enroll, certify, maintain, and reverify eligibility for all participating providers.
   2. Process provider applications and status changes in a timely manner to maintain control over and ensure complete processing of all applications and information changes.
   3. Maintain cooperative efforts with the Iowa medical community and encourage participation in the Medicaid program.

g. As part of the enrollment process, the Provider Services contractor staff is responsible for entering data in multiple databases including the PMF in the MMIS that the Core MMIS contractor maintains and the ISIS that the Department

maintains. The contractor also is responsible for accommodating volume spikes in the number of incoming provider applications, credentialing waiver providers, linking Healthcare Common Procedure Coding System (HCPCS) codes and atypical codes to providers in ISIS, conducting Iowa Medicaid Electronic Record System (I-MERS) provider security review, processing new provider categories when they are added to the Medicaid program, and processing long-term care applications.

h. Consumer-directed attendant care (CDAC) providers who participate in the American Federation of State, County and Municipal Employees (AFSCME) union can follow documented procedures to authorize AFSCME to deduct CDAC union dues.

6.4.1.1.1 State Responsibilities

a. Establish policy regarding provider eligibility, service coverage, reimbursement and related issues.

b. Direct the Provider Services contractor to update the PMF subsequent to provider suspensions or terminations as the result of state or federal investigations

c. Direct Provider Services contractor to update the PMF with institutional and other provider enrollments.

d. Review and approve the periodic provider enrollments at the option of the Department.

e. Approve all provider tracking functionality.

f. Monitor the contractor's performance of provider enrollment activities.

6.4.1.1.2 Contractor Responsibilities

a. Assign internal legacy provider numbers as appropriate and update the PMF to accommodate enrollment of providers.

b. Ensure that provider enrollment applications and related forms have been scanned and stored in the imaging system provided by the Core MMIS contractor and that they can be retrieved as needed.

c. Promote participation in the Medicaid program through communication with Iowa medical providers.

d. Ensure that providers are qualified to render specific services under the Medicaid program by screening applicants for licensure, certification or other enrollment requirements upon initial enrollment (and upon expiration date of license) for compliance with federal participation requirements and for continuous specialty board certification.

e. Receive and process provider applications, agreements and changes, determine provider eligibility and enroll all provider types.

f. Provide copies of provider agreements and applications and other documentation from the provider files to the Department upon request.

g. Provide responses to provider enrollment inquiries.

h. Maintain provider enrollment status codes with associated date spans. At a minimum, the enrollment codes include:

1. Application pending
2. Enrolled for all programs
3. Enrolled only for special program (such as a waiver)
4. Preferred provider arrangement
5. Enrollment suspended
6. Designated as on-review
7. Termination status codes (such as voluntary or involuntary)
8. Enrolled as a serving provider only

i. Track and maintain all provider enrollment activities including the location of the enrollment application throughout the process, the numbers of applications in each step of the process and the elapsed time between each step of the provider enrollment process. The workflow process management system will provide some of this data. The Provider Services contractor needs to be able to produce a report on request on any aspect of the provider enrollment process captured by the tracking system. Inquiry to the PMF is available via provider name or provider number.

j. Maintain an online cross-reference of individual, rendering and group numbers and affiliations for each provider.

k. Make modifications to enrollment procedures in accordance with the CDAC Memorandum of Understanding (MOU).

l. Process requests from the Department for suspending or terminating providers as the result of state or federal investigations.

m. Process additions, changes, terminations, and purges of provider records according to the established procedures.

n. Process requests from the provider for voluntary withdrawal from the Iowa Medicaid Program

o. Report providers as inactive after 24 months of no claim activity. Contact all providers appearing on the inactive report to ascertain whether they desire to continue participating in the Medicaid program. Allow 60 days for a response before sending a follow-up notice. Allow 30 additional days before changing to terminated status.

p. Terminate providers after 24 months in an inactive status.

q. Maintain provider group membership effective dates; enrollment status; electronic media claims (EMC) billing data; restriction and on-review claim types; billing categories of service; certifications, including Clinical Laboratory Improvement Amendments (CLIA); identification numbers; specialty; and other user-specified provider status codes and indicators.

r. Capture and maintain all data elements described in detailed enrollment procedures.

s. For institutional providers, capture the number of beds (Medicaid beds and total beds) in the facility and capture reimbursement rates and update this data in the PMF.

t. Process additions, changes, terminations, and purges of provider records according to the established procedures.

u. Capture and update nonprofit status indicators in the PMF.

v. Renew provider agreement periodically, as determined by the Department. Currently, this is a minimum of every six years.

w. Capture and update information necessary to verify provider eligibility for services authorized in ISIS.

x. If the provider uses a third-party vendor for billing identify the entity and enter this data on the PMF.

y. Identify providers that use electronic claims submission, electronic remittance advices and electronic funds transfer and enter the data in the PMF.

z. Verify qualifications of providers in accordance with any applicable state and federal licensing and certification standards, all applicable accrediting standards and any other standards or criteria established by the Department.

aa. Suspend any provider application when it becomes known that the provider has been convicted or sanctioned and report to the appropriate authorities.

bb. Maintain multiple addresses for a provider, including pay-to and service locations.

cc. Identify providers in the managed care program and maintain the number of members enrolled and the maximum enrollment allowed for these providers. This data is used in the assignment of enrolled managed care members to primary care providers.

dd. Provide a means to prevent enrollment under the same or different names of providers suspended or terminated from either the Medicare or Medicaid program through a comparison of license number, social security number, or similar identifier.

ee. Produce and provide enrollment approval or denial letters and letters requesting additional information.

ff. Maintain the following interfaces:

1. Providers to obtain information needed for a provider to enroll in the Iowa Medicaid Program and information regarding changes in provider data (such as changes in the practice of the provider, group affiliation changes, address changes)

2. Provider associations or other entities as part of the outreach activities to encourage provider participation in the Medicaid program.

gg. Provide to the Department, upon request, copies of provider agreements, applications, and other documentation from the provider files.

hh. The Provider Services contractor will conduct ongoing license verification for all licensed professional Medicaid providers.

1. Verify online current license status.

2. If online verification is unavailable, call provider to send in license information and send paper verification request to the provider.

3. Update system with license numbers and end dates for continued enrollment.

ii. Track new enrollments to ensure data is transferred to other databases at www.imeservices.org, which is known as the web tool

jj. Enter national provider identifier (NPI) and taxonomy codes to the web tool after the data transfer (usually overnight)

kk. Process increased volume of requests for groups

ll. Process increased volume of provider applications (for example, the Mayo Clinic).

mm. Assist the Department in converting provider enrollment functions to a web-based service.

nn. In response to provider enrollment inquiries, send 100 percent of the provider enrollment packets to the provider no later than one business day following the receipt of the request from the provider.

oo. Verify quality and maintain 100 percent accuracy rate for online update transactions.

pp. Identify and correct errors within one business day of error detection.

qq. In response to provider inquiries, send 100 percent of the provider enrollment packets to the provider no later than one business day following the receipt of the request from the provider.

6.4.1.1.3 Performance Standards

a. 95 percent of the provider enrollment applications requests must be approved, assigned an internal provider number, entered in the provider file, denied, or returned to the provider for additional information within five business days of receipt of the application. 100 percent of this work must be completed within 30 business days.

b. 100 percent of the provider enrollment applications will be verified against the appropriate licensing entity and against the additional specialty credentials.

c. 100 percent of the providers will have valid licensing criteria and the specialty credentials at the time of approval of the provider enrollment application.

d. Perform online updates to provider data within one business day of receipt of the update.

h. If automatic verification not possible, but online verification is available, the contractor will verify 100 percent of all licenses for which no automated updates are available against an appropriate licensing authority (and update the MMIS license end date) within 30 days after an MMIS license expiration date. Note that updated licensure information is not always available for verification prior to expiration.

i. If neither automatic nor online verification is available, the contractor will solicit 100 percent of all licenses with both a letter and a phone call within 30 days after an MMIS license expiration date and enter the data within one business day of receipt of the information.

j. 95 percent of new enrollment NPI and taxonomy codes are added to the web tool within two business days after a provider file has been added to MMIS. 100 percent of this work must be completed within 10 business days.

6.4.1.2 Criminal Background Checks

As part of the provider enrollment process, the Provider Services contractor will run a criminal background check on all individual CDAC providers prior to completion of their enrollment. Consumer choice option (CCO) background checks will be completed upon request from the CCO contractor.

6.4.1.2.1 Contractor Responsibilities

a. Obtain a signed release with each individual CDAC and CCO enrollment.

b. Complete referrals for background checks on individual CDAC and CCO providers.

c. Enroll individual CDAC providers if background check is approved.

d. Notify the Financial Management Service Agency of CCO background check approval or denial.

e. Report on individual CDAC providers who do not have an approved background check.

f. Report on individual CCO providers who do not have an approved background check.

g. Report monthly on individual CDAC background checks completed.

h. Report monthly on individual CCO background checks completed.

i. Assure that 100 percent of owners' and managing employees' background checks are complete and have acceptable results.

6.4.1.2.2 Performance Standards

a. 95 percent of individual CDAC and CCO applicants will be referred for criminal background check by the end of the week following the week in which they received a status of complete.

b. 95 percent of provider enrollment CDAC and CCO applications must be verified for completeness or returned to the provider for additional information within five days of receipt of the application. Complete applications will have a background check run and will be completed within 30 days as approved or denied.

6.4.2 Provider Inquiry and Provider Relations

The provider inquiry and provider relations function consists of responding to provider inquiries regarding claims submissions and status, Iowa Medicaid policies and procedures, and other inquiries regarding the Iowa Medicaid Program. As part of this function, the contractor will also identify general billing problems, refer callers to the provider training staff for inclusion in the provider training sessions, and provide one-on-one training with providers who need assistance in submitting claims or other data. The data sources for this function are:

a. Inquiries from providers

b. Policy clarifications from the Department

c. Claims and other data from MMIS and data warehouse

6.4.2.1 State Responsibilities

a. Monitor all provider inquiry/provider relations functions and performance statistics.

b. Refer problem claim situations, or billing resolution inquiries to the Provider Services contractor's field representative for follow-up with providers

c. Provide state policy and procedures clarifications to the Provider Services staff based on inquiries.

d. Approve the contractor’s standard letters to be used in responding to provider inquiries.

6.4.2.2 Contractor Responsibilities

a. Respond to all provider inquiries received in writing and by telephone or e-mail and conduct problem resolution for all providers. Provide trained personnel who have online access to MMIS data to staff incoming dedicated toll-free lines for in-state and out-of-state Medicaid providers, enabling immediate responses to inquiries.

b. Staff and maintain a communications function that includes toll-free telephone lines that are staffed by full-time provider services representatives from 7:30 a.m. to 4:30 p.m., Central Time, Monday through Friday, excluding state holidays. Callers are restricted to Medicaid providers and the Department staff.

c. Use the call center management system provided by the Department (which has the capability of answering calls in sequence, recording and printing statistics, and indicating calls that have been placed on hold for a specific time limit) to provide weekly statistical performance reports to the Department that contain call abandonment rates calculated on weekly averages, based on the first business day through the last business day of the week.

d. Obtain written approval from the Department to block any caller.

e. Maintain and staff a provider inquiry unit to respond to written and telephone inquiries.

f. Maintain and staff a separate Inquiry Unit for CDAC providers to respond to telephone and written inquiries.

g. Use the Medicaid-dedicated incoming toll-free lines provided by the Department for in-state and out-of-state providers. The toll-free lines will roll incoming calls to open lines or activate the hold feature when all lines are busy that informs callers that all lines are busy and that they will be put on hold and helped as soon as a line is open.

h. Assure that provider inquiry staff is trained in billing procedures, current Iowa Medicaid Program policies and procedures, reimbursement methodology, and appropriate telephone soft skills and etiquette.

i. Use the workflow process management system to track and report on the number of written inquiries and the Department-provided call management system to track and report on the number of telephone inquiries, the number of days elapsed between

inquiry and resolution of the inquiry, and similar information. The tracking system maintains a log of inquiries (written and telephone), including provider ID number, date of receipt, date of response, nature of inquiry, and disposition of inquiry. The log is available for review by the Department at any time.

j. Respond to provider inquiries regarding completion of claim forms, billing procedures, claims disposition, reimbursement, program coverage and policies, questions related to the contractor's duties, and other inquiries regarding the Iowa Medicaid Program. Provider inquiries include written correspondence, telephone communications, e-mails, and face-to-face contacts.

k. Provide to the Department for any time period requested a report of provider inquiry activity that will include, at a minimum, the number and nature of inquiries received (both written and by telephone) and the average response time for all inquiries.

l. Contact specific providers in person, by telephone, or in writing at the request of the Department to answer questions or provide assistance and training.

m. Assist in responding to inquiries submitted to the Department by providers or other parties on behalf of providers. This responsibility includes contacting the provider by phone, developing a written draft response for the Department, or responding with a written response to the inquirer as a result of requests for information (RFIs) or directors' letters.

n. Respond to provider inquiries regarding billing and other claim submission problems to ensure that valid claims are submitted.

o. Provide individual training to providers as necessary based on analysis of provider billing problems to reduce suspensions and denials of valid claims.

p. Maintain the following interfaces:

    1. Department staff to obtain and clarify state policies and procedures, and to obtain approval of any correspondence used in the provider inquiry/provider relations process.

    2. Providers, to accept inquiries and provide assistance regarding state policies and procedures and to resolve billing problems

q. Generate letters to providers in response to written inquiries.

r. Provide statistical reports on the provider inquiry and provider relations activities

6.4.2.3 Performance Standards

a. Screen and resolve 95 percent of pended and denied claims within 15 business days from identification of a provider requiring proactive support. Complete 100 percent within 30 business days.

b. Maintain a service level of 80 percent for incoming calls that is calculated with this equation:

$$SL = ((T – (A + B) / T) * 100)$$

where T = all calls that enter the queue
A = calls that are answered after 30 seconds
B = calls that are abandoned after 30 seconds

c. Respond with a complete response to 90 percent of written, faxed, or e-mailed inquiries within five business days of receipt. Provide an interim response within the five business days if a complete response is not possible by then. Provide complete responses to 100 percent of inquiries within fifteen business days.

6.4.3 Stale-Dated Checks

Following are the Provider Services component's activities for stale-dated checks.

6.4.3.1 Contractor Responsibilities

a. Research provider requests for stop payment.

b. Send stop-payment requests to the Department of Human Services, Division of Fiscal Management.

c. Create and mail stale-dated check notices.

d. Request mass history credits for stale-dated checks.

e. Mail remittance advice copy with reissued checks.

f. Provide check request affidavits as needed.

6.4.3.2 Performance Standards

a. 95 percent of provider requests for stop payment will be researched within one business day of receipt of request; 100 percent of provider requests for stop payment will be researched within five business days of receipt of request.

b. 95 percent of requests for stop payment will be made to Fiscal Management within two business days of receipt of request; 100 percent of requests for stop payment will be made to Fiscal Management within four business days of receipt of request.

c. 95 percent of stale dated check notices will be created and mailed five business days prior to the 90 day and 120 day intervals of an issued check; 100 percent of stale dated check notices will be created and mailed six business days prior to the 90 day and 120 day intervals of an issued check.

d. 95 percent of remittance advice copies related to the reissued checks will be mailed within one business day from receipt of check from Fiscal Management; 100 percent of remittance advice copies related to the reissued checks will be mailed within two business days from receipt of check from Fiscal Management.

e. 95 percent of check request affidavits will be delivered to the mailroom within one business day of request. 100 percent of check request affidavits will be delivered to the mailroom within two business days of request.

6.4.4 Provider Outreach and Education

The Provider Outreach and Education function consists of the development and distribution of provider manuals, bulletins, and newsletters. This function also includes the development and maintenance of a provider web site.

6.4.4.1 State Responsibilities

a. Direct, review, make updates to and approve the creation and maintenance of the Medicaid Provider Manuals.

b. Review and approve newsletters, bulletins, informational letters and other provider-related publications that are produced and published by the Provider Services contractor, including remittance advice (RA) messages and accompanying notices.

c. Produce messages or bulletins for Provider Services contractor distribution on or with RAs; prepare and write Department provider communications for the Provider Services contractor to produce and mail.

d. Write policy-related sections for provider manuals

e. Approve provider billing manuals, special notices, bulletins, and other publications prior to release and distribution

6.4.4.2 Contractor Responsibilities

a. Develop, print and distribute materials regarding the Iowa Medicaid Program and the claims processing system, including provider manuals, manual updates, informational letters and bulletins, newsletters, and claim forms, all of which must be available in electronic format and in hard copy.

b. Organize and print all materials in the manner prescribed by the Department after receipt of Department approval and before public release. Ensure that all materials identify the Iowa Department of Human Services as the principal organization and contain the Provider Services contractor's address and telephone number for communication purposes.

c. Print, stock and mail claim forms for targeted medical care and ambulance claims in sufficient quantity to respond immediately to all provider requests for claim forms.

d. Maintain an automated inventory control system and obtain approval from the Department before printing each new supply of claim forms to prevent printing large quantities of claim forms that will become obsolete due to form revisions.

e. Develop, write, and submit to the Department for written approval billing instructions for inclusion in provider manuals. Maintain the provider manual in a format dictated by the state that facilitates updates. Include step-by-step billing instructions. Collaborate and coordinate Medicaid provider manual billing instruction sections, order, print, and distribute provider manuals. Assist in the development of other portions of the manuals at the Department's request.

f. Ensure that provider manuals contain information about the policies of the Iowa Medicaid Program, detailed instructions about claims submittal, and information

regarding remittance statements. Organize and print manuals in the manner prescribed by the Department.

g. Develop, print, and distribute provider informational letters and bulletins, as requested by the Department.

h. Mail, or make available electronically, at the provider's discretion, provider manuals to newly enrolled providers

i. Print and distribute other forms, such as the forms for request for prior authorization, abortion certification, sterilization consent, provider enrollment, provider change of address, and provider reverification.

j. In emergency situations, facilitate expediting the printing and mailing as emergencies occur due to quick implementation of changes to policies or procedures because of new or changed state or federal requirements. The Department will determine if the specific situation constitutes an emergency.

k. Keep a log showing printing and mailing dates, number of impressions, and cost. Make the log available for review by the Department.

l. Provide in electronic and hard copy, current lists of all providers by provider type, in-state providers, border-state providers, all other out-of-state providers, and all providers by provider type by county to the Department on a semi-annual basis or upon request.

m. Inform providers about the policies and procedures for participation in the Iowa Medicaid Program, including the enrollment process, service coverage and limitations, claim and other form submission requirements, and the processes to inquire about submitted claims and to request assistance.

n. Notify providers of any changes in Medicaid program policies and procedures.

o. Provide any Iowa-specific forms for submission of data to the Iowa Medicaid Program.

p. Maintain the following interfaces:

    1. Providers to distribute provider manuals, bulletins and newsletters and through the provider web site

    2. Provider associations to disseminate information, in addition to the direct distribution to providers

q. Produce the following outputs:

    1. Provider bulletins and informational letters

    2 Content of provider web site

    3. Iowa-specific forms

6.4.4.3 Performance Standards

a. Submit for publication to the web site, bulletins, inserts or other special mailings within three business days of written approval by the state.

b. Distribute supplies of targeted medical claim forms and other provider forms to providers within two business days after request.

c. Distribute provider manuals to newly enrolled providers within three business days of receipt of the request.

d. Update within two business days of approval of information by the Department the web site for disseminating provider publications online.

e. In emergency situations, facilitate publication of informational letters and bulletins within two business days following approval by the Department

6.4.5 Provider Training

The Provider Training function consists of developing and obtaining Department approval of provider training schedules and training materials and conducting formal statewide training sessions during the implementation of the new contract and annually thereafter.

6.4.5.1 State Responsibilities

a. Approve provider training plans and revisions, scripts, and materials prior to their use in training sessions.

b. Monitor the training done by the Provider Services contractor's provider field representatives to ensure consistent communication of policy and billing information throughout the state.

6.4.5.2 Contractor Responsibilities

a. Meet the following objectives:

   1. Inform providers via formal statewide training sessions about the Iowa Medicaid Program, policies, and procedures.

   2. Provide assistance to providers in resolving billing problems by addressing common billing problems in the formal training sessions.

   3. Provide information on policy and procedure changes during the annual training sessions or in special training sessions when major changes are made.

b. Educate providers about the Iowa Medicaid Program policies, procedures, and billing requirements, including conducting provider training workshops and individual provider training, developing training materials and packages, media (with Department approval), scheduling dates and arranging for facilities.

c. Identify and reduce problems in billing for all providers and encourage participation in the Iowa Medicaid Program.

d. Conduct on-site provider training annually for all provider types and additionally as directed by the Department to explain any change in billing and processing procedures or upon implementation of new policy or procedures in at least eight statewide locations as identified by the Department.

e. Use a tracking process for all provider training to record invited and trained providers for seminars, specialized training, and individual provider visits.

f. Assume all costs associated with training sessions unless expressly noted by the Department.

g. Submit the annual provider training plan and quarterly updates to the Department for approval. Include in the training plan, details of the training exercise. Provide quarterly updates to the training plan.

h. Develop and submit training dates, seminar topics, outline, script and training materials to the Department for approval prior to all training sessions, as requested by the Department.

i. In the event that the Department determines that there is a need for the Department staff or other contract staff to make presentations to providers at any of the training sessions, the Provider Services contractor shall allow time for such presentations.

j. Provide specialized training to the Department staff upon request.

k. Provide issue-specific training to providers upon request of the providers, the Department or the Provider Services contractor. Document all visits and place documentation in provider files, with a copy to the Department.

l. Provide a report summarizing each training seminar, specialized training and individual provider visit that includes the invitees, the number of attendees at each location by provider type and the areas of concern on the part of providers. Include a narrative for all group and individual sessions. For individual sessions with providers, include a complete description of the problem, the topics covered, the resolution, and any prescription for follow-up. Adjust the report format and content at the request of the Department.

m. Provide information on policy and procedure changes during the annual training sessions or in special training sessions when major changes are made.

n. Maintain the following interfaces:

    1. Providers to notify them of the training schedule and provide training in formal training sessions

    2. Provider associations to disseminate information regarding the training schedule in addition to the direct distribution to providers

o. Produce the following required outputs:

    1. Training plans

    2. “Notification of training” letter

    3. Training schedule

    4. Training agenda

    5. Training materials or media

    6. Report of training activities

p. Provide the annual training plan to the Department 60 days prior to training of each calendar year of the contract. Provide requested corrections within 10 business days of receipt of comments by the Department. Provide quarterly updates within 10 business days from the end of the quarter.

q. For each training session or individual provider visit, present a report to the Department within 10 business days of the session or provider visit.

r. Publish and distribute to the web site, bulletins, inserts or other special mailings within three business days of written approval by the state.

s. Within two business days of approval of information by the Department, update the web site for disseminating provider publications online.

t. Measure training performance using counts of attendees, provider evaluations of training classes, and ratings of satisfactory or above on questions related to training on the annual provider satisfaction survey.

6.4.5.3 Performance Standards

a. Receive ratings of satisfactory or above on all provider evaluations of training classes and all questions related to training on the annual provider satisfaction survey.

6.4.6 IME Support Services

The Iowa Medicaid Support Services function includes the receptionist for the IME, managing provider access and recruiting providers for the managed care programs.

6.4.6.1 IME Receptionist

The IME receptionist is responsible for delivering outstanding customer service, routing mail as appropriate and assisting with stale dated checks.

6.4.6.1.1 Contractor Responsibilities

a. Meet and greet the IME visitors.

b. Sign in and issue ID badges to IME visitors.

c. Research and route mail from the workflow management system.

d. Notify IME units of parcel mail delivery.

e. Assist Stale Dated Check Clerk as needed.

f. Assist with security by periodically reviewing security cameras.

g. Answer the telephone as needed and route calls appropriately.

h. Each business day, the receptionist area shall have 100 percent coverage from 7:30 a.m. to 5:00 p.m. Central Time, Monday through Friday, excluding State holidays,

i. 100 percent of all visitors requiring visitor passes shall sign in, be issued a visitor badge and shall be escorted by the appropriate staff into the building.

j. Notification to the IME units shall occur within two hours of receipt of delivery of parcel mail delivery.

6.4.6.1.2 Performance Standards

a. 95 percent of researching and routing of mail from the miscellaneous queue from the workflow management system shall be routed to the appropriate unit within two business days from the date it enters the queue. 100 percent shall be completed within three business days.

6.4.6.2 Managing Provider Access

The Provider Services contractor supports users and assists Iowa Medicaid providers in managing their electronic mail (e-mail) accounts and access to online remittance advice statements. This scope of work is limited to assisting providers using the new functionality, reporting technical issues to the appropriate technical team within the Department, and contacting the provider once the issues are resolved. The contractor's scope of work does not include resolution of hardware or software technical issues.

6.4.6.2.1 Contractor Responsibilities

a. Within one business day of request, assist providers with creating and managing provider accounts, including but not limited to those set up to receive mass e-mails, to obtain access to secure web sites, to submit claims, to view remittance advices and to report incidents.

b. Provide phone and e-mail support for all providers requiring assistance.

c. Forward all technical issues to the designated technical team.

d. Contact providers for follow-up of technical issues within one business day.

e. Report monthly on provider usage of e-mail functionality and online remittance advice access and usage.

f. Conduct ongoing verification of licensure, certification or other enrollment requirements for all licensed professional Medicaid providers.

6.4.6.2.2 Performance Standards

a. Demonstrate progressively increasing provider participation in receipt of mass e-mails, electronic claims, remittance advices, and incident reporting.

6.4.6.3 Managed Care Recruitment

The managed care function of the Provider Services component consists of recruiting providers to participate in the Iowa Medicaid managed care program and providing support and assistance to managed care providers to retain them in the program. The data sources for this function are the provider file data to identify providers to be recruited and the telephone calls or correspondence from IowaCare or MediPASS providers.

6.4.6.3.1 State Responsibilities

a. Provide policy and procedure information regarding the enrollment of managed care providers.

b. Approve any publications or letters used by the Provider Services contractor in the managed care function.

c. Monitor the performance of the Provider Services contractor in conducting its managed care activities.

6.4.6.3.2 Contractor Responsibilities

a. Meet the following objectives:
    1. Support the management and administration of the MediPASS and IowaCare programs by recruiting, enrolling and disenrolling providers, and processing changes in enrollment.
    2. Support the recruitment, maintenance and education of the IowaCare and MediPASS providers.
    3. Support MediPASS and IowaCare providers in their interface with the Iowa Medicaid Program.
    4. Support the oversight activities of the Core MMIS contractor regarding the Managed Health Care Advisory Committee (MHCAC).
    5. Expand managed care into all appropriate geographic locations.
b. Recruit and educate IowaCare and MediPASS providers, maintain contract agreements, staff the call center and provide support.
c. Conduct continuing educational and administrative activities (including technical support) to assure sufficient levels of participation.
d. Assist the Department in the education and technical support of managed care providers.
e. Maintain and staff the call center which is available to support the Iowa Care and MediPASS providers.
f. Ensure that federal requirements for MediPASS contracting are met.
g. Recruit new providers to participate in the MediPASS program and as care coordinators.
h. Manage provider agreements, including recruiting, disenrollment, changes in enrollment, and contract termination or modification.
i. Review contracts with the Department for approval.
j. Maintain originals of all provider contracts.
k. Educate MediPASS providers regarding Medicaid and managed health care policies and procedures.
l. Prepare and submit to the Department statistical reports regarding participation, provider enrollment and capacity.
m. Conduct appointment surveys including availability of after-hour access, perform follow-up phone calls and send educational letters to the providers.
n. Send a monthly enrollment roster (currently produced on paper) to each MediPASS provider listing each individual enrolled with the provider.
o. Coordinate with the Core MMIS contractor to issue administrative fee payment to each MediPASS provider based on the total number of individuals enrolled.

p. Maintain and staff the call center which is available to support the MediPASS and HMO providers.

q. Oversee the Managed Health Care Advisory Committee (MHCAC), which includes:

   1. Soliciting physicians for participation on the Managed Health Care Advisory Committee and send letters of solicitation

   2. Coordinating, attending, participating and sponsoring quarterly meetings with MHCAC

r. Maintain the following interfaces:

   1. Providers, to recruit new managed care providers and encourage existing managed care providers to remain in the program

   2. Provider associations, to disseminate information regarding enrolling providers as managed care providers

s. Produce the following outputs:

   1. MediPASS recruitment letters to providers

   2. MediPASS informational pamphlets

   3. MediPASS recruitment activity reports

6.4.6.3.3 Performance Standards

a. Increase MediPASS provider participation by five percent per year for each contract year from base year. The base year is the 12-month period prior to the effective date of the new IME contract.

6.4.7 ISIS Support

It is the Department's intent that the Provider Services contractor take over the ISIS help desk and quality assurance functions that staff from the Office of Field Support currently perform. Types of inquiries and requests include but are not limited to password resets; questions about ISIS screens; policy questions; and updates to program type, level of care, and date spans.

6.4.7.1 State Responsibilities

a. Provide initial training for Provider Services contractor staff who will perform these functions.

b. Provide policy and procedure information regarding the update of information in ISIS related to the affected waivers and programs.

c. Provide password-reset instructions for ISIS.

d. Provide guidelines for responses to and referral of policy questions.

e. Provide guidelines for response to and referral of technical issues related to using ISIS.

f. Provide a menu option for ISIS support for incoming telephone calls to the provider call center.

g. Provide a means for automated workflow management, tracking and trending of telephone and e-mail inquiries and requests for ISIS help desk and quality assurance functions.

h. Provide a dedicated e-mail box for receipt of requests to update data in ISIS.

i. Provide guidelines to verify authorization for requests to update ISIS data.

j. Review and approve the procedures manual by the Provider Services contractor in the ISIS help desk and quality assurance functions.

k. Review and approve log of inquiries as needed and periodic required performance reporting when delivered.

l. Monitor the contractor's performance of ISIS help desk and quality assurance activities.

6.4.7.2 Contractor Responsibilities

a. After initial state training, assume responsibility for training staff who will perform these functions in how to use ISIS, workflow management system, and call center system to respond to, track, and report on telephone and e-mail inquiries..

b. Provide trained personnel who have online access to ISIS to respond to incoming telephone or e-mail inquiries from all ISIS users, including case managers, providers and other outside entities.

c. Transfer calls to ISIS support personnel through the existing toll-free telephone lines that are staffed by full-time provider services representatives from 7:30 a.m. to 4:30 p.m., Central Time, Monday through Friday, excluding state holidays.

d. Include the ISIS help desk in the call center management system provided by the Department (which has the capability of answering calls in sequence, recording and printing statistics, and indicating calls that have been placed on hold for a specific time limit) so that ISIS calls can be included in weekly statistical performance reports to the Department that contain call abandonment rates calculated on weekly averages, based on the first business day through the last business day of the week.

e. Obtain written approval from the Department to block any caller.

f. Assure that ISIS help desk and quality assurance staff members are trained in current Iowa Medicaid Program policies and procedures, ISIS functions, and appropriate telephone soft skills and etiquette.

g. Use the workflow process management system to track and report on the number of e-mail inquiries and the Department-provided call management system to track and report on the number of e-mail and telephone inquiries, the number of days elapsed between inquiry and resolution of the inquiry, and similar information. The tracking system maintains a log of e-mail and telephone inquiries, including the caller's ID number, date of receipt, date of response, nature of inquiry, and disposition of inquiry. The log is available for review by the Department at any time.

h. Respond to ISIS user inquiries regarding how to use the application. Information about the ISIS application is available in the ISIS User Guide at this link: *www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Master/14-M.pdf*.

i. Respond to policy questions as directed by the Department according to the information in the Medicaid Waiver Services chapter of the Individual And Family Support And Protective Services title of the employee manual available at this link: *http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Master/16-K.pdf*

j. Refer to Department-specified policy staff any questions that are outside the bounds of Department-approved guidelines for the Provider Services contractor's allowable handling of policy questions.

k. Accept e-mail requests for ISIS data updates, verify submitters' authorization as directed by the Department, and enter updates in ISIS that the submitters provide on the Iowa DHS Request for Medicaid Services Data Changes and Verifications form available at this link: *http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/FORMS/470-3923.pdf#search='470-3923*'

l. Provide to the Department for any time period requested a report of ISIS support activity that will include, at a minimum, the number and nature of inquiries received (both written and by telephone) and the average response time for all inquiries.

6.4.7.3 Performance Standards

a. Maintain a service level of 80 percent for incoming calls that is calculated with this equation:

$$SL = ((T - (A + B) / T) * 100)$$

where T = all calls that enter the queue
A = calls that are answered after 30 seconds
B = calls that are abandoned after 30 seconds

b. Respond with a complete response to 90 percent of e-mailed requests within one business days of receipt. Provide an interim response within one business day if a complete response is not possible by then. Provide complete responses to 100 percent of inquiries within three business days.

6.5 Member Services

The Member Services component includes activities related to interacting with people who receive services through the Iowa Medicaid or IowaCare Programs. The Department's income maintenance workers (IMWs) determine the individuals' eligibility for benefits, and the Department develops policy for all Medicaid and IowaCare programs. The Member Services contractor will serve as the managed health care (MHC) enrollment broker. Members shall be able to obtain answers to their inquiries regarding their MHC enrollment and their services received and payable under their Medicaid or IowaCare program without having their call transferred to other areas. The Member Services contractor will also provide departmental publications that assist members in their understanding of Iowa's Medicaid and IowaCare policies and benefits provided.

The Member Services component also includes the activities related to monitoring member care: locking in members to particular providers when necessary and managing treatment for particular conditions. In addition, the Member Services contractor will conduct activities related to improving the outcomes of delivery of services to members, including but not limited to analysis of and intervention with high-cost populations.

The Member Services component includes the following responsibilities:

- 6.5.1 Managed Health Care Enrollment Broker
- 6.5.2 Member Inquiry and Member Relations
- 6.5.3 Member Outreach and Education
- 6.5.4 Member Quality Assurance
- 6.5.5 Medicare Part A and Part B Buy-In
- 6.5.6 Lock-In
- 6.5.7 Disease Management
- 6.5.8 Enhanced Primary Care Management

6.5.1 Managed Health Care Enrollment Broker

Department staff members make eligibility determinations using the Automated Benefits Calculation (IABC) system. This information is sent to the state-operated Title XIX system. It sends a daily update and monthly full file electronically to notify the Core MMIS contractor of individuals eligible to be enrolled in medical managed health care, either through health maintenance organizations (HMOs) or the MediPASS program. After the Core MMIS contractor staff receives this file, they use a Department-specified algorithm to tentatively assign the member to HMOs or MediPASS provider. The Core MMIS contractor will then notify the Member Services contractor of these eligibles and the tentative provider assignments.

The Member Services staff sends an enrollment packet to each member advising them of their tentatively assigned provider and giving them a limited number of days to choose a different provider. If no choice is made, the individual is automatically enrolled with the tentative provider (referred to as a “force enrollment”). Individuals who choose a provider are referred to as “choice enrollments.” With limited exceptions, individuals must remain enrolled with the provider for six months. After each six-month period, the individual is sent a letter advising them that they may change providers. The Member Services contractor is responsible for enrolling members in HMOs and MediPASS (based on eligibility information supplied by the Department) and for furnishing the Department with the member’s assigned primary care provider.

The Member Services contractor does not provide administration services for the managed mental and substance abuse carve-out known as the Iowa Plan

The Member Services contractor must comply with all federal requirements for the enrollment broker activity as specified by 42 CFR 438. Details of those requirements appear in RFP Section 6.5.1.2 Contractor Responsibilities so that the bidder can respond to them individually.

Following are the data sources for this function:

a. File of potentially eligible MHC members from MMIS
b. Telephone calls or mail received from MHC members to notify the Member Services contractor of their selection of an MHC provider
c. Enrollment and disenrollment selections

6.5.1.1 State Responsibilities

a. Define algorithm to be used for auto assignment of potential enrollees into HMO and MediPASS programs.
b. Oversee enrollment process for MHC programs
c. Approve materials to be sent to potential enrollees, both for contractor developed materials and HMO developed materials.
d. Review and advise the Department on access requirements for the implementation and continued enrollment in specified counties.

6.5.1.2 Contractor Responsibilities

a. Process enrollment, disenrollment and demographic change notices for members and update MMIS files with the information. Refer member address changes to the member’s IMW or the DHS call center for updating in the state eligibility system.
b. Produce and mail an enrollment packet to Medicaid eligible individuals advising them of their tentatively assigned provider and giving them a limited number of days to choose a different provider.
c. Send the appropriate Department-approved letter, a Your Choice booklet, HMO materials (if applicable), and an enrollment form to new managed care enrollees that have not been enrolled in managed health care in the past 12 months. Send the same materials to members previously enrolled in managed care except the Your Choice booklet and enclose a different Department-approved letter.

d. Automatically enroll any members who fail to choose a different provider with their tentative provider. With limited exceptions, individuals must remain enrolled with the provider for six months. After each six-month period, send the individual a letter advising them that they may change providers. Assign member to HMO or MediPASS according to Department program rules.

e. Advise the Department of any access issues that may be brought to the attention of Member Services staff from calls from members or others.

f. Educate members and process enrollment and disenrollment for MediPASS and HMO programs, which includes:

    1. Maintaining and staffing the member managed care call center, which is available to managed care members Monday through Friday from 8:00 a.m. to 5:00 p.m.

    2. Processing member enrollment in MHC, disenrollment and changes in enrollment (including data systems design, operation, mailing decision notices, processing enrollment forms, and similar functions)

    3. Providing member education regarding program policy, compliance, and provider selection for new enrollees

    4. Providing ongoing education to currently enrolled members regarding program policy, preventive health issues, provider selection and change, and similar topics

    5. Supporting statistical reporting, including enrollment, disenrollment, and enrollment changes

    6. Monitoring the daily update file and monthly full enrollment file sent by the Core MMIS contractor to the Title XIX system that contains member enrollment and disenrollment status

    7. For Medicaid individuals who regain eligibility within 90 days, automatically reinstating the enrollee with the last provider on record if still active in the Medicaid member's demographic area

    8. Receiving member lock-in data from Iowa Medicaid Enterprise (IME) Medical Services contractor and disenrolling the member from the MediPASS provider

    9. Processing special exclusions as per Department criteria

g. On a quarterly basis or as needed, update the MMIS with the MHC Participating Provider List by County. Provide each member with a copy of their respective county MHC Participating Provider List with their enrollment package.

h. For those members who have been ineligible for Medicaid for three consecutive months, remove them from (or move them to inactive on) the HMO or MediPASS provider's member list.

i. Coordinate with the Core MMIS contractor to conduct mass enrollment and disenrollment changes/transfers between HMO plans or between MediPASS providers on behalf of active or inactive managed care enrollees. Types of situations in which this action might be necessary include:

1. A change of ownership has occurred and the provider has subsequently been issued a new tax number or Medicaid national provider identification number.
2. One HMO is bought by another HMO and is maintaining the same clientele.
3. An individual MediPASS provider has stopped serving the Medicaid population or has changed the parameters of participation in the program.

j. Maintain enrollment/eligibility data, eliminating duplicate member records by ensuring non-overlapping enrollment segments.

k. Update the date tables related to the MHC subsystem on an annual basis

l. Produce the following required outputs:

1. Enrollment packets for members
2. Daily, monthly, and quarterly managed health care reports to the Department
3. Letters to members after each six-month period, advising them that they may change providers or other managed care changes
4. File updates for the Department and MHC providers (daily, monthly, quarterly, annual)

n. Advise Department regarding materials that should be changed to meet member needs or new legal and regulatory requirements.

o. Provide, gather and collate materials necessary for any state or federal reviews. Participate in such reviews as may be required by the Department.

p. Make all standard reports available online for review by Department staff on the following schedule:

1. Daily reports by end of the next business day after the scheduled production date
2. Weekly reports by end of the next business day after the scheduled production date
3. Monthly reports by end of the third business day after month end cycle
4. Quarterly reports by end of the fifth business day after quarterly cycle

q. Independence: Describe how the bidder will assure continually that the contractor and any subcontractor that will act as the enrollment broker for the Department is independent from any managed care entity (MCE) and health care provider that provides coverage in Iowa. State expenditures for the use of enrollment brokers are eligible for federal financial participation (FFP) only if the broker and its subcontractors are independent of any managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), primary care case management (PCCM) or other health care provider in any state in which they provide enrollment services. A broker or subcontractor is not considered independent if it meets any of the following conditions:

1. Is an MCO, PIHP, PAHP, PCCM or other health care provider in Iowa
2. Is owned or controlled by an MCO, PIHP, PCCM or other health care provider in Iowa

3. Owns or controls an MCO, PIHP, PAHP, PCCM or other health care provider in Iowa

r. Freedom from conflict of interest: Describe how the bidder will assure continually that the contractor and any subcontractor that will act as the enrollment broker for the Department and enrolling eligible recipients (members) into managed care plans may not have a conflict of interest. No person who is an owner employee consultant or has a contract with the enrollment broker or who has any direct or indirect financial interest with such an entity or health care provider or has been excluded from participation in the program debarred by any federal agency or subject to civil money penalty may be involved with the duties of the enrollment broker. State expenditures for the use of enrollment brokers are eligible for FFP only if the broker and its subcontractors are free from conflict of interest. A broker or subcontractor is not considered free from conflict of interest if any person who is the owner, employee or consultant of the broker or subcontractor or has any contract with them if it meets any of the following conditions:

1. Has any direct or indirect financial interest in any entity or health care provider that furnishes services in Iowa
2. Has been excluded from participation under Title XVIII or XIX of the Social Security Act
3. Has been debarred by any federal agency
4. Has been or is now subject to civil money penalties under the Social Security Act

s. Conflict of interest safeguards: Describe how the bidder will assure continually that the contractor and any subcontractor acting as the enrollment broker for the Department and enrolling eligible members into managed care plans has no conflict of interest preventing enrollment of members and that the bidder and any subcontractors will abide by applicable state and federal regulations specifically the requirements specified in Section 27 of the Office of Federal Procurement Policy Act [as listed in Title 41 of the United States Code (41 USC) Part 423]. Affected parties include all state and local officers and employees and agents of the state who have responsibilities relating to the MCO, PIHP or PAHP contracts or the default enrollment process specified in Title 42 of the Code of Federal Regulations (42 CFR) Section (§) 438.50(f) for states with 1932 SPA programs.

t. Enrollment discrimination prohibited: Describe how the bidder will assure continually that the contractor and any subcontractor shall not discriminate in choice counseling and enrollment activities. By contract with the state, MCOs, PIHPs, PAHPs or PCCMs must accept individuals in the order in which they apply without restriction (unless authorized by the regional administrator) up to the limits set under the contract.

u. Enrollment not discriminatory health status: Describe how the bidder will assure continually that the contractor any subcontractor acting as the enrollment broker for the Department and enrolling eligible members into managed care plans will not discriminate against individuals eligible to be covered under contract on the basis of health status or need for health services. The enrollment broker will not conduct counseling and enrollment activities to allow MCO, PIHP, PAHP or PCCM entities to discriminate against individuals eligible to enroll on the basis of health status or need for health care services.

v. Enrollment not discriminatory general: Describe how the bidder will assure continually that the contractor and any subcontractor acting as the enrollment broker for the Department and enrolling eligible members into managed care plans will not discriminate against individuals eligible to enroll on the basis of race, color or national origin and will not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin.

w. Compliance with contracting rules: Describe how the bidder will assure continually that the contractor and any subcontractor comply with all federal and state laws and regulations including Title VI of the Civil Rights Act of 1964: Title IX of the Education Amendments of 1972 regarding education programs and activities; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

x. Enrollment broker contract functions: Perform the following enrollment broker functions.

   1. Enrollment broker means an individual or entity that performs choice counseling or enrollment activities or both.
   2. Enrollment services means choice counseling or enrollment activities or both.
   3. Choice counseling means activities such as answering questions and providing information in an unbiased manner on available MCO, PIHP or PCCM delivery system options and advising on what factors to consider when choosing among them and in selecting a primary care provider.
   4. Enrollment activities means activities such as distributing, collecting and processing enrollment materials and taking enrollments by phone or in person.
   5. Enrollee means a member who is currently enrolled in an MCO, PIHP, PAHP or PCCM in a given managed care program.
   6. Potential enrollee means a member who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program but is not yet an enrollee of a specific MCO, PIHP, PAHP and,PCCM.

y. Basic rules: Provide all enrollment notices, informational materials and instructional materials relating to enrollees and potential enrollees in a manner and format that is easily understood by enrollees and potential enrollees. The Department must approve all written materials prior to use.

z. Language requirements: Make written information available in the prevalent non-English languages in the contractor's and any subcontractors' particular service area. Written information shall be available in Spanish. Additional languages will be made available in the future as requested by the Department.

aa. Interpretation services: Make oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those that the Department identifies as prevalent. Potential enrollees and enrollees shall not be charged for interpretation services.

bb. Notification interpretation: Notify enrollees that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services.

cc. Mechanism: Have in place a mechanism to help enrollees and potential enrollees understand Iowa's managed care program. Accomplish this by assisting any enrollee or potential enrollee who contacts the contractor and any subcontractors. Use written materials or oral counseling to help the enrollee of potential enrollee understand the differences in the options available.

dd. Information regarding non-covered services: Inform potential enrollees of services not covered by the managed care entity and how to receive such services. Make available to potential enrollees and new enrollees written information of any benefits to which the enrollee may be entitled but are not available to the enrollee by the managed care entity. Such information shall include where and how the enrollee may access benefits not available to the enrollee through the MCE.

ee. General information for all enrollees of MCOs, PIHPs, PAHPs and PCCMs: Information must be furnished to MCO, PIHP, PAHP and PCCM enrollees as follows.

1. The enrollment broker must notify all enrollees of their disenrollment rights at a minimum annually. The enrollment broker must send the notice no less than 60 days before the start of each enrollment period.

2. The enrollment broker must notify all enrollees at least annually of their right to request and obtain information about the health plan, covered services, providers available and enrollee rights and responsibilities including the information in 42 CFR § 438.10(f)(6) for PCCMs as applicable as follows.

   i. Names, locations, telephone numbers of and non-English languages spoken by current contracted providers in the enrollee's service area including identification of providers that are not accepting new patients. For MCOs, PIHPs, and PAHPs, this includes at a minimum information on primary care physicians, specialists and hospitals.

   ii. Any restrictions on the enrollee's freedom of choice among network providers

   iii. Enrollee rights and protections as specified in 42 CFR § 438.100

   iv. Information on grievance and fair hearing procedures and for MCO and PIHP enrollees the information specified in 42 CFR § 438.10(g)(1) and for PAHP enrollees the information specified in § 438.10(h)

   v. The amount, duration and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled

   vi. Procedures for obtaining benefits including authorization requirements

   vii. The extent to which and how enrollees may obtain benefits including family planning services from out-of-network providers

   viii. The extent to which and how after-hours and emergency coverage are provided including:

      A. What constitutes emergency medical condition, emergency services and poststabilization services with reference to the definitions in 42 CFR § 438.114(a)

      B. The fact that prior authorization is not required for emergency services

C. The process and procedures for obtaining emergency services including use of the 911 telephone system or its local equivalent

D. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and poststabilization services covered under the contract

E. The fact that subject to the provisions of 42 CFR 438.10 the enrollee has a right to use any hospital or other setting for emergency care

1. The poststabilization care services rules set forth at 42 CFR § 422.113(c)
2. Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider

ix. Cost sharing if any

x. How and where to access any benefits that are available under the state plan but are not covered under the contract including any cost sharing and how transportation is provided. For a counseling or referral service that the MCO, PIHP, PAHP or PCCM does not cover because of moral or religious objections, the MCO, PIHP, PAHP or PCCM need not furnish information on how and where to obtain the service. The Department must provide information on how and where to obtain the service.

ff. Information to MCO enrollees: Provide the following information to enrollees.

1. The enrollment broker must notify all enrollees at least annually of their right to request and obtain information about the health plan, covered services, providers available and enrollee rights and responsibilities including the information in 42 CFR § 438.10(f)(6) for PCCMs as applicable as follows

i. Grievance appeal and fair hearing procedures and timeframes as provided in 42 CFR § 438.400 through § 438. 424 in a Department-approved description that must include the following:

A. For a state fair hearing

1. The right to a hearing
2. The method for obtaining a hearing
3. The rules that govern representation at the hearing
4. The right to file grievances and appeals

B. The requirements and timeframes for filing a grievance or appeal

C. The availability of assistance in the filing process

D. The toll-free numbers that the enrollee can use to file a grievance or an appeal by phone

E. When requested by the enrollee:

1. Benefits will continue if the enrollee files an appeal or a request for a state fair hearing within the timeframes specified for filing.
2. The enrollee may be required to pay the cost of services furnished while the appeal is pending if the final decision is adverse to the enrollee.

F. Any appeal rights that the Department chooses to make available to providers to

challenge the failure of the organization to cover a service

G. Advance directives as set forth in 42 CFR § 438.6(i)(1)

gg. Freedom of choice: Inform each enrollee at the time of enrollment of the enrollee's rights to choose his health professional in the HMO, PHIP or PAHP to the extent possible and appropriate change providers or disenroll enrollment for cause whether that enrollment is with an MCO or a PCCM provider

hh. Information for potential enrollees: Provide the information specified in this section to each potential enrollee as follows.

1. At the time the potential enrollee first becomes eligible to enroll in a voluntary program or is first required to enroll in a mandatory enrollment program
2. Within a timeframe that enables the potential enrollee to use the information in choosing among available MCOs, PIHP, PAHP or PCCMs

ii. The information for potential enrollees must include the following:

1. General information about
   i. The basic features of managed care
   ii. Which populations are excluded from enrollment subject to mandatory enrollment or free to enroll voluntarily in the program
   iii. MCO, PIHP and PCCM responsibilities for coordination of enrollee care

jj. Information specific to each MCO, PIHP, PAHP or PCCM program operating in potential enrollee's service area. A summary of the following information is sufficient but the Department or enrollment broker must provide more detailed information upon request.

1. Benefits covered
2. Cost sharing if any
3. Service area
4. Names, locations, telephone numbers of and non-English language spoken by current contracted providers and including identification of providers that are not accepting new patients. For MCOs and PIHPs, this includes at a minimum information on primary care physicians, specialists and hospitals.
5. A listing of all enrollee rights and responsibilities including the right to file a grievance or appeal and the manner in which such may be filed
6. Benefits that are available under the state plan but are not covered under the contract including how and where the enrollee may obtain those benefits any cost sharing and how transportation is provided to include a counseling or referral service that the MCO, PIHP or PCCM does not cover because of moral or religious objections

kk. Alternative formats: Make written material available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who for example are visually limited or have limited reading proficiency.

ll. Notification – alternative formats: Inform all enrollees and potential enrollees that information is available in alternative formats and how to access those formats.

mm. States with mandatory enrollment under state plan authority: Provide the following information on MCOs and PCCMs in a comparative chart-like format

1. The MCO's or PCCM's service area
2. The benefits covered under the contract
3. Any cost sharing imposed by the MCO or PCCM
4. To the extent available, quality and performance indicators including enrollee satisfaction

nn. When the information must be furnished: Furnish the information as follows.

1. For potential enrollees
   i. At the time the potential enrollee becomes eligible to enroll in a voluntary program or is required to enroll in a mandatory enrollment program
   ii. At a time that enables the potential enrollee to use the information in choosing among available MCOs, PIHP or PCCMs
2. For enrollees annually and upon request to include the chart-like comparison report card

oo. Limitations on enrollment 1932 SPA states: Exclude special populations from mandatory enrollment. The default algorithm to be used will ensure that, in implementing the state plan managed care option, the enrollment broker will not require the following groups to enroll in an MCO or PCCM:

1. Enrollees who are also eligible for Medicare
2. Indians who are members of federally recognized tribes except when the MCO or PCCM is
   i. The Indian Health Service
   2. An Indian health program or urban Indian program operated by a tribe or tribal organization under a contract grant cooperative agreement or compact with the Indian Health Service
3. Children under 19 years of age who are:
   i. Eligible for SSI under Title XVI
   ii. Eligible under § 1902(e)(3) of the Social Security Act
   iii. In foster care or other out-of-home placement
   iv. Receiving foster care or adoption assistance
   v. Receiving services through a family-centered, community-based coordinated care system that receives grant funds under § 501(a)(1)(D) of Title V and is

defined by the Department in terms of either program participation or special health care needs

pp. Priority for enrollment: Give priority to enrollees already enrolled in an MCO or PCCM to continue that enrollment if the MCO or PCCM does not have the capacity to accept those seeking enrollment under the program. The default algorithm shall use the history of managed care enrollment to ascertain the last enrollment in managed care for any potential enrollment. When such previous enrollment is found the potential enrollee will be assigned a default enrollment with the most recent provider if that provider is still participating in the managed care program and is still available to the enrollee's county of residence. Changes made by the provider to the participation agreement may preclude enrollment of persons with that provider. In such cases, members will be enrolled as though no historical enrollment exists. When no historical enrollment exists, potential enrollees will be assigned a default enrollment into an HMO or PCCM at an equitable rate of 50/50 or as otherwise required to assure that there is an equitable distribution across participating plans.

Enrollment in medical managed care is always prospective. When the determination of eligibility is made, the local DHS office transfers this information to the Title XIX system. The system then sends notification to the enrollment broker indicating that enrollment is necessary. The enrollment broker sends an informational packet to the prospective enrollee and allows a minimum of 10 days for the enrollee to select a managed care provider. If no selection is made, the default enrollment will be entered for enrollment to begin no earlier than the first day of the following month.

qq. Enrollment by default in 1932 SPA states: Use the above algorithm to assure that:

1. A default enrollment process exists for assigning enrollees who do not choose an MCO or PCCM during their enrollment periods.
2. The process must preserve existing provider enrollee relationships and relationships with providers that have traditionally served Medicaid enrollees. If that is not possible, enroll the enrollees equitably among qualified MCOs and PCCMs excluding those that are subject to the intermediate sanction described in 42 CFR § 438.702(a)(4).
3. An existing provider-enrollee relationship is one in which the provider was the main source of Medicaid services for the enrollee during the previous year. This may be established through Department records of previous managed care enrollment or fee for service experience or through contact with the enrollee.
4. A provider is considered to have traditionally served Medicaid enrollees if it has experience in serving the Medicaid population.

rr. Disenrollment requirements – applicability: These provisions apply to all managed care arrangements whether enrollment is mandatory or voluntary and whether the contract is with an MCO, PIHP, PAHP or a PCCM. Assist the Department in disenrollment functions by receiving requests for disenrollment and following Department policies for the demonstration of good cause. When good cause is established by the Department, disenroll the enrollee and process a new enrollment as directed by the Department.

ss. Disenrollment limitations: Terminate or change the enrollee's enrollment under the following conditions:

1. For cause at any time
2. Without cause at the following times
3. During the 90 days following the date of the enrollee's initial enrollment with the MCO, PIHP, PAHP or PCCM or the date the enrollee is notified of the enrollment, whichever is later
4. At least once every 12 months thereafter, the Department currently allows changes every
5. 6 months without cause
6. Upon automatic reenrollment if the temporary loss of Medicaid eligibility has caused the enrollee to miss the annual disenrollment opportunity
7. When the Department imposes the intermediate sanction specified in 42 CFR § 438.702(a)(3)

tt. Disenrollment without cause requested by the enrollee: An enrollee may request disenrollment without cause during the 90 days following the date of the enrollee's initial enrollment with the MCO, PIHP, PAHP or PCCM or the date the enrollee is notified of the enrollment, whichever is later.

uu. Annual disenrollment: A member may request disenrollment without cause at least once every 6 months after the initial 90-day period.

vv. Automatic reenrollment : A member may request disenrollment upon automatic reenrollment if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. If the state plan so specifies, automatic reenrollment of a member who is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less shall occur so that the member is enrolled with the previous managed care plan.

ww. Disenrollment by the enrollee with intermediate sanctions: When the Department imposes the intermediate sanction specified in 42 CFR § 438.702(a)(3), members will be allowed to disenroll from the current plan and make a new enrollment selection.

xx. Request for disenrollment by the enrollee: The enrollee or his or her representative must submit an oral or written request to disenroll to the Department.

yy. Cause for disenrollment: The following are cause for disenrollment.

1. The enrollee moves out of the MCO's, PIHP's, PAHP's or PCCM's service area
2. The plan does not because of moral or religious objections cover the service the enrollee seeks
3. The enrollee needs related services (for example, a cesarean section and a tubal ligation) where the related services are not available within the network and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk
4. Other reasons including but not limited to poor quality of care, lack of access to services covered under the contract o or lack of access to providers with experience in the enrollee's health care needs

zz. Action on request for disenrollment by the enrollee. Disenroll an enrollee if the request for disenrollment meets the criteria and policies established by the Department. In no case may the enrollment broker disenroll a member outside established policies developed by the Department unless the Department first grants approval of such disenrollment. A change in health status may not be sufficient to meet the requirements of this paragraph unless it can be determined that maintaining current enrollment is detrimental to the enrollee.

aaa. Timeframes: Make a disenrollment determination within 30 days of the request, or the disenrollment is considered approved.

bbb. Action on disenrollment requests: Process disenrollment requests. For a request received directly from the enrollee or for a request referred by the MCO, PIHP, PAHP, or PCCM, take action to approve or disapprove the request based on the following:

1. Reasons cited in the request
2. Information provided by the MCO, PIHP, PAHP or PCCM at the Department's request (The enrollment broker may not allow an MCO, PIHP, PAHP or PCCM to request disenrollment because of a change in the enrollee's health status or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs except when his or her continued enrollment in the MCO, PIHP, PAHP or PCCM seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees.

ccc. Disenrollment timeframes: Regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee or the MCO, PIHP, PAHP or PCCM files the request. If the enrollment broker fails to make the determination within these timeframes, the disenrollment is considered approved.

ddd. Notice and appeals: Since the Department restricts disenrollment, take the following actions:

1. Provide that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period.
2. Ensure access to a state fair hearing for any enrollee dissatisfied with a state agency determination that there is not good cause for disenrollment

eee. Basic requirement: The Department must ensure that each managed care enrollee is guaranteed the rights in 42 CFR § 438.10(f)(3), which require the state, its representative, or enrollment broker to inform the enrollees of their rights. The Department delegates informing enrollees of their rights to the enrollment broker. The enrollment broker must provide the following information to the Medicaid enrollee.

1. An enrollee of an MCO, PIHP or PCCM has the following rights:

The right to --

i. Receive information in accordance with 42 CFR § 438.10.

ii. Be treated with respect and with due consideration for his or her dignity and privacy.

iii. Receive information on available treatment options and alternatives presented in a manner appropriate to the enrollee's condition and ability to understand.

iv. Participate in decisions regarding his or her health care, including the right to refuse treatment.

v. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

vi. If the privacy rule as set forth in 45 CFR Parts160 and164 Subparts A and E applies, the enrollee may request and receive a copy of his or her medical records and request that they be amended or corrected as specified in 45 CFR Part 164.

vii. Receive timely, appropriate and accessible medical care.

viii. Obtain a second opinion regarding a medical diagnosis with a referral from the managed care provider.

ix. Choose a provider from the available managed care providers.

x. Change a managed care provider as allowed by program policy.

xi. Appeal any adverse action.

xii. Be treated without discrimination with regards to sex, age, race, national origin, creed, color, physical or mental disability, religion or political belief.

xiii. Receive health care services in accordance with 42 CFR § 438.206 through 438.210.

xiv. Exercise his or her rights without adversely affecting the way the MCO, PIHP, PCCM, providers or Department treat the enrollee.

xv. Participate in decisions regarding his or her health care, including the right to refuse treatment.

6.5.1.3 Performance Standards

a. Distribute enrollment packets to eligible managed health care participants within two business days from receipt of eligibility alert from Title XIX system.

b. Validate 100 percent of MediPASS provider enrollment overrides daily.

6.5.2 Member Inquiry and Member Relations

The Member Services contractor is responsible for responding to all member inquiries regarding Medicaid or IowaCare eligibility, claim status, access to care, bills from providers, or provider complaints. These inquiries come through personal visits, telephone calls, e-mails and written correspondence. Responses to member inquiries concerning a bill from a provider establish a member's right to appeal.

The Department maintains toll-free telephone lines for member inquiries. This function requires staffing of the member call center.

The Department provides the telecommunication software to support the call center. All IME contractors will use this call center in support of the IME. Specifications on the state telecommunication network are available in the resource library.

Data sources for this function include the following types of communication:

a. Telephone calls, written correspondence or e-mail inquiries from members

b. IME data systems as described in the RFP Section 5 Operating Environment

6.5.2.1 State Responsibilities

a. Provide policy and guidelines on eligibility, service requirements, benefit packages, bill inquiries and other Medicaid or IowaCare requirements.

b. Define policies related to MHC program administration activities.

c. Define requirements to be performed by the contractor and monitor activities

d. Provide the call center system for the telecommunication function.

6.5.2.2 Contractor Responsibilities

a. Accept, research and respond to member inquiries.

b. Track member inquiries from initial receipt through resolution, identifying any steps that may exceed Member Services resolution time guidelines.

c. Provide reports as required to the Department indicating potential trends in enrollment, provider complaints, or access to care issues.

d. Staff and operate a member call center from 8:00 a.m. to 5:00 p.m., Monday through Friday excluding state holidays, and accept callers that are Medicaid or IowaCare members, representatives of members or Department staff members. (Calls received outside of these hours receive a voice message that lists the hours of member call center availability.)

e. Verify accurate spelling of member names and addresses in the eligibility files and forward any changes to the member's IMW or as directed by the Department.

f. Research inquiries, including contacting providers directly for additional information and assisting providers to resolve claim-processing problems. For two court-ordered circumstances that are described in the bidders library, send a letter to the member with the information required to support a potential appeal. The content of this notice must be approved by the Department.

g. Order 95 percent of needed member claim histories from the MMIS within one business day of request for billing inquiries with dates of service older than the prior 24 months.

h. Provide the certification of creditable coverage process for member inquiries that complies with the Health Insurance Portability and Accountability Act (HIPAA) guidelines within five business days.

i. Make follow-up calls related to prior member inquiries within two business days.

j. Use the Department-supplied call center system with telephone tree architecture for the member call center.

k. In response to Medicaid or IowaCare member telephone inquiries, provide answers about the following topics:

   1. Claim status
   2. Benefits and coverage (including questions about the provider network and available providers for managed care organizations)
   3. All long-term care Medicaid programs, including remedial, habilitation, and HCBS waiver programs
   4. Third-party liability
   5. Accounts payable and receivable (for which all billing inquiries also require a written response)
   6. A grievance system that includes the appeals process
   7. Other information requests

l. Participate and recommend solutions for projects to improve member access to information

m. Track member inquiries using the workflow process tool provided by the Department, monitoring open tickets until the issues have been resolved.

n. For auditing or appeal purposes, update workflow process call logs that identify through the use of specific category codes the reason for a member's inquiry to the call center, the resolution provided, and copies of any notification sent related to the inquiry.

o. Provide a daily report showing the number of calls received by the type of inquiry.

p. Access the front-end options to assist members who do not speak English and to provide Telecommunication Device for the Deaf (TDD) support

q. Issue notices of decision to members about bill inquiries within 30 days of the initial inquiries, as directed by the Department.

r. Maintain the following interfaces:

   1. Department staff and case managers
   2. Providers on behalf of members who inquire

6.5.2.3 Performance Standards

a. For 95 percent of telephone inquiries (except billing inquiries) in which a member speaks to a call center representative for which an answer is not immediately available to the call center representative, research and forward the inquiry to the Department within 48 hours of receipt of the inquiry.

b. Respond to all bill inquiries with written notices of decision as directed by the Department within 20 business days of the initial inquiry.

c. Maintain a service level (SL) percentage of at least 80 percent for incoming calls as calculated by the following formula:

$$SL = ((T - (A + B) / T) * 100$$

where T = all calls that enter the queue
A = calls that are answered after 30 seconds
B = calls that are abandoned after 30 seconds

d. Respond to at least 90 percent of written, faxed, or e-mailed inquiries within five business days of receipt excluding bill inquiries. If a complete response cannot be made within five business days, provide an interim response within the first five business days and every five days thereafter until resolved. Provide final resolution of 100 percent of inquiries within 15 business days.

6.5.3 Member Outreach and Education

The Member Outreach and Education function consists of providing publications to members and providing a web site for member access to information and resources. The Department produces the publications and provides them to the Member Services contractor for distribution to members. The web site will provide Department-approved information and hyperlinks to other Iowa web sites that contain information for members on the Iowa Medicaid Program, as well as a form for submission of e-mail questions to the Member Services contractor. The data sources for this function are:

a. This web site: *http://www.ime.state.ia.us/Members/index.html*

b. Member comments and questions

c. Feedback from the Member Quality Assurance function

d. Requests from Department staff

6.5.3.1 State Responsibilities

a. Provide training on existing Medicaid policy with additional training as required with policy.

b. Provide the contractor with an initial supply of all pertinent departmental forms or communications and include the contractor in the distribution of any new or revised publications.

c. Provide input on items to be included in the member web site.

d. Review and approve all information posted on the web site.

e. Review initiatives that the contractor proposes for member education.

6.5.3.2 Contractor Responsibilities

a. Meet the following objectives:

   1. Provide content with related information of interest to members.

   2. Review and advise the Department regarding materials to assure meeting federal requirements found at 42 CFR 438 for member communications.

   3. Respond to inquiries submitted via e-mail from the web site.

4. Recommend improvements for member outreach and education.
5. Educate members in the appropriate use of the health care system.
6. Increase effective and preventive use of program services and decrease inappropriate use of program services.

b. Represent IME Member Services on behalf of the Department with external entities.

c. Acknowledge receipt within two business days of electronic member inquiries and provide a response within five business days.

d. Send publications to members, as appropriate, including but not limited to the following examples:

1. Your Guide to Medicaid, Communication (Comm.) 20
2. Medicaid for Medically Needy, Comm. 30
3. The Health Insurance Premium Payment (HIPP) Program for Iowa Medicaid members, Comm. 91
4. Estate Recovery Program, Comm. 123
5. Presumptive Medicaid Eligibility for Pregnant Woman, Comm. 69
6. Information Practices for Family Investment Program, Medicaid, Food Stamps and Emergency Assistance, Comm. 51
7. Medicaid for SSI-Related Persons, Comm. 28
8. Medicaid Qualified Medicare Beneficiaries, Comm. 60
9. Important Notice to property Owners and Renters, Comm 121.
10. Medicaid for Employed Persons with Disabilities, Comm. 180
11. Medicaid for People in Nursing Homes and Other Care Facilities, Comm. 53
12. Protection of Your Resources and Income, Comm. 72
13. Care for Kids, Comm. 4
14. Medicaid for FMAP-Related Persons, Comm. 27

e. Identify information and hyperlinks to be included on the member web site and obtain Department approval of the information before it is posted to the web site.

f. Make recommendations for changes to departmental publications.

g. Publish (in hardcopy and on the web site) a provider directory for the use of members and update the list quarterly.

h. Order Healthy Start books and prepare for mailing.

i. Complete monthly report of Healthy Start mailings.

j. Maintain supply of designated brochures in lobby of IME building.

k. Provide the following reports:

1. Monthly report of member web site activity, including number of hits and number of inquiries received via the e-mail functionality.

2. Monthly report of publications distributed to members.
3. Recommendations for changes to web site information and departmental publications

l. Create and mail member newsletters as requested by the Department

m. Maintain the following interfaces:

1. Department staff and case managers

n. On monthly basis, access monthly system management report for newly-enrolled Program of All-Inclusive Care for the Elderly (PACE) members and send cover letter and PACE introductory booklet to each new member.

o. Provide monthly reports by the fifth business day following the end of the month.

p. Submit approved information to the IME webmaster to update the web site with approved information by the third business day following receipt of the approval.

q. Make recommendations to the Department for targeted education programs to member populations that are similar to standard screening, periodicity and treatment programs.

r. Implement the targeted member education programs upon receipt of Department approval.

6.5.3.3 Performance Standards

a. Submit for publication to the web site, bulletins, inserts or other special mailings within three business days of written approval by the state.

b. Present at least six recommendations annually to the Department to broaden the scope of field communications.

c. Present information at a minimum of two provider association meetings annually.

d. Present at least six recommendations annually to the Department for targeted education programs for member populations.

6.5.4 Member Quality Assurance

The Member Services contractor will support the Department in the management of quality oversight for IME programs. The Department will develop and administer the quality plan to encompass all programs with support from the Member Services and Medical Services components. The Member Services contractor will be responsible for the member satisfaction portion of the quality plan, while the Medical Services contractor will be responsible for the quality of care portion of the quality plan. The data sources for this function are:

a. Surveys

b. Claims files

c. Encounter data

d. Data Warehouse/Decision Support (DW/DS) system

e. Eligibility files

f. Enrollment files

g. Complaints and appeals files

6.5.4.1 State Responsibilities

a. Review and approve the Member Services contractor's plans for assessment of member satisfaction.

b. Review and approve the Member Services contractor's survey tools.

c. Review and approve the Member Services contractor's survey results and recommendations for improving member satisfaction.

d. Develop and implement recommendations for improvement across the IME with the component contractors

e. Monitor the Member Services contractor's performance of the member quality assurance function.

6.5.4.2 Contractor Responsibilities

The contractor will develop survey and assessment tools to ascertain member satisfaction with the Iowa Medicaid Program and provide recommendations for improving member satisfaction. The assessments will evaluate member satisfaction with access to care, the quality of care provided, the quality of the customer service provided, and responsiveness of the IME to the needs of members.

a. Develop, and submit to the Department for approval, an annual plan for assessment of member satisfaction with the Iowa Medicaid Program, including both managed care and fee-for-service populations. This plan will include the following information:

    1. Approach to annual survey

    2. Annual survey to representative sample of all members and other surveys as requested by the Department

    3. Plan for utilizing information gathered from the Member Services call center inquiries and other sources (such as Management and Administrative Reporting Subsystem (MARS) recipient participation reports, claims processing and encounter data from the DW/DS system, and complaint activity)

    4. Methodology for development of survey tools, evaluations of surveys, and determination of outcomes

    5. Approach to development of recommendations for improvement

    6. Anticipated schedule for surveys

b. Develop and submit to the Department for approval the survey tools to be used in support of the plan

c. Upon Department approval, implement the assessment plan

    1. Conduct member satisfaction surveys.

    2. Compile survey results and information from the Member Services call center.

    3. Evaluate results.

d. Coordinate member quality assurance activity with the Department, including assessment activities.

e. Develop and submit to the Department an annual member quality assurance assessment report that includes the following information:

   1. Surveys conducted and other activities included in the assessment (such as analysis of Member Services call center inquiries, analysis of MMIS claims and encounter date, analysis of MARS recipient reports, analysis of complaint activity)

   2. Results of assessment, including differences in member satisfaction between the managed care and fee-for-service populations

   3. Trends in member satisfaction from previous reporting periods

   4. Recommendations for improving member satisfaction

   5. Plans for improvements in assessments

f. Implement recommendations for improvements in assessments as approved by the Department

g. Participate in all federal and state reviews as may be required by the Department.

h. Submit reports and documents as required by the Department to complete the required MHC monthly reporting.

i. Meet the following objectives:

   1. Assessment of members' satisfaction with the quality of care being provided by the IME programs

   2. Assessment of members' satisfaction with the responsiveness of Iowa Medicaid to their needs

   3. Assessment of the differences in member satisfaction levels between the managed care and fee-for-service sectors of the Iowa Medicaid Program

   4. Improvement in member satisfaction with the Iowa Medicaid Program

j. Maintain the following interfaces:

   a. Department staff and case managers

k. Produce the following outputs:

   1. Annual member satisfaction assessment plan

   2. Member quality assurance activity report

   3. Annual member assurance assessment report

l. Conduct annual PACE satisfaction survey for Department-approved sample of members in each PACE organization that is both valid and reliable, make it available electronically and on paper, summarize results, and prepare corresponding report.

m. Submit the annual member quality assurance assessment report by the end of each calendar year.

n. Meet monthly with Department staff to review assessment activity and issues identified during the assessment activities.

6.5.4.3 Performance Standards

a. Receive a rating of satisfactory or above on all member satisfaction survey questions related to timeliness of responses from the member call center and receipt of requested information.

6.5.5 Medicare Part A and Part B Buy-In

For Medicaid members who are eligible to receive Medicare services, the Department submits Medicare premium payments to the Centers for Medicare and Medicaid Services (CMS) on the members' behalf. This function involves researching and verifying member eligibility for Medicare services, initiating the premium payments, and validating the members' presence on Medicare buy-in rosters that CMS sends to the state.

6.5.5.1 State Responsibilities

a. Provide instruction to research inquiries.

b. Provide instruction on error resolution process.

6.5.5.2 Contractor Responsibilities

a. Respond to inquiries from IME Provider Services Unit, centralized call center (which is the income maintenance call center), IM workers, members, Social Security Administration (SSA), CMS and other states regarding buy-in issues.

b. Resolve errors listed on monthly error reports generated from the buy-in system based on instruction from the Department.

6.5.5.3 Performance Standards

a. Within seven business days of receipt, respond to 95 percent of requests regarding resolution of buy-in issues. Complete 100 percent of requests within 15 business days.

b. Complete work on monthly error reports within 30 days of issuance.

6.5.6 Lock-In

The contractor will coordinate the member health education program (MHEP) and lock-in (LI) program. This includes the analysis of member surveillance and utilization reports, claim analysis, and referrals.

The contractor will review medical utilization of members to identify overutilization, duplication of services, drug abuse, and possible drug interaction. The contractor will restrict members found to be misusing medical services to one physician, pharmacy, hospital, or combination of these providers.

6.5.6.1 State Responsibilities

a. Determine compliance with overall federal regulations and state laws.

b. Establish policy regarding the administration of the member LI program.

c. Define all parameters regarding utilization to be used by the contractor in administering the LI program.

d. Approve the contractor's procedures for LI program administration.

e. Monitor the contractor's performance of LI program activities.

f. Conduct appeals and fair hearings related to LI decisions as needed.

g. Respond to member inquiries regarding LI status and LI processes.

6.5.6.2 Contractor Responsibilities

a. Meet the following objectives:

   1. Improve care and health of members
   2. Reduce wasteful and duplicative services and therapies
   3. Program savings

b. Review member utilization of medical services to identify misuse, drug abuse and duplicative services and secure medical providers to provide services to restricted members.

c. Provide supportive professional and administrative services for appeals, prepare case summaries, and provide testimony regarding the review process during the administrative hearing.

d. Using all available claims, enrollment and eligibility data in the MMIS and the DW/DS system, identify members for the LI program. The criteria for identifying candidates for the LI program will include, at a minimum:

   1. Number of physicians
   2. Number of pharmacies
   3. Number of prescriptions
   4. Controlled drugs
   5. Diagnoses
   6. Total cost

e. For members identified for LI, set up a case in the workflow process and send a medical alert letter to the member notifying the member of the problem.

f. Evaluate the member's utilization after one quarter to determine if utilization has been reduced. If no reduction in utilization has occurred, notify the member by letter requesting that the member choose a primary care provider and report to the Department.

g. If the member chooses a primary care provider, prepare and send a letter to the chosen provider requesting the provider to become the primary care provider for the member. Contact the provider by telephone as a follow-up to the letter.

h. If the member does not choose a primary care provider, identify a provider who is willing to serve as the primary care provider.

i. Recruit providers who are willing to serve as primary care providers in all geographical areas of the state. If no providers in a specific area are willing to serve, notify the Department of the problem area.

j. On approval of the provider, prepare and send a letter to the member notifying the member of the primary care provider and report to the Department.

k. Set the LI indicator on the MMIS member database for each primary care provider for one year.

l. No less frequently than every quarter, review the member's utilization to determine if the problems have been corrected. If utilization is still high, recommend a course of action and extend the restriction for one additional year. If the problems have been corrected, release the member from restriction. Prepare and send notification letters to the primary care provider and the member as approved by the Department and report to the Department.

m. After a member has been released from the LI program restriction, review the member's utilization after two quarters to determine whether to reapply the LI, and notify the Department of the results of the review. Prepare and send letters to the primary care provider and the member as approved by the Department and report to the Department.

n. Reassign a member to a primary care provider if a selected primary care provider requests the reassignment or can no longer serve as the primary care provider.

o. Log all LI program activity in the workflow process, including the type of activity and the date the activity occurred.

p. Provide information to the Department on LI activities when requested for use in appeals and fair hearings, including preparing case summaries and providing testimony regarding the review process during the administrative hearing.

r. Meet monthly with Department staff to review restricted members, problems, and changes in review processes

s. Assist the Department with communications to provider and member who have health care quality issues.

t. Report the number of members on MHEP and on lock-in within 10 business days of the end of each quarter.

u. Provide professional medical staff to perform Member Services services such as lock-in, disease management and enhanced primary care management as directed by the Department, including a medical director (an experienced managing physician who can be an MD or DO), nurses, and peer consultants (such as psychologists, dentists, therapists and other medical professionals) with recognized credentials in the service area being reviewed. These medical consultants must be licensed or otherwise legally able to practice in the state of Iowa and possess the professional

credentials to provide expert witness testimony in hearings or appeals. The Member Services contractor's medical director will coordinate with the Chief Medical Director in Medical Services as needed.

6.5.6.3 Performance Standards

a. On a quarterly basis, report the MHEP and LI program savings and a quarterly measurable growth rate from preenrollment to postenrollment for LI members. Outline the methodology for this analysis based on claims data to a level of detail that enables Department staff to substantiate the report's content.

6.5.7 Disease Management

Disease management is an innovative intervention for improving care, outcomes, and costs for individuals with certain disease conditions. The use of quality indicators that reflect accepted guidelines for members with specified disease processes and address many of the disease-related objectives of Healthy People 2010 can improve the quality of care for members and use resources efficiently.

Disease management is an organized, proactive approach to healthcare delivery that engages the member in self-management of their disease. Because many diseases are controlled primarily by the member living with the disease, an emphasis on self-management support is a means to change behaviors to improve disease control and health status.

Key components of disease management are identification of the population with specified diseases, evaluation of candidates for disease management based on cost effectiveness guidelines, and use of recognized practice guidelines or performance standards for managing identified members. It is also imperative that the providers of service associated with members be involved with the education and intervention developed by the contractor.

The contractor will be required to develop a limited disease management protocol for non-HMO members, for presentation and approval by the Department. The contractor may propose a risk-based provision that would allow the contractor to assume limited risk for the outcomes of the disease management population, in exchange for receiving a bonus for positive outcomes. Performance standards will be identified and agreed upon in the final contract based upon the disease management approach that the successful bidder proposes.

The data sources for the Disease Management function are:

a. Service utilization data from paid claims, encounters and Healthplan Employer Data and Information Set (HEDIS) findings

b. Medical profile indicators from disease management protocols

6.5.7.1 State Responsibilities

a. Approve the clinical guidelines and requirements for enrollment in the disease management program.

b. Review and approve the contractor's proposal for and any expansion to the disease management program.

c. Monitor the activities of the contractor as they relate to the educational activities and clinical regimens developed and applied by the contractor.

d. Require changes in the plan for management of individually identified members or the program parameters as a whole, based on review of contractor's activity.

e. Supply access to the MMIS data Point of Sale (POS) data or enterprise data warehouse tools and data stored therein.

6.5.7.2 Contractor Responsibilities

a. Meet the following objectives:

   1. Improvement of health status for selected members with chronic conditions.
   2. Reductions in costs for high users of services who have specific medical maladies covered under the disease management program.
   3. Design of protocols for better management of chronic diseases.

b. Maintain the following interfaces:

   1. MMIS and Data Warehouse/Decision Support (DW/DS) system for information on providers, members, services and costs
   2. Communication with providers participating in the disease management protocols
   3. Any contractor that may analyze data

c. Obtain all data files necessary to accomplish the goals of the program.

d. Use recognized guidelines to review disease classes that may be amenable to intervention. This universe will include, at a minimum, diabetes, congestive heart failure, asthma and juvenile asthma. The contractor may suggest other disease management initiatives and processes that might show significant positive health outcomes and subsequent reductions in overall cost to the Department, such as high-risk maternity, pharmacy case management, breast and cervical cancer, and other high-cost conditions.

e. Undertake studies as directed by the Department.

f. Prepare an annual proposal identifying potential diseases and/or individual members for development of a program in disease management and present the proposal to the Department. Include any criteria that the Department requests.

g. Submit clinical guidelines and enrollment requirements to the Department for approval prior to enrolling members in the disease management program.

h. Enroll members in the disease management program.

i. Develop reports and other monitoring devices as requested by the Department to demonstrate the results of the program.

j. Report on clinical outcomes experienced by the enrolled members on a proposed schedule approved by the Department. These reports would include self-assessments of health status and physician assessments of member health status.

k. Obtain Department approval before undertaking outreach to members or providers of service regarding disease management programs. Report outcomes of the Department-approved outreach to the Department.

l. Develop and obtain Department approval of the methodology to be used in reviewing Medicaid utilization data to identify new diseases to be added as disease management candidates.

m. Report to the Department, annually, on the cost effectiveness of the disease management program, including base line service utilization data and overall health status, intervention during the year, new baseline health status and cost, plus changes in utilization and cost. Outline the methodology for this analysis based on claims data to a level of detail that enables Department staff to substantiate the report's content.

n. Any enrolled member who has designated a primary care or primary medical provider will have that provider involved with the management of the member. This means that the active medical management of the member may only be done with the consultation and approval of the primary medical provider.

o. Coordinate with the Iowa Plan for persons enrolled in the Iowa Plan with physical diseases that have a mental health or substance abuse issue or who are referred from the Iowa Plan due to physical issues'.

p. Prepare a monthly report of member participation in disease management program, their service utilization and cost.

q. Send enrolled members a satisfaction survey within 10 business days of the member's sixth and twelfth month of enrollment.

6.5.7.3 Performance Standards

a. Complete initial health status assessments for each member within 30 days of enrollment.

b. Complete health status assessments on all members who have been enrolled for at least one year within 30 days of the anniversary date of the member's enrollment.

c. Make recommendations for at least six studies that the Department agrees are valid.

6.5.8 Enhanced Primary Care Management

In addition to the MediPASS primary care case management program, the Department operates an enhanced primary care management program for members with high costs or high utilization of services. A primary care provider is responsible for providing or authorizing certain Medicaid services for these members. Medicaid members in the enhanced primary care management program receive all Medicaid services to which they are entitled. Iowa Medicaid State Plan services are included, except emergency services, transportation, family planning, mental health and substance abuse services; annual eye examinations, and school-based or well-child clinics. All optional services and other services not specifically mentioned above are not managed.

The data sources for the enhanced primary care management function are:

a. Interviews with member, family, service providers, current service workers, or case managers or other applicable sources
b. Copies of medical records or previously accessed/authorized services plans
c. Program policies for LTC eligibility
d. Claim information
e. Care management member satisfaction survey

6.5.8.1 State Responsibilities

a. Provide guidelines for qualifications of contractor staff and primary care providers who will perform the enhanced primary care management functions.
b. Provide written policy regarding care management.
c. Provide written guidelines for an appeal process.
d. Provide referrals for care management to the contractor.
e. Monitor the performance of the care management process.
f. Approve care management edits and audits.

6.5.8.2 Contractor Responsibilities

a. Meet the objective to improve access to needed care and to reduce unnecessary and inappropriate utilization and costs.
b. Maintain the following interfaces:
    1. Members referred for care management
    2. Case managers
c. Accept referrals for care management upon request from the Department.
d. Obtain additional information that is needed from the member's medical providers to determine the individual's need.
e. Perform a prescreening assessment on each member referred for care management.
f. Provide professional medical staff to perform the care management functions.
g. Prepare care plans for each member receiving care management and maintain documentation.
h. Notify members and the Department of the results of the prescreening assessment in a format determined by the Department.
i. Respond to phone calls regarding members enrolled in care management.
j. Survey members regarding satisfaction of care management activities.

k. Identify outliers in cost, utilization and treatment patterns that could benefit from enhanced primary care management and provide recommendations to the Department.

l. Submit reports in a format and frequency approved by the Department.

   1. Summary of care management activities and services authorized for members
   2. Comparison of services and funding prior to and after receiving care management
   3. Summary of satisfaction survey of members
   4. Length of time that members receive care management

m. Participate in meetings and develop a plan to review claims data for foster care children to determine compliance with current EPSDT standards. When outliers are noted, the care management team would get involved to intervene as necessary. For psychotropic medications, the IME will transfer data to Magellan and request that they perform a review to determine that the right medications are being prescribed at the right intervals.

6.5.8.3 Performance Standards

a. Upon referral, complete initial member contact for care management services for 95 percent of the members within five business days.

b. Maintain a minimum enrollment of 50 members.

c. Send enrolled members a satisfaction survey within 10 business days of the member's sixth month of initial enrollment and annually on the anniversary of their enrollment.

d. Contact 95 percent of the care-managed members within one business day following discharge from hospital.

e. Demonstrate cost-avoidance through a decrease in emergency room visits annually for members enrolled for at least 11 of 12 months.

f. Demonstrate cost-avoidance through a decrease in hospitalizations annually for members enrolled for at least 11 of 12 months.

6.6 Revenue Collections

The Revenue Collections contractor is generally responsible for all third-party liability (TPL) activities for the Iowa Medicaid Program. The Revenue Collections component encompasses an array of collection functions for the Medicaid program, including identification and recovery of funds owed to the Department as a result of third-party insurance payments, liens, tax offsets and provider overpayments. The third-party insurance function is the major activity of this component, which includes identifying third-party insurance resources, updating the TPL files, identifying funds to be recovered, requesting funds from the liable party, tracking and follow-up on the requests, and tracking payments received. The Revenue Collections section includes the following topics:

- 6.6.1 General Requirements
- 6.6.2 TPL Recovery
- 6.6.3 Lien Recovery
- 6.6.4 Provider Overpayment
- 6.6.5 Provider Withholds
- 6.6.6 IowaCare Premium Payments
- 6.6.7 Credit Balance Recovery

6.6.1 General Requirements

Following are the general requirements for the Revenue Collections component.

6.6.1.1 State Responsibilities

a. Monitor Revenue Collections contractor performance.

6.6.1.2 Contractor Responsibilities

a. Pursue collections and track payments received.

b. Work as part of a larger integrated unit consisting of staff from other contractors obtained through this procurement, plus requisite state employees.

c. Ensure that the money amounts of each offset do not exceed the state or federal regulations governing monetary garnishments. For example, current statutes do not allow for more than 50 percent of an individual's income to be garnished at each payment interval for child support payments.

d. Within one business day of their preparation for deposit, deposit checks or money orders received at the Iowa Medicaid Enterprise (IME) facility by all contractors to the state-owned Title XIX recovery bank account.

e. Provide deposit receipt and a check log to the Department within 24 hours of depositing the refund checks. The log should include the daily beginning number and

amount of checks located in the state-owned safe, the number and amount of the daily deposit, and the ending number and amount of checks located in the state-owned safe.

f. Research and obtain correct addresses for returned checks of providers and mail returned checks to new addresses for providers once the corrected information is updated in Medicaid Management Information System (MMIS) by the IME Provider Services unit.

g. Void returned checks when the provider cannot be located or when the provider notifies the IME that the claims are to be voided.

h. If the provider does not contact the IME, hold the undeliverable check for 30 days from the issuance date and then void the check.

i. Deposit undeliverable checks into the state-owned Title XIX recovery bank account on day 31 or the next banking day.

j. Submit credits or adjustments associated with the claims for the non-deliverable check to the Core MMIS contractor within 10 business days of depositing the undeliverable check.

6.6.2 TPL Recovery

TPL recovery consists of identifying and verifying third-party resources for Medicaid and IowaCare members, updating the TPL files, and recovering funds from third-party insurers for pay-and-chase claims. Following are the primary inputs to the TPL subsystem:

a. Supplemental insurance questionnaire forms (SIQs) completed by Department income maintenance workers (IMWs)

b. Health insurance premium payment (HIPP) file showing individuals with TPL for whom the Department has paid the premium

c. Child support file showing TPL coverage provided by noncustodial parents

d. Correspondence and phone calls from members, carriers, providers, employers, field staff and the Centers for Medicare and Medicaid Services (CMS)

e. Data match information received from other insurers

f. Insurance carrier data updates from insurance companies

g. TPL-related data from the claim processing function, including but not limited to indication that TPL payment has been made for a claim

h. TPL-related information for court-ordered medical support

i. Paid claims for tracking and potential recovery

j. Other files used in the TPL process for reference data, including the recipient eligibility file, claims files, procedure, drug, diagnosis, diagnosis related group (DRG), ambulatory payment classification (APC) and exception control files

6.6.2.1 State Responsibilities

a. Establish and direct TPL policies.

b. Receive and review TPL reports.

c. Provide the SIQ forms on members with potential TPL to the Revenue Collections contractor for verification of the third-party coverage and updating the MMIS.

d. Manage the TPL action plan that is approved by CMS.

6.6.2.2 Contractor Responsibilities

The Core MMIS contractor and the Revenue Collections contractor perform TPL processing functions. The Core MMIS contractor maintains the TPL data and performs cost avoidance activities through the claims processing function. The Revenue Collections contractor performs the manual processes associated with the TPL function, including verification of insurance coverage, updating TPL files, and pay-and-chase activities. The Revenue Collections contractor is responsible for the following TPL activities.

a. Meet the following objectives:

    1. Identify and verify third-party resources for Medicaid and IowaCare members.

    2. Pursue recovery of third-party insurance payments for claims designated by the Department as pay-and-chase.

    3. Meet federal and state reporting requirements for TPL activities.

b. Maintain the following interfaces:

    1. Members and Medicaid providers to obtain information on third-party insurance coverage

    2. Insurance companies to verify coverage and submit pay-and-chase claims

c. Verify insurance coverage for Medicaid and IowaCare members based upon claims information, SIQ forms, or any other forms of TPL notification submitted by Department income maintenance workers, providers, staff of the Member Services unit, or any other entity providing TPL updates.

d. Perform all recovery activities for pay-and-chase claims, which includes submission of claims to third-party insurers, recovery tracking, receipt of recovery payments, and production of reports on recovery activities.

e. Update third-party carrier information, as it becomes known, on the TPL carrier file in the Core MMIS, including carrier ID and carrier name, carrier address, including city, state and zip code, carrier phone number and name of contact person.

f. Maintain third-party resources by member ID on the TPL subsystem of the MMIS that must, at a minimum, include:

    1. First and last names of policyholder

    2. Social security number (SSN) of policyholder

    3. Full insurance company name

4. Group number, if available
5. Name and address of policyholder's employer, if known
6. Insurance carrier ID
7. Type of policy and coverage, including identification of covered types of services under the policy
8. Effective date of coverage, if new
9. Termination date of coverage, if ended

g. Identify paid claims for TPL tracking and potential recovery, including all federally mandated pay-and-chase services.

h. Maintain a TPL tracking capability for post-payment recovery of paid claims and claims denied by health insurance carriers.

i. Identify and record reasons by type and reason for denial of post-payment billed claims by TPL carrier.

j. When retroactive TPL resources are identified for a Medicaid or IowaCare member, identify paid claims for up to three years prior and bill insurance carrier for these claims.

k. Identify type and amount of recovery, utilizing the paid claims file.

l. Meet all minimum TPL processing requirements defined in Chapter 3, Section 3900 of the State Medicaid Manual.

m. Track and adjudicate all post-payment requests for reimbursement to a final payment or denial and identify denial by type and reason.

n. Perform data matches with other governmental and private insurers as required to identify TPL resources for Iowa Medicaid members.

o. Provide subject matter expertise and Iowa claims data for regular, ongoing TPL-related national settlements and mass torts.

p. Produce the following reports.

1. Reports to meet federal and state requirements:
   i. Amounts billed and collected, current and year-to-date (monthly)
   ii. Recoveries and unrecoverable amounts by carrier, type of coverage, and reason (quarterly)
   iii. CMS-approved TPL action plan (as needed)
2. TPL activity reports (quarterly)
3. Internal reports used to investigate possible third-party liability when a paid claim contains a TPL amount and no resource information is on file
4. Monthly quality assurance sample to the Department verifying the accuracy of TPL updates applied during the previous month
5. Monthly pay-and-chase carrier bills

q. Assist the Department in defining its TPL responsibilities and report any changes in content of the TPL action plan to the Department.

r. Initiate follow-up activities on denied postpayment billings as agreed with the Department within five business days of receipt of the denial notice.

s. Log and prepare all TPL recoveries to be deposited in the state-owned Title XIX recovery bank account according to Request for Proposal (RFP) Section 6.1.8 Banking Policies.

t. Deposit all payments received by all IME units except Estate Recovery Services to the Title XIX recovery bank account according to Request for Proposal (RFP) Section 6.1.8 Banking Policies.

6.6.2.3 Performance Standards

a. Post TPL recovery amounts and denial information within two business days of receipt of the recovery data to track benefit recoveries.

b. Initiate follow-up activities on unpaid postpayment carrier billings within 30 days.

c. Complete the verification or validation of TPL and update MMIS with the data within 10 business days of receiving the Medicaid or IowaCare member TPL leads.

d. Ensure 100 percent accuracy of TPL data in MMIS files based on the monthly quality assurance audit of the sample data. The quality assurance audit should consist of a one percent sample of all new policies added or termed policies deleted for the prior month.

e. Report to the Department all third-party health insurance coverage information for IowaCare members within five business days of the end of each month.

6.6.3 Lien Recovery

The lien recovery process consists of identifying trauma and accident cases for which a third party is potentially liable, pursuing recovery from the third party, and receiving and tracking funds recovered for trauma and accident cases. The Revenue Collections contractor uses TPL-related data from the claims processing function, including but not limited to indicators of accident-related treatments and trauma-related diagnoses.

6.6.3.1 State Responsibilities

a. Identify trauma and accident related diagnoses and procedures.

b. Arrange for the Core MMIS contractor to provide the Revenue Collections contractor with reports identifying accident related diagnoses and procedures, by member.

c. Identify minimum dollar expenditures for pursuing recovery.

d. Monitor the contractor's performance of the lien recovery activities.

6.6.3.2 Contractor Responsibilities

a. Meet the following objectives:

1. Identify trauma and accident cases where funds expended by Medicaid or IowaCare can be recovered from liable third parties.
2. Recover funds from liable third parties for trauma and accident cases.

b. Maintain the following interfaces:
   1. Liable third parties
   2. Attorneys for members

c. Review claims with trauma indicators to identify potential cases for subrogation; prepare records of the medical services provided to the member based on the medical assistance claims.

d. Identify potential cases for subrogation and prepare reports of the amount of medical services provided to the member based on the medical assistance claims data.

e. Provide case data to the state attorney general's office for subrogation cases that are appealed.

f. Track all subrogation cases from initial intake to final disposition. Provide a monthly report of these cases to the Department within 10 business days following the end of each month.

g. Maintain a process or utilize a tool to select individual claims online to build recovery cases (such as tort cases related to auto accidents).

h. Provide to the Department the following types of reports to meet federal and state requirements:
   1. Listings of potential recovery claims based on user input section parameters (subrogation)
   2. Amounts billed and collected, current, and year-to-date (monthly)
   3. Potential trauma or accident claims (monthly)

i. Log and prepare all recoveries to be deposited in the state-owned Title XIX recovery bank account according to RFP Section 6.1.8 Banking Policies.

6.6.3.3 Performance Standards

a. Provide monthly reports of lien recovery activity by the tenth business day of the month with state fiscal year-to-date data and updated for the previous month's activity.

b. Prepare and process credits or adjustments against recoveries received within 20 business days.

6.6.4 Provider Overpayment

The provider overpayment function consists of receiving refunds from providers and processing adjustments associated with the refunds for overpayments from providers. The data sources for the provider overpayment function are:

a. Provider refunds

b. Returned warrants

c. Claims history

6.6.4.1 State Responsibilities

a. Determine policies regarding processing of provider overpayments.

b. Review and approve contractor's procedures for processing provider overpayments.

c. Provide the bank account for deposit of refund checks from providers.

d. Monitor the contractor's performance of the provider overpayment function.

6.6.4.2 Contractor Responsibilities

a. Meet the following objectives:

   1. Identify providers who have been overpaid, through interfaces with the Core MMIS
   2. Receive refund checks and returned warrants from providers.
   3. Process claim adjustments for provider refunds to update claims history on the MMIS claims system
   4. Ensure that refund checks and returned warrants are controlled and processed according to procedures approved by the Department.

b. Maintain the following interfaces:

   1. Providers for receipt of refunds and requesting additional information if necessary to process the refunds

c. Prepare and process credits or adjustments against refund checks, including credits or adjustments resulting from provider audits with recoveries performed by the Department of Inspections and Appeals (DIA), Investigations Division, Audits Unit.

6.6.4.3 Performance Standards

a. Log and prepare all refund checks to be deposited in the state-owned Title XIX recovery bank account according to RFP Section 6.1.8 Banking Policies.

b. Prepare and process credits or adjustments against refunds within 10 business days of receipt of the refund unless additional information is required to determine the action to be taken.

c. If additional information is required in order to determine the action to be taken on the credit or adjustment related to a provider refund, request the additional information within five business days of determination of the need for additional information.

d. For refunds requiring additional information from the provider, enter claim credits or adjustments within five business days of receipt of additional information from the provider.

6.6.5 Provider Withholds

This function consists of identifying withholds against providers, setting up the withhold recovery in the MMIS, and monitoring processing to ensure recovery of the funds. The Revenue Collections contractor obtains withhold data from the Department of Administrative Services (DAS) Offset Program file, Department of Human Services (DHS) Child Support Recovery Unit, Internal Revenue Service and other sources as necessary.

6.6.5.1 State Responsibilities

a. Monitor the contractor's performance of the withhold processing.

6.6.5.2 Contractor Responsibilities

a. Provide withhold data to the Core MMIS contractor for processing.

b. Meet the following objectives:

   1. Identify withholds against providers to be recovered from Medicaid payments.
   2. Recover withholds from claims submitted for payment and forward the recovered funds to the requesting entity.

c. Maintain the following interfaces:

   1. DAS to obtain withhold data
   2. DHS Child Support Recovery Unit to obtain withhold data
   3. Internal Revenue Service to obtain withhold data

d. Process all requests for offsets within one business day of receipt.

e. Validate the processing of offsets within one business day after each adjudication cycle.

f. Identify the provider number of the entity for which an offset is required.

g. Enter offset and assignment information to be used in directing or splitting payments to the provider and the entity who has requested the offset.

h. Monitor the recovery of the offset amounts and verify processing of offsets against the claims file.

i. Ensure that the money amounts of each offset do not exceed the state or federal regulations governing monetary garnishments.

6.6.5.3 Performance Standards

a. Process all requests for offsets within one business day of receipt of request.

b. Validate the processing of offsets within one business day after each adjudication cycle.

6.6.6 IowaCare Premium Payments

The IowaCare program is a limited provider network, limited benefit Medicaid expansion operating under an 1115 waiver. Some IowaCare members are required to pay monthly premiums depending on their income level as a percent of poverty. This contractor is responsible for processing the IowaCare premium payments.

6.6.6.1 State Responsibilities

a. Initiate and interpret all policy and make administrative decisions regarding the IowaCare program.

b. Notify the contractor regarding changes to the IowaCare premium policies.

6.6.6.2 Contractor Responsibilities

a. Receive copies of enrollees' monthly premium checks and premium coupons. (Original checks will be forwarded directly to a bank lock box.)

b. Post all checks to the system designed to record IowaCare premium information. The Department has established an automated bar coding system that electronically captures the required information. Most premium payment transactions are received from the bank electronically. For those that are not, the posting function will be a manual process.

6.6.6.3 Performance Standards

a. For premium payment checks that are received manually, post the checks to the system designed to record IowaCare premium information within one business day of receipt from the bank.

6.6.7 Credit Balance Recovery

The Revenue Collections contractor will be required to pursue recoveries from Medicaid providers who have a credit balance and have no billing activity for at least six months.

6.6.7.1 State Responsibilities

a. Establish and direct credit balance recovery policies.

b. Establish the credit balance write-off threshold.

c. Approve all requests for credit balance write-offs.

6.6.7.2 Contractor Responsibilities

a. Follow-up on balances due to the Department from providers that have not been recouped through the claims processing system if there has been no activity for six months.

b. Refer to the Iowa attorney general's office any providers with credit balances who have filed for Chapter 7 or Chapter 11 bankruptcies.

c. Refer to the Estate Recovery Services contractor any deceased providers with credit balances.

d. If a provider is in a credit balance and their federal tax identification number matches that of an actively enrolled provider, prepare and submit the adjustment forms to transfer the credit balance amount to the actively enrolled provider.

e. If the amount of the credit balance is below a threshold, as determined by the Department, prepare and submit the adjustment forms to write off the credit balance as bad debt.

f. Within 10 business days of the provider being reported as being in a credit balance and having no activity for six months, notify the provider by letter of the amount due and request that the provider send a refund check for the amount due.

g. Prepare and process credits or adjustments against recoveries received within 30 days of receipt of the recoveries.

h. If the provider does not respond to the initial letter within 30 days, send a second letter within 10 business days.

i. If the provider does not respond to the second letter within 30 days, telephone the provider within 10 business days to request the refund and log the date of the call and the response.

j. If there is still no response after the telephone contact, refer the account to the Department within 10 business days with recommendations for other action to be taken by the Department.

k. Record payments received in the IME accounts receivable system for generally accepted accounting principle (GAAP) reporting and bank account reconciliation purposes.

l. Represent the Department at appeal hearings if the provider appeals the credit balance amount.

6.6.7.3 Performance Standards

a. Prepare and process credits or adjustments against recoveries received within 30 days of receipt of the recoveries.

b. Send initial provider notification letter within 10 business days of the provider being reported as being in a credit balance and having no activity for six months.

c. If the provider does not respond to the initial letter within 30 days, send a second letter within 10 business days.

d. If the provider does not respond to the second letter within 30 days, telephone the provider within 10 business days to request the refund and log the date of the call and the response.

e. If there is still no response after the telephone contact, refer the account to the Department within 10 business days with recommendations for other action to be taken by the Department.

6.7 Provider Cost Audits and Rate Setting

The Provider Cost Audit and Rate Setting contractor is generally responsible for all activities related to fiscal analyses and recommendations for rate setting for the Iowa Medicaid Program. This component encompasses the tasks to determine reimbursement rates for the Department-specified provider types and for auditing the accuracy of provider cost records. The Provider Cost Audits and Rate Setting component includes the requirements listed in the following sections:

- 6.7.1 Rate Setting, Cost Settlements, and Cost Audits
- 6.7.2 State Maximum Allowable Cost Program Rate Setting
- 6.7.3 Rebasing and Diagnosis Related Group and Ambulatory Payment Classification Recalibration
- 6.7.4 Reimbursement Technical Assistance and Support
- 6.7.5 IowaCare

6.7.1 Rate Setting, Cost Settlements, and Cost Audits

The Provider Cost Audits and Rate Setting component consists of two related responsibilities: rate setting for providers not reimbursed on a fee basis; and cost audits for most cost-based providers in the program. The general description of these requirements is provided in this subsection with details for both activities included in the remainder of the section.

Provider rate setting, cost settlement and cost audit activities include reviewing cost and statistical information to use in rate-setting, performing desk reviews and on-site audits, and arranging for specialty program audits aimed at provider rate setting and program compliance. The intent of the provider rate setting, cost settlement and cost audits activity is to establish appropriate payment rates and maintain reimbursement in accordance with state and federal requirements. Reimbursement methodologies include cost-based with or without a cost settlement provision, per diem, modified price-based per diem, percent of charges, fee-based, per capita rate, rate for specific procedure/revenue code and others.

6.7.1.1 State Responsibilities

The Department has the following responsibilities for this function.

a. Provide the contractor with the list of providers covered by the scope of work for this component

b. Establish policies that govern the rate methodologies used to reimburse providers.

c. Approve allowed rates or fees.

d. Approve all audit schedules, reimbursement rates and cost settlements and authorize collection of overpayments

6.7.1.2 Contractor Responsibilities

The contractor has the following responsibilities for this function.

a. Meet the following objectives:
    1. Perform rate setting and cost settlements to ensure that payments made to Medicaid providers are in accordance with state and federal requirements
    2. Perform desk reviews or on-site field audits to ensure the accuracy of financial information submitted by Medicaid providers (including review of financial statements to determine provider unit costs), to compile and analyze fiscal and statistical data from the financial statements, and to advise and assist the Department as necessary in administering the Medicaid program.
b. The contractor will be responsible for reviewing cost and statistical information to use in rate-setting calculations for the following provider types:
    1. General medical/surgical hospitals
    2. Critical access hospitals
    3. Psychiatric (mental) hospitals
    4. Psychiatric medical institutions for children (PMICs)
    5. Nursing facilities (NFs)
    6. Intermediate care facilities for people with mental retardation (ICFs/MR)
    7. Residential care facilities (RCFs)
    8. Home health agencies
    9. Rural health clinics (RHCs)
    10. Rehabilitation agencies
    11. Home health agencies and other providers providing services under Home and Community-Based Services (HCBS) waivers
    12. Federally qualified health centers (FQHCs)
    13. Case management providers
    14. Remedial service providers
    15. Habilitation service providers
    16. Providers under the purview of the Departments of Education and Public Health
    17. Adult rehabilitation option providers
c. The contractor will be responsible for performing cost audits (desk reviews or field audits, if necessary) of provider records to ascertain the accuracy of their financial records and billing practices for the following provider types:
    1. Critical access hospitals

2. Psychiatric (mental) hospitals
3. PMICs
4. Home health agencies
5. Rural health clinics
6. Rehabilitation agencies
7. Home health agencies and other providers providing services under HCBS waivers
8. FQHCs
9. Case management providers
10. Nursing facilities
11. ICFs/MRs
12. RCFs
13. Remedial service providers
14. Habilitation service providers
15. Adult rehabilitation option providers

d. Audits shall be sufficiently detailed to enable the contractor to express an opinion on total costs and statistical data provided by the cost report.

e. Maintain the following interfaces:

1. Providers to conduct audits
2. Medicare intermediaries operating in the State of Iowa to obtain Form CMS 2552, Hospital and Healthcare Complex Cost Report or other Medicare cost reports
3. Contractors for information stored in the minimum data set (MDS) data repository

f. Develop and maintain a Medicaid desk review program for the providers identified by the Department. Include recognition of the differences between Medicare coverage, rules, and regulations and those of Medicaid.

g. Develop arrangements with all Medicare intermediaries operating in the State of Iowa to obtain Form CMS 2552, Hospital and Healthcare Complex Cost Report or other Medicare cost reports. Use the final Medicare cost report in reconciling the Medicaid costs.

h. Gather necessary information to perform desk reviews, including Form CMS 2552, Hospital and Healthcare Complex Cost Report or other Medicare cost reports and supporting work papers from providers.

i. Assist providers in understanding Medicaid regulations and make recommendations on filing of cost reports.

j. Send, via regular mail or electronic mail attachment, the appropriate blank cost reporting forms to providers on a timely basis.

k. Receive cost reports and process requests for extension of due dates. Contact providers who are untimely and enforce Department regulations regarding timely

submittal of cost reports. The contractor shall have the ability to accept cost reports submitted electronically.

l. Perform the provider audit or desk review, the cost settlement, and the rate determination function, when applicable, for the provider types listed in RFP Section 6.7.1.2 Contractor Responsibilities. Cost settlements entail a mix of retrospective and prospective methodologies. The contractor shall notify each provider in writing of any corrections made as a result of a desk review. Ensure the thoroughness and mathematical accuracy of submitted reports and ensure conformance to the requirements for allowance of costs as stated in the Code of Federal Regulations (CFR) and Iowa Administrative Code (IAC).

m. For NFs, the contractor shall conduct an annual desk review of each financial and statistical report received from each nursing facility. The contractor shall calculate rates for these facilities on an annual basis, with a quarterly case-mix adjustment based on the Medicaid Case Mix Index of each NF, with rebasing in July 2011 and every two years thereafter. The contractor shall utilize the Medicare costs reports for the hospital-based NFs and utilize the annual Medicaid financial and statistical reports for the other NFs rate calculation. A “rate sheet” shall be sent to each NF on a quarterly basis based on the Case Mix Index.

n. Perform on-site audits for providers identified by the Department on request. Audits shall be sufficiently detailed to enable contractor to express an opinion on total costs and statistical data provided by the cost report. The protocol for and selection of providers subject to on-site audits (for provider types listed under RFP Section 6.7.1.2 Contractor Responsibilities) will be based on criteria developed by the contractor and will be subject to approval by the Department.

o. Recognize and honor the Agreements for Exchange of Medicare and Medicaid Information that the Department has entered into with the Medicare intermediaries that serve Iowa. Since Medicaid generally follows the Medicare reimbursement methodology for institutional providers, the Medicare audit will suffice. Perform such an audit if Medicaid utilization or other factors indicate the need, even if the provider does not participate in Medicare or if Medicare utilization is so low that a Medicare on-site audit is not required. Enter into a Data Use Agreement (DUA) with CMS for purposes of utilizing MDS information for nursing facility rate setting.

p. Correct submitted cost reports, incorporating adjustments from adjustment reports.

q. Correct rate sheets, incorporating reimbursement revisions.

r. Develop interim rates for providers who are reimbursed on a percentage of-charges basis. The interim rates are a percentage of charges (as obtained from historical data and expected future costs). Test the interim rates at least every six months by verifying the rate with the provider's cost statements or work papers. Make adjustments, if necessary, and adjust provider rates as appropriate.

s. Calculate overpayments or underpayments that result from adjustments of interim rates.

t. Maintain the per diem rates for hospitals with Medicaid-certified physical rehabilitation units and update the rates, as specified by the Department. Submit the rates to be loaded in the MMIS.

u. Provide the Notice of Provider Reimbursement to cost-based providers, including comparisons of submitted and audited data. In the notice, require that overpayments be remitted to the Provider Cost Audits and Rate Setting contractor for processing or offset future payments in the claims payment system, if applicable (such as an offset to claims versus a recovery).

v. Submit adjustments to Core MMIS contractor for repayment of underpayments.

w. Reopen cost report settlements as a result of amendments to Medicare or Medicaid regulations or because of a provider appeal.

x. Provide documentation and participate in administrative appeals or court hearings in the event of an appeal of a cost report or a rate.

y. Provide activity reports monthly to the Department that indicate the number of cost reports received and processed, the number of desk audits, and the amounts of over- and underpayments.

z. Submit to the Department a monthly report summarizing field audit activity. The report includes, at a minimum, the names of providers audited, the dates of each audit, and audit findings.

aa. Upon request, release the rates established for Iowa providers to other states' Medicaid programs. Assist in publication of Iowa Medicaid rates to the Iowa Medicaid Enterprise (IME) web site when requested to do so.

bb. Prepare annual compilation reports of costs and other statistical data taken from the cost reports for NFs, hospital-based NFs, ICFs/MR, RCFs, and HCBS waiver services. These reports will be used to set individual payment rates for providers, establish statewide reimbursement limits, calculate annual pay-for-performance measures, and to evaluate changes in cost that can be used to assist the Legislature and the Department in determining fiscal impacts to proposed changes and in developing budgets.

cc. Notify the Department of suggestions for improving provider accounting procedures and unusual cost discrepancies, including failure of the provider records to substantiate costs reported to the Department.

dd. Nursing facility pay-for-performance responsibilities shall include:

1. Updates and refinements to the pay-for-performance component of the NF case mix reimbursement system. The contractor shall gather applicable data, monitor results and include this component in NF payment calculation based on the adopted rules in the Iowa Administrative Code 441, Chapter 81.

2. Management reports and analyses to assist the Department in monitoring trends in acuity and pay-for-performance measures, plus other applicable trends, across the NF industry. Includes quarterly estimates of the NF budget compared to the cap identified in the annual appropriations bill.

ee. The NF Employee Turnover and Evaluation report shall be provided to the Department annually. The NF Employee Turnover and Evaluation report includes an analysis of NF employee turnover, a comparison of individual NF turnover rates with the state average, recommended improvements and trends, or other information the Department deems appropriate to be included in the annual report.

ff. The Resource Utilization Group (RUGs) report shall be provided to the Department each quarter. RUGs are a measure of the acuity level of persons living in NF's based on the MDS submission by the NFs.

gg. Per House File 911 from the 2007 Iowa legislative session, NFs can apply for up to $1M for reconstruction or renovation of their facility to rectify a violation of life safety code requirements, or to develop home-and-community-based waiver program services. Additional costs associated with specific renovation or construction must be recognized in the facility's Medicaid reimbursement rate prior to the next facility rebasing. If funding is appropriated for this purpose, review and process applications from NFs interested in applying for this increased reimbursement to determine whether they meet the criteria. Monitor NF providers with approved applications to ensure continued compliance with all requirements and track expenditures to report, upon request, to the Department.

hh. The contractor shall maintain sufficient knowledge about federal requirements for funding of services for which costs are being reported so that the contractor will:

1. Know what costs are allowable.
2. Be familiar with any reporting that may be required for receipt of those funds in order to assist the Department in complying with federal requirements.

ii. Log and prepare all payments to be deposited in the state-owned Title XIX Recovery bank account according to RFP Section 6.1.8 Banking Policies.

- Record payments received in the IME accounts receivable system for generally accepted accounting principle (GAAP) reporting and bank account reconciliation purposes.
- Produce an annual analysis and report of the relationship between Iowa Medicaid payment rates and those of other third-party payers before the end of each state fiscal year (SFY).
- If the contractor receives a revised cost report with extensive changes within 30 days of the contractual deadline, the contractor can add 30 days to the deadline to give the contractor's staff enough time to adequately review the cost report.

mm. Provide a rate sheet to each NF on a quarterly basis based on the case mix index adjustment or as needed if the provider submits an amended cost report.

nn. Complete the compilation reports according to the Department's schedule for each provider type.

oo. Compile information received from nursing facility providers for consideration for pay-for-performance rate add-on. The contractor will determine rate add-on and complete rate adjustments by August 15 of each calendar year or as directed by the Department.

pp. Provide to the Department the acuity analysis report for pay-for-performance measures semiannually by March 1 and August 1 of each contract year and the pay-for-performance measures report annually by June 15 of each contract year.

6.7.1.3 Performance Standards

The contractor will be required to meet the following standards.

a. Perform annual desk reviews of all providers including cost settlements and calculation of interim rates; settle cost reports for all institutional providers; and notify the provider and the Department of the new payment rate (if applicable) by sending a rate sheet within 90 days of receipt of the financial and statistical report.

b. In SFY 2011, Iowa shall realize state savings through collection of overpayments or avoidance of overpayments by the Provider Cost Audits and Rate Setting contractor of no less than $850,000. These savings are expected to result from the more intense scrutiny provided by the cost and payment audit activity described in the RFP. In SFY 2012 and thereafter, the amount of the state savings shall be increased by 10 percent a year over the previous year's state savings.

6.7.2 State Maximum Allowable Cost Program Rate Setting

The role of the contractor will be to comprehensively support, update, and maintain the State Maximum Allowable Cost (SMAC) program for multiple source prescription drugs that are reimbursed by the Iowa Medicaid Program. The goal is to maintain and update the Iowa SMAC program and achieve the Department's goals of promoting good health outcomes for Medicaid beneficiaries, establishing reimbursement reflective of Iowa pharmaceutical market conditions and quickly and accurately responding to stakeholders' questions or concerns about the SMAC program or reimbursement. The contractor shall update or make changes to the methodologies, to comply with any change in federal or state law. The data sources for the SMAC program include:

a. Monthly claims files from the pharmacy point-of-sale (POS) system contractor.

b. Invoices, electronic registers of purchase history or current acquisition cost information provided by pharmacies or wholesalers.

6.7.2.1 State Responsibilities

Following are the state responsibilities for the SMAC program.

a. Initiate and interpret all policy and make administrative decisions regarding SMAC.

b. Provide guidelines and approve reporting requirements to the Department.

c. Review and approve any communications prior to release.

d. Supply access to the MMIS data, POS data, preferred drug list/prior authorization (PDL/PA) data or data warehouse/decision support (DW/DS) tools and data stored therein.

e. Provide a liaison for contractor to Drug Utilization Review Commission and Iowa Pharmacy Association's Medicaid Advisory Committee.

6.7.2.2 Contractor Responsibilities

The following subsections list the contractor responsibilities for the SMAC program:

- 6.7.2.2.1 General Responsibilities
- 6.7.2.2.2 State Maximum Allowable Cost Program and Rate Schedule Maintenance
- 6.7.2.2.3 Program Monitoring, Product and Rate Review and Adjustments
- 6.7.2.2.4 State Maximum Allowable Cost Program Administrative Support and Assistance to the Department
- 6.7.2.2.5 Support for Prescribing Providers and Pharmacies
- 6.7.2.2.6 Technical Support, Pharmacological Expertise, and Evaluation Services

6.7.2.2.1 General Responsibilities

a. Provide the following services:
   1. Update and maintain SMAC program reimbursement rates.
   2. Adjust the list of drugs subject to the SMAC program.
   3. Confer with the Department and the Pharmacy Medical Services contractor regarding recommendations prior to implementation of any changes.
   4. 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.
   5. Provide internet and telephone support to investigate and respond to service provider questions and concerns regarding the SMAC program.
   6. Coordinate with other contractors to update and maintain the SMAC rate file for claims processing.
   7. Monitor important trends in reimbursement and service utilization.
   8. Assist the Department in the development, evaluation, and implementation of policies supporting the SMAC program.
b. Meet the following objectives:
   1. Comprehensively support, update, and maintain the SMAC program for multiple source prescription drugs that are reimbursed by the Iowa Medicaid Program.
   2. Maintain and update the Iowa SMAC program and achieve the Department's goals of promoting good health outcomes for Medicaid beneficiaries, establishing reimbursement reflective of Iowa pharmaceutical market conditions and quickly and accurately responding to stakeholders' questions or concerns about the SMAC program or reimbursement.
c. Maintain the following interfaces:
   1. Providers to conduct audits and respond to questions or concerns
d. Provide the following reports to the Department in a format and scheduled approved by the Department:

1. Provide a monthly report on the savings associated with the SMAC.
2. Provide recommendations every two months on updates to the SMAC.
3. Provide an annual acquisition cost study summary.
4. Provide a quarterly report on SMAC program operation and utilization trends.

6.7.2.2.2 State Maximum Allowable Cost Program and Rate Schedule Maintenance

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

b. Respond to changing circumstances in the drug marketplace that require SMAC fees to be removed, suspended or developed.

c. Maintain a web site approved by the Department and available to all providers. 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.

d. Demonstrate annual savings in total outlays for prescription drugs associated with the SMAC program.

6.7.2.2.3 Program Monitoring, Product and Rate Review and Adjustments

a. Monitor product availability at a national level from periodicals (Red Book) and other information sources (Food and Drug Administration).

b. Employ rigorous data analysis; research, track and assist with the implementation of methods to ensure the identification of drugs that lose patent protection, test product availability.

c. Perform programmatically driven data analysis to identify changes in drug volume, utilization patterns and other factors.

d. Perform an acquisition cost study, at least annually, to evaluate and update SMAC pricing to reflect prevailing Iowa pharmaceutical market conditions. The acquisition cost study collects submitted copies of invoices, electronic registers of purchase history, or current acquisition cost information provided by a sample of enrolled Iowa Medicaid pharmacies or their wholesaler.

e. 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.

f. 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 changes in providers' acquisition costs and assess the need for adjustments to the SMAC rates.

g. Identify new drug products available from at least the minimum number of sources (as determined by the Department) in the pharmaceutical marketplace that have not received a rating of lower than "A" by the Food and Drug Administration (FDA), or identify new drug products based on criteria as designated by the Department, and assess the need to add new drug products to the SMAC program and establish reimbursement rates.

h. Identify drug products subject to the SMAC program that may no longer be available from the minimum number of sources (as determined by the Department) in the pharmaceutical marketplace or that have not received a rating of at least "A" by the FDA, or identify drug products subject to the SMAC program, based on criteria as designated by the Department, and assess the need to remove the drug products from the SMAC program.

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

6.7.2.2.4 State Maximum Allowable Cost Program Administrative Support and Assistance to the Department

a. Receive monthly claims files from the appropriate IME contractor to support the evaluation and management of the SMAC program.

b. Provide experienced staff sufficient to work with large sets of Medicaid claims data and identify and analyze trends affecting the SMAC program.

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

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

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

f. Develop all draft documents, which are approved by the Department, to promulgate administrative rules necessary to support the SMAC program.

g. Develop all draft documents, which are approved by the Department, to submit to the Kansas City, MO. Regional Office of the Centers for Medicare and Medicaid Services, to amend the Medicaid State Plan to support the SMAC program.

h. Prepare all information requests, required findings and assurances, and respond to all inquires from CMS related to the SMAC, as requested by the Department.

i. Design, develop, and implement protocols to 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.

j. 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.

k. Analyze, review, and research utilization and service delivery patterns for brand and generic drugs to identify inappropriate incentives for drug selection, examine potential fraud or attempts to circumvent the SMAC rate schedule, analyze beneficiary access to pharmacy services and drugs, and assess opportunities for adjustments to the SMAC rate schedule or the drugs affected by the rate schedule.

l. Prepare and submit to the Department an update on SMAC program operation and utilization trends upon request. Updates include, at a minimum, a summary of MAC program rate changes and market activity and an analysis of utilization trends and activities potentially impacting the SMAC program.

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

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

o. Employ a registered pharmacist with sufficient training and certifications to evaluate and maintain the clinical and pharmacological integrity of the SMAC program, having a thorough knowledge of pharmacology, pharmacoeconomics, pharmacy law, and therapeutic evaluation.

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

q. Provide all necessary assistance to the Department with the administration of the SMAC program and utilization goals, including but not limited to, provider and legislative relations, and monitoring of POS claims payment issues.

r. Provide quarterly reports in a format and on a schedule determined by the Department indicating the savings associated with the SMAC program. Provide financial projections with any recommended changes to the SMAC.

6.7.2.2.5 Support for Prescribing Providers and Pharmacies

a. Provide a telephone contact whereby pharmacies may report problems with SMAC fees, product availability, and utilization.

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

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

d. Coordinate with the Iowa Pharmacy Association’s Medicaid Advisory Committee and the Iowa Drug Utilization Review Commission to update them, periodically, regarding the SMAC program and to obtain their input and recommendations on the SMAC program.

e. Receive and respond to written requests from pharmacy providers who wish the Department to consider adjustments to SMAC rates or other concerns about the SMAC program. Contact pharmacy providers, as necessary, to request supporting documentation or other information to assist in the evaluation of their request or concern.

f. Notify pharmacy providers at least 30 days prior to the effective date of any new drugs being added to the SMAC fee schedule and notify providers of any changes in reimbursement rates and any deletions of drug products from the SMAC fee schedule on a regular basis.

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

6.7.2.2.6 Technical Support, Pharmacological Expertise and Evaluation Services

a. Examine the drugs and drug groups eligible for inclusion in the SMAC rate schedule to identify opportunities to protect Medicaid patient outcomes and ensure that the SMAC rate schedule does not offer inappropriate incentives in drug selection.

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

c. Ensure that drug products included in the SMAC program are only those brand and generic drugs of similar chemical composition, package size, dose, and form that are available from at least the minimum number of sources (as determined by the Department) in the pharmaceutical marketplace and have not received a rating of lower than “A” by the FDA or a rating as designated by the Department.

d. Complete required reports accurately and timely.

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

f. Be knowledgeable of and apply all state and federal requirements.

6.7.2.3 Performance Standards

a. 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.

b. 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.

6.7.3 Rebasing and Diagnosis Related Group and Ambulatory Payment Classification Recalibration

Inpatient services for general medical/surgical hospitals are reimbursed using the diagnosis related group (DRG) system, and most outpatient services for general medical/surgical hospitals are reimbursed using the ambulatory payment classification (APC) system. IAC requires that hospital base, capital cost, direct and indirect medical education, and disproportionate share rates be recalculated (rebasing) and DRG and APC weights associated with these reimbursement systems be recalculated (recalibration) every three years. The data sources for this function are:

a. Form CMS 2552, Hospital and Healthcare Complex Cost Reports

b. Iowa Medicaid paid claims file

6.7.3.1 State Responsibilities

a. Establish policies that govern the triennial hospital rebasing and recalibration project.

b. Oversight and management of the rebasing and recalibration project.

c. Approve all rates.

6.7.3.2 Contractor Responsibilities

a. Meet the following objectives:

   1. Accurate triennial rebasing of hospital base, capital cost, direct and indirect medical education, and disproportionate share rates.

   2. Accurate triennial recalibration of DRG and APC weights.

b. Maintain the following interfaces:

   1. 3M Health Information Systems, Core MMIS contractor, or the Department for historical data

      i. For inpatient services for use of the Medicare DRG grouper, with Medicaid-specific weights

      ii. For those outpatient services subject to reimbursement under the APC system for APC weights

   2. Medicare intermediaries operating in the State of Iowa to obtain Form CMS 2552, Hospital and Healthcare Complex Cost Report or other Medicare cost reports.

c. Perform calculations to apportion costs to Medicaid from hospital cost reports (Form CMS 2552, Hospital and Healthcare Complex Cost Report), rebase the base, capital cost, direct and indirect medical education, and disproportionate share rates, and recalibrate the weights for APCs and DRGs every three years, or as specified by the Department.

d. Maintain and operate the DRG-based prospective payment system for inpatient hospital services. Update the base and capital cost rates by applying an inflation index to these rates, if authorized by the Department to do so. Submit the rates to be loaded in the MMIS.

e. Maintain and operate the APC-based prospective payment system for (most) outpatient hospital services. Update the base rates by applying an inflation index to these rates, if authorized by the Department to do so. Submit the rates to be loaded in the MMIS.

f. Provide the following reports:

   1. Hospital-specific and statewide average inpatient and outpatient case-mix index schedules.
   2. Revised DRG and APC weight schedules.
   3. Hospital-specific and statewide average rate sheets, documenting calculations used to derive revised base, capital cost, direct and indirect medical education, and disproportionate share rates.
   4. Summary of projected charges to projected payments based on hospital cost report and claims data.
   5. Hospital payment estimation report for inpatient services and payment simulation report for outpatient services, using revised case-mix indices, base, capital cost, direct and indirect medical education, and disproportionate share rates.

6.7.3.3 Performance Standards

a. Ensure complete accuracy in calculations to apportion costs to Medicaid for each hospital submitting Form CMS 2552, Hospital and Healthcare Complex Cost Report, for use in calculating the base, capital cost, direct and indirect medical education, and disproportionate share rates.

b. Ensure complete accuracy in calculating hospital case-mix indices, inpatient base, capital cost, direct and indirect medical education, and disproportionate share rates and outpatient base and direct medical education rates.

c. Ensure complete accuracy in calculating DRG and APC weights when determined using Medicaid paid claims data or when determined based on other negotiated or manually calculated means.

6.7.4 Reimbursement Technical Assistance and Support

The role of the contractor will be to comprehensively support, update and monitor provider reimbursement systems, including the modified price-based case-mix reimbursement system for nursing facilities that includes a case-mix adjusted component and a non-case-mix adjusted component, as authorized in 2001 Iowa Acts, HF 740. The goal is to maintain a reimbursement system that:

a. Improves access to care

b. Increases consumer choice

c. Recognizes cost containment

d. Balances institutional and non-institutional alternatives for long term care

e. Improves the quality of lives of Iowans

The contractor also will perform the upper payment limit tests for hospitals and nursing facilities on an annual basis and provide other technical assistance and monitoring as requested by the Department or as required due to federal or state law.

6.7.4.1 State Responsibilities

Following are the state responsibilities for this function.

a. Establish policies that govern the reimbursement methodology.

b. Review and approve the contractor's proposals and work plans.

c. Provide guidelines and approve reporting requirements to the Department.

d. Review and approve any communications prior to release.

e. Supply access to the MMIS data, MDS data or DW/DS tools and data stored therein.

f. Review and approve approaches or methodologies proposed to conduct upper payment limit tests for inpatient and outpatient hospital services and nursing facility services in government-owned or operated and privately-owned and operated hospitals and nursing facilities.

g. Review draft documents that amend the Medicaid State Plan and submit to CMS regional office, as necessary

h. Review and approve draft documents that amend policies referenced or contained in state administrative rules, employee manuals, or provider manuals

i. Conduct presentations to the Council on Human Services, the State Administrative Rules Review Committee and other legislative and industry groups as necessary with the assistance of the contractor.

j. Review technical specification changes to the MMIS claims payment system that are necessitated by the implementation of new methodologies.

6.7.4.2 Contractor Responsibilities

The following topics list the contractor responsibilities for this function:

- 6.7.4.2.1 General Responsibilities
- 6.7.4.2.2 Upper Payment Limit Tests
- 6.7.4.2.3 Other Technical Assistance and Monitoring
- 6.7.4.2.4 Reporting

6.7.4.2.1 General Responsibilities

a. Update or make changes to rate methodologies to comply with any change in federal or state law.

b. Meet the following objectives:

   1. Maintain a monitoring and reporting system for nursing facilities.

   2. Provide technical assistance for the modified price-based case-mix reimbursement system for nursing facilities.

   3. Provide technical assistance for method of reimbursing hospitals and nursing facilities for coinsurance and deductible amounts for dually eligible recipients.

   4. Provide technical assistance on Medicaid payment policies designed to maximize available federal financial participation (such as implementation of provider taxes).

c. Respond within five business days of the request to update rates that are updated as routine maintenance.

d. Upon request, analyze new CPT, ICD and HCPCS codes in the fourth quarter of each calendar year and recommend to the Department by January 1 of the next year the coverage status and the pricing amount or logic if incorporated into an existing reimbursement system.

e. Conduct analysis and provide data to support assurances and findings regarding the adequacy of institutional reimbursement rates as required in 42 CFR 447.253.

f. Conduct analysis and assist the Department in the development of new reimbursement methodologies for institutional or other providers.

g. As requested by the Department, participate in or make presentations at training, meetings, or conferences for federal or state staff or providers in the development of reimbursement methodologies. Staff workgroups or task forces as subject matter experts.

h. Provide ongoing technical assistance to the Department in analyzing alternative reimbursement systems; provide findings related to state plan amendments, and assist with other special projects.

i. Upon request of the Department, provide assistance with policy-related items such as the state plan, Iowa Administrative Rules, Iowa Code, and provider manual updates.

6.7.4.2.2 Upper Payment Limit Tests

a. Maintain the following interfaces:

   1. Providers for information on or clarification of their cost report information

b. Review and analyze hospital and nursing facility Medicaid and Medicare reimbursement data and other hospital and nursing facility financial and statistical data for hospitals and nursing facilities, including hospital and nursing facility cost reports, and hospital and nursing facility forecasting data.

c. Use this information to develop an approach or methodology that can be used to perform the upper payment limit tests for all hospital and nursing facility services in

hospitals and nursing facilities. The approach or methodology must comply with federal regulations.

d. Based on the approved upper payment limit approach or methodology, accurately perform the upper payment limit tests each year and provide the information and supporting documentation to the Department, for all hospitals and nursing facilities for inpatient and outpatient hospital services and nursing facility services.

e. Update or make changes to the approach or methodology to comply with any change in federal or state law.

6.7.4.2.3 Other Technical Assistance and Monitoring

a. Provide support for the Payment Error Rate Measurement (PERM) Project by following up on all requests for pricing claims or explaining reimbursement methodologies for findings related to the PERM Project.

b. Provide support and technical assistance to the Department for the development, implementation and monitoring of the NF provider tax.

c. 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.

d. Provide support and technical assistance for any updates to MDS.

e. Provide support and technical assistance to the Department for development and monitoring of the medical assistance budget.

f. 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.

g. Provide draft policy changes related to all work performed under this RFP to meet the timeframes for the filing processes required by:

    1. CMS for Medicaid State Plan Amendments

    2. The Department for state administrative rules and provider or employee manuals

6.7.4.2.4 Reporting

a. Provide the following reports:

    1. On a quarterly basis, track, monitor and assist the Department in projecting expenditures and recommend adjustments to reimbursement systems based on the findings.

    2. Annually, compile and provide a detailed analysis to demonstrate growth of NF direct care costs, increased acuity and care needs of residents.

    3. Annually, compile and provide detailed analysis of cost reports submitted by providers and the resulting desk review and field audit adjustments to reclassify and amend provider cost and statistical data.

4. Other reports, as requested by the Department, from the monitoring and reporting system for the NF modified price-based case-mix reimbursement methodology.

6.7.4.3 Performance Standards

a. Provide annual reports of upper payment limit test results and fiscal analyses for hospital and nursing facility services within 30 days after the beginning of each state fiscal year, applicable (prospectively) for that state fiscal year.

6.7.5 IowaCare

The IowaCare program is a limited provider network, limited benefit Medicaid expansion operating under an 1115 waiver. The providers are reimbursed for claims associated with services they provide using a prospective interim payment. The IowaCare providers may also qualify to receive disproportionate share hospital (DSH) payments and medical education payments if they have qualifying expenditures.

6.7.5.1 State Responsibilities

a. Initiate and interpret all policy and make administrative decisions regarding the IowaCare program.

b. Review and approve annual reconciliation of IowaCare funding sources.

6.7.5.2 Contractor Responsibilities

a. Assist the Department in administration of the IowaCare Program.

b. Prepare monthly expenditure analysis after the last day of each month.

c. Prepare annual reconciliation of IowaCare funding sources after receipt of the annual Medicare cost report, including all Medicaid supplemental schedules and disproportionate share survey data.

d. Reconcile claims with prospective interim payments that are received monthly and make the determination whether the IowaCare providers qualify to receive DSH and medical education payments.

6.7.5.3 Performance Standards

a. Prepare monthly expenditure analysis within 20 days after the last day of each month.

b. Prepare annual reconciliation of IowaCare funding sources for the IowaCare-designated providers within 30 days after receipt of the annual Medicare cost report, including all Medicaid supplemental schedules and disproportionate share survey data.

6.8 Estate Recovery Services

Estate recovery refers to the federal requirement that Medicaid expenditures made on behalf of certain Medicaid members be recovered from their estate upon the death of the member. The contractor will need to identify deceased members and the medical expenditures made on their behalf, identify assets that exist for recovery and take the necessary steps to collect from the identified assets. The data sources for the Estate Recovery Services function are:

a. Medicaid Management Information System (MMIS)

b. Department of Public Health files of deceased members

c. Buy-in files

The Estate Recovery Services component includes the requirements listed in the following sections:

- 6.8.1 Recoverable Assets
- 6.8.2 Criteria for Exemptions and Delays
- 6.8.3 Estate Recovery
- 6.8.4 Medical Assistance Income Trusts and Special Needs Trust Recovery

6.8.1 Recoverable Assets

a. Under federal statute, the provision of medical assistance on or after July 1, 1994, to an individual who is age 55 or older, or who is under age 55 and a resident of a nursing facility (NF) or intermediate care facility for the mentally retarded (ICF/MR) and cannot return home, creates a debt to the Department. The Medicaid payments consist of fee-for-service payments and capitation payments. The Medicaid payments may be recovered from the member's estate or the estate of a spouse, a disabled child, a child turning age 21 or the estate of a child who dies before reaching age 21, up to the amount of the Medicaid debt, but no more than the amount inherited.

b. At the time of the eligibility determination for Medicaid, certain assets of a member are not considered in the eligibility determination. These types of assets include, but are not limited to, homes or life estates. At the time of death, the assets that were not considered and any other assets comprise the estate and are subject to recovery.

c. The recovery from the estate of a member is limited to the amount of assets remaining in the estate at the time of the member's death after higher priority expenses are subtracted. According to Iowa Code Section 633.425, the expenses with a higher priority include:

    1. Court costs
    2. Other costs of administration
    3. Reasonable funeral and burial expenses
    4. All debts and taxes having preference under the laws of the United States

5. Reasonable and necessary medical and hospital expenses of the last illness of the decedent, including compensation of people attending at the decedent's illness
6. All taxes having preferences under the laws of this state

6.8.2 Criteria for Exemptions and Delays

a. All Medicaid expenditures paid on or after July 1, 1994 are subject to recovery unless exempt. In some situations the recovery is delayed or limited. The criteria for exemptions and delay are as follows:
    1. People in a NF or ICF/MR and under age of 55 do not have to repay the Medicaid received while in the medical institution if they leave the institution within six months of entry to return home. Return home means a return to living in the community.
    2. People under the age of 55 living in a NF or ICF/MR are exempt from repayment of Medicaid if they could return home as verified by the organization contracting with the Department for these decisions.
    3. If there is a spouse, a child under the age of 21, or a disabled child who inherits the estate upon the member's death, the collection is waived until the death of the spouse or disabled child, or until the child, who was under the age of 21 at the time of the member's death, turns 21 or is deceased before attaining age 21.
b. Recovery may be delayed when there is undue hardship. Collection may be suspended until hardship no longer exists or the death of the person who was granted hardship whichever comes first. Undue hardship exists when total household income is less than 200 percent of the poverty level for a household of the same size, total household resources do not exceed $10,000, and application of estate recovery would result in deprivation of food, clothing, shelter, or medical care such that life or health would be endangered. On a case-by-case basis, the Department determines undue hardship. For this purpose, income and resources are defined in the same manner as they are defined in the family investment program at 441 Iowa Administrative Code, Chapter 41.
c. When a person age 65 or older is eligible for Medicaid due to purchasing and using pre-certified or approved long-term care (LTC) insurance or due to enrolling in a prepaid health care delivery plan that provides LTC services under 191 Iowa Administrative Code, Chapter 72, then recovery is limited to the amount of the assets not disregarded by the long-term care asset disregard policy. The income maintenance worker (IMW) makes the determination of asset disregard and shall be contacted by the contractor for the amount of asset disregard when the representative alleges that the member was eligible for Medicaid due to the long-term care asset offset policy.
d. Medicaid paid on behalf of the member prior to purchasing LTC insurance or enrolling in a prepaid health care delivery plan shall be subject to recovery.
e. The federal government has a unique trust responsibility for American Indian (AI) Tribes and Alaskan Native (AN) Villages and their members. Funds excluded from resource consideration in making the eligibility determination are not subject to recovery.

f. People who receive Medicaid under the Home- and Community-Based Services Waivers (HCBS) waivers and under age 55 are not included in this program and all amounts paid for regular Medicaid or HCBS are not subject to recovery.

g. Interest accrues on the debt due under estate recovery policy at the rate provided in Iowa Code section 535.3, beginning six months after the death of the medical assistance member, the surviving spouse, the disabled child or the child who was under the age of 21 or who dies before reaching age 21.

6.8.3 Estate Recovery

6.8.3.1State Responsibilities

The Department has the following responsibilities for this function.

a. Monitor the performance of the Estate Recovery Services contractor in regards to all aspects of the estate recovery provisions.

b. Provide the contractor with a file of names of members who are deceased and were age 55 and older or in a nursing home, date of death, and representative's address if one is on file with the Department.

c. Arrange for the Core MMIS contractor to provide the amount of Medicaid paid on behalf of the member upon request by the Estate Recovery Services contractor.

d. Provide an electronic eligibility file for accessing the state identification (SID) numbers for members.

e. Provide, through income maintenance staff, decisions on undue hardship.

f. Provide, through income maintenance staff, asset disregard when contacted by the contractor for a determination.

6.8.3.2 Contractor Responsibilities

The contractor has the following responsibilities for this function.

a. Meet the following objectives:

   1. Recover Medicaid expenditures from assets of eligible deceased members.

   2. Identify assets of the deceased member that are available for estate recovery.

   3. Take all necessary steps to collect from identified assets and interest when applicable.

   4. Provide education to the public about estate recovery.

b. Maintain the following interfaces:

   1. The Iowa Department of Public Health (IDPH), for official death records to match against the eligibility file. The format of this file will be established by the IDPH.

c. The Estate Recovery Services contractor must comply with all requirements to pursue recoveries from estates of deceased Medicaid members, as required in Iowa Code section 249A.5.

d. Receive names of deceased Medicaid members from the IDPH Vital Statistics data or from other available sources.

e. Advise the Attorney General's (AG's) office in writing of any case in which a person refuses to cooperate with the contractor's recovery process or any case requiring court proceedings.

   1. This notice must describe the issues involved and must be provided to the AG's office within seven business days of the refusal to cooperate or discovery that a court proceeding is required.

   2. Pursuant to Iowa Code Section 13.7, the AG's office has exercised its discretion to have the contractor's attorney appear and represent the Department in all probate and/or district court proceedings related to the estate recovery program.

   3. The AG's office, however, will retain the discretion to determine pursuant to Iowa Code Section 13.7 whether the AG's office will represent the Department in any given probate or district court proceeding related to the estate recovery program.

   4. The Estate Recovery Services contractor must coordinate all representation in probate and/or district court proceedings with the AG's office. The AG will represent the Department in any matters appealed to the Iowa Supreme Court or Court of Appeals.

   5. The Estate Recovery Services contractor must provide copies of relevant paperwork regarding court proceedings to the AG's office upon request. The contractor shall also provide copies of relevant paperwork regarding court proceedings when the contractor's attorney deems it necessary to provide such paperwork.

f. Cooperate with and provide information and assistance to the AG's office as necessary.

g. Provide assistance and information to representatives of members and members concerning the recoveries under the contract. This includes, but may not be limited to, attending public meetings, association meetings, and seminars.

h. Staff a dedicated toll-free telephone number for representatives of members, the Department staff, or general public to access regarding estate recoveries. At a minimum, the telephone number must be staffed Monday through Friday from 7:30 a.m. to 5:30 p.m., Central Time, excluding state holidays.

i. Submit history credits or adjustments to the Core MMIS contractor, utilizing the format designated by the Core MMIS contractor, within 10 business days of receipt of payments related to estate recoveries. Apply credits or adjustments to the oldest claims, in terms of dates the services were provided, first.

j. Provide sufficient staff to answer questions from attorneys, representative of members, the Department staff, and public concerning recoveries.

k. Log and prepare all payments to be deposited in the state-owned Title XIX recovery bank account according to Request for Proposal (RFP) Section 6.1.8 Banking Policies.

l. Submit request for refund payments received in error to the Department, Division of Fiscal Management within 10 business days of receiving the request for refund or

discovering the error. The Estate Recovery Services contractor must return to the Department any fee paid to the contractor for the erroneous recovery.

m. Identify deceased members through information obtained from various sources including eligibility files from the Department, files of reported deaths from the Department of Public Health, information from attorneys and any other sources, or as otherwise directed by the Department.

n. Identify medical assistance subject to recovery from the estate of a member, a surviving spouse, or a surviving child in accordance with Iowa Code Section 249A.5(2)(d).

o. File an estate recovery claim in probate court on behalf of the Department for deceased members whose estates have been opened.

p. When an estate subject to recovery is opened in probate, and a Notice of Probate has been received, notify the representative of the deceased within 10 business days.

q. Determine the value of the estate subject to recovery, the expenses of the estate, and the priority of the expenses by requesting information on the member's assets and the expenses from the member's representative.

r. Determine the amount of Medicaid paid on behalf of the member subject to recovery by obtaining the member’s history of paid claims from the MMIS. The Estate Recovery Services contractor must obtain a history of paid claims for any deceased person referred by any source. The following Medicaid payments are subject to recovery:

    1. The Estate Recovery Services contractor must recover Medicaid funds for a Medicaid eligible person under age 55, when the person was living in a NF, an ICF/MR, or a mental health institute, and wasn’t reasonably expected to be discharged and return home for six consecutive months or longer, or dies before staying six consecutive months.

    2. The Estate Recovery Services contractor must recover funds if the Iowa Medicaid Enterprise (IME) Medical Services Unit has determined that a member under age 55 could return home in six months even though the member stayed in the NF or ICF/MR longer than six months, or the member died before returning home. If a representative of the member alleges that there is such a determination, the Estate Recovery Services contractor must verify this information and request documentation of the decision. The Estate Recovery Services contractor must document in the member’s file the reason recovery was not made.

    3. The Estate Recovery Services contractor must not recover Medicaid funds if the member is under age 55 and receiving HCBS waiver services. If the person receiving HCBS Waiver services subsequently enters a NF or ICF/MR, as indicated by the eligibility files, the Medicaid paid for a partial month in the NF or ICF/MR is subject to recovery.

    4. The eligibility file has aid types and waiver codes that identify people in a NF, ICF/MR, or HCBS waiver.

s. After the amount of the estate subject to recovery and the amount of Medicaid payments are determined, notify the representative to pay the lesser of these amounts. The Estate Recovery Services contractor will add interest accrued to the Medicaid debt in accordance with Iowa Code Section 535.3.

t. Have the ability to receive vital statistics data from the IDPH as formatted.

u. Educate the public, disseminate information and answer inquires about the estate recovery program. This responsibility includes:

   1. Participating in seminars, and meetings with the bar association, social services agencies, the Department employees, members' representatives, members of the public, and other organizations as requested.

   2. Preparing and distributing material describing the estate recovery program. The Department must approve all written material prior to distribution.

v. Notify the representative of the right to claim undue hardship and a waiver to recovery at the same time the Estate Recovery Services contractor notifies the representative of the debt due the Department. The contractor must also inform the representative of the 30-day time limit to request a hardship waiver.

w. Process undue hardship claims as follows:

   1. Upon receipt of an undue hardship request, the contractor will determine if the request is timely or if there is a reason to grant extension beyond the 30-day period.

   2. If the request is not made within the 30-day period and an extension is not granted, the Estate Recovery Services contractor must notify in writing the person claiming a hardship and requesting a waiver, that the request is denied as untimely. The notice must give the legal basis for denial [441 Iowa Administrative Code 76.12(7)] and inform the person of the right and the timeframe to file an appeal in writing with the Department.

   3. If the hardship request is timely, the Estate Recovery Services contractor must obtain income and resource information to support the request for a recovery waiver. The contractor must outline the undue hardship process and inform the person making the request of the process.

   4. If the income and asset information is not received within 90 days, the Estate Recovery Services contractor will follow up with the requestor. If the information has not been supplied, the contractor shall deny the hardship claim with a written notice informing the requestor of the right and timeframe to file an appeal.

   5. The Estate Recovery Services contractor must obtain the Department approval for all notice formats required by this section.

   6. The Estate Recovery Services contractor shall request of the person requesting a hardship waiver a description of the circumstances whereby the disapproval of hardship would result in deprivation of food, clothing, shelter, or medical care such that life or health would be endangered.

   7. The Estate Recovery Services contractor must then determine if recovery would result in deprivation of food, clothing, shelter, or medical care such that life or health would be endangered and present the waiver request to the Department

for review. The Department will determine if the hardship waiver of recovery will be granted.

8. The Estate Recovery Services contractor must track all requests for a waiver and their disposition.

x. Provide the following reporting:

1. The contractor must provide monthly reports to the Department by the 10th of each month for the preceding month. The reports must include, but may not be limited to the following information:

   i. Member's SID (sort field in ascending order)

   ii. Name of member

   iii. Amount of recovery so the recovery can be matched to the contractor's deposits.

   iv. Total amount recovered in the preceding months, and year to date

   v. Interest earned in the preceding months

   vi. Total number of cases in which a letter was sent requesting recovery from an estate

   vii. Total number of cases pending each month

   viii. Total number of cases processed with a recovery

   ix. Total number of cases processed without a recovery and the reason recovery did not occur

   x. Total number of cases deferred due to a surviving spouse, disabled child or minor child

2. Any month, in which the contractor returns money to a representative, the contractor must include in the monthly report the following:

   i. Documentation as to the reason for the return of funds

   ii. Entity the funds were returned to

   iii. Member name and SID for whom the funds were returned

   iv. Amount returned

3. The contractor must provide an annual report to the Department no later than August 15 of each contract year. The annual report shall include, but may not be limited to, the following information:

   i. A summary of the year's activities

   ii. Total dollars collected

   iii. Number of cases pending

   iv. Dollar value of the cases pending

   v. Any case referred to the AG's office

vi. Total Medicaid expenditures paid out on behalf of the members for whom recovery is requested

vii. Percentage of the amount recovered from Estate Recovery compared to the total amount of Medicaid paid for the member

viii. Total number of cases referred to the AG's office

ix. The total dollar amount of estates where recovery did not occur

x. Average number of months to settle a case from initial identification to collection

xi. Total number of undue hardship requests

xii. Total number of undue hardship requests granted and denied

xiii. Total number of cases deferred due to undue hardship

6.8.3.3 Performance Standards

The contractor will be required to meet the following standards.

a. Collect state funds through the activities of the Estate Recovery Services contractor of at least 115 percent of the net state revenue collected in the immediately preceding state fiscal year.

b. Provide monthly reports of ongoing cases and collections to the Department within 10 business days of the end of the month.

c. Provide an annual report, with summary case information for the most recent state fiscal year, to the Department no later than August 15 of each contract year. The information in the annual report should include identifying information for all estates opened during the state fiscal year, those closed during the state fiscal year, the resolution of each case (such as hardship waiver, closed with a collection, closed without a collection, still open), the money amount owed to Medicaid and the money amount, if any, that was collected.

d. When an estate subject to recovery is opened in probate, and a notice of probate has been received, notify the representative of the deceased within 10 business days.

e. Within 30 days of receiving the report of death, notify the representative of the deceased that there is an amount due the Department as a result of estate recovery.

6.8.4 Medical Assistance Income Trust and Special Needs Trust Recovery

Three types of trusts exist for which the state receives all amounts remaining in the trust upon termination of the trust or death of the individual, up to the amount equal to the total medical assistance paid on behalf of the individual: a medical assistance income trust, a special needs trust for disabled individuals under age 65, and a special needs trust for disabled individuals of all ages. These trusts are not subject to probate or expenses with higher priority. The balance in these trusts is owed to the Department and

must be collected. The data sources for the Medical Assistance Income Trust and Special Needs Trust Recovery are:

a. The MMIS

b. The Department of Public Health's file of deceased members

c. Buy-in files

6.8.4.1 State Responsibilities

a. Determine medical assistance income trust and special needs trust policies.

b. Meet with the contractor on a regular basis to discuss policy changes or issues.

c. Provide the contractor with the names of individuals who have established a medical assistance income trust or special needs trust.

d. Monitor the performance of the contractor in regard to collections.

e. Approve any changes to recovery procedures, forms, or publications.

6.8.4.2 Contractor Responsibilities

a. Meet the following objectives:

   1. Identify individuals on Medicaid that have established a medical assistance income trust or special needs trust.

   2. Ensure tracking of these individuals for termination of the trust.

   3. Determine the amount of Medicaid paid on behalf of these members and notify trustees of the amount due the Department

   4. Collect up to the amounts in the trust upon death of the individual or when the trust is terminated.

b. Maintain the following interfaces:

   1. Income Maintenance Staff to identify individuals with trusts

c. Provide the capability to include and maintain information from trusts and similar sources into a case tracking system or database.

d. Record the names of individuals who have terminated a medical assistance income trust or special needs trust that is subject to recovery.

e. Determine the amount of Medicaid paid on behalf of the member subject to recovery by obtaining the member's history of paid claims from the MMIS system and the Medicare buy-in file.

f. Determine the amount in the trust after final deposits are made, and trustees fees, and medical expenses are paid.

g. Notify the trustee/representative in writing of the amount due the Department, which is the lesser of the balance in the terminated trust, up to the amount of medical assistance paid.

h. Notify the representative and refer any cases to the AG's office where the trustee or representative does not respond to recovery efforts.

i. Log and prepare all trust recoveries to be deposited in the state-owned Title XIX recovery bank account according to RFP Section 6.1.8 Banking Policies.

j. Attend meetings with the Department staff to discuss policy changes or issues.

k. Provide technical assistance to the Department, if requested, including but not limited to attendance at public meetings, organization meetings of specific organizations, or seminars.

l. Provide timely and accurate assistance to trustees with questions.

m. Provide monthly reports of ongoing cases and collections to the Department within 10 business days of the end of the month.

6.8.4.3 Performance Standards

a. Provide monthly reports of ongoing cases and collections to the Department within ten business days of the end of the month.

b. Notify the representative/attorney of the deceased of the obligation of the trust to relinquish funds in repayment of medical assistance payments within 10 business days of identification of the existence of a medical assistance income trust or a special needs trust.

c. Provide an annual report with summary information for the most recent state fiscal year to the Department no later than August 15 of each contract year. The information in the annual report should include identifying information for all trusts acted on during the state fiscal year, the resolution of each trust case (such as closed with a collection, closed without a collection, still open), the money amount owed to Medicaid and the money amount (if any) that was collected.

7 PROPOSAL FORMAT AND CONTENT

These instructions describe the format and content of the bid proposal and are designed to facilitate the submission of a bid proposal that is easy to understand and evaluate. Failure to adhere to the bid proposal format shall result in the disqualification of the bid proposal. This section contains the following topics:

- 7.1 Instructions
- 7.2 Technical Proposal
- 7.3 Cost Proposal
- 7.4 Company Financial Information

7.1 Instructions

a. A bid proposal consists of three volumes with these titles: the Technical Proposal, the Cost Proposal, and Company Financial Information.

b. Each bid proposal shall be sealed in a box or boxes, with the Cost Proposal and Company Financial Information portions each sealed in separate, labeled envelopes inside the same box or boxes.

c. If multiple boxes for each bid proposal are used, the boxes shall be numbered in the following fashion: 1 of 4, 2 of 4, and so forth.

d. Boxes shall be labeled with the following information:

   1. Bidder's name and address
   2. Issuing officer’s name and delivery address:
      Mary Tavegia, Issuing Officer
      Iowa Department of Human Services
      Iowa Medicaid Enterprise
      200 Army Post Road, Suite 2
      Des Moines, Iowa 50315
   3. RFP title and reference number:
      Iowa Medicaid Enterprise Professional Services Procurement
      RFP MED-10-001
   4. RFP component for which the bid proposal is being submitted for consideration:
      i. Medical Services
      ii. Pharmacy Medical Services
      iii. Provider Services
      iv. Member Services
      v. Revenue Collections

vi. Provider Cost Audits and Rate Setting

vii. Estate Recovery Services

e. Bidders submitting bid proposals for more than one of the separate contract awards must box each bid proposal separately.

f. All bid proposal materials shall be printed two-sided on 8.5” x 11” paper.

g. The Technical Proposal materials shall be presented in a spiral, comb, or pasteboard binder separate from the sealed Cost Proposal and Company Financial Information materials. Technical Proposals received in 3-ring, loose-leaf binders will not be accepted and will be returned without evaluation.

h. The Cost Proposal and Company Financial Information materials shall be submitted in separate spiral, comb, or pasteboard binders. Cost Proposals and Company Financial Information materials received in 3-ring, loose-leaf binders will not be accepted and will be returned without evaluation.

i. If the bidder designates any information in its bid proposal as confidential, the bidder must submit one sanitized copy of bid proposal materials from which any confidential or proprietary information has been excised or redacted. The confidential material must be excised in such a way as to allow the public to determine the general nature of the material removed and to retain as much of the bid proposal as possible. Bidders cannot designate their entire proposal as confidential or proprietary. Sanitized versions of bid proposals must provide a sufficient level of information to understand the full scope of services to be provided.

j. Bidders will submit one original, eight copies, and one sanitized copy of the Technical and Cost Proposals and one original of the Company Financial Information – each in a separate binder (or set of binders) – for each bid proposal submitted. As explained above, bidders submitting bid proposals for more than one of the separate contract awards would therefore submit one original, eight copies, and one sanitized copy of the Technical Proposal and Cost Proposal and one original of the Company Financial Information for each separate RFP Component contract under consideration.

k. All materials shall be submitted in a timely manner to the issuing officer.

l. The bound original bid proposal materials shall be labeled “Original.” The bound copy of the bid proposal materials shall be labeled “Copy.” The bound sanitized copy of the bid proposal materials shall be labeled “Sanitized Copy.”

m. The Technical Proposal and Cost Proposal must also be submitted on CD-ROM. The Company Financial Information should not be included on the CD-ROM. The Department is requiring two CD-ROM copies per bid proposal. One submitted CD-ROM will contain one full version of the Technical Proposal and the Cost Proposal. The second CD-ROM will contain the “sanitized” version of the Technical Proposal and a copy of the Cost Proposal. Electronic proposal files must be submitted as protected PDF files that individually identify the component name, proposal volume title, and full or excised status (such as Medical Services Cost Proposal Sanitized).

n. As much as possible, Technical Proposal sections should be limited to discussion of elements relevant to the proposed solution for Iowa. The “Services Overview” and

"Corporate Organization, Experience, and Qualifications" sections of the Technical Proposal allow bidders to expound in greater detail about past or current projects.

7.2 Technical Proposal

The Technical Proposal will consist of the following sections in the order listed below and separated by tabs.

Figure 5: Technical Proposal Sections

Section Title	Tab Number
Table of Contents	1
Transmittal Letter	2
Checklist and Cross-References	3
Executive Summary	4
General Requirements	5
Professional Services Requirements	6
Project Plan	7
Project Organization	8
Corporate Qualifications	9

7.2.1 Table of Contents (Tab 1)

The Table of Contents will identify all sections (which are separated by tabs), all subsections contained therein, and the corresponding page numbers. The Table of Contents found at the beginning of this RFP provides a representative example of what is expected for the Technical Proposal Table of Contents.

7.2.2 Transmittal Letter (Tab 2)

An individual authorized to legally bind the bidder shall produce and sign a transmittal letter on official business letterhead. Transmittal letters should be numbered in sequence with the remainder of the Technical Proposal.

The designated original copy of the Technical Proposal will include the original signed letter. A photocopy of the transmittal letter shall be included in each of the remaining copies of the Technical Proposal. The transmittal letter is evaluated as part of the screening for bid proposal mandatory submittal requirements and shall include:

a. The bidder's mailing address

b. Electronic mail address, fax number, and telephone number for both the authorized signer and the point of contact designated by the bidder

c. A statement indicating that the bidder is a corporation or other legal entity

    1. All subcontractors should be identified, and a statement included that indicates the exact amount of work to be done by the prime contractor (not less than 60 percent) and each subcontractor, as measured by percentage of total contract price.

    2. The technical proposal must not include actual price information.

d. A statement confirming that the prime contractor is registered or agrees to register to do business in Iowa and providing the corporate charter number (if currently issued), along with assurances that any subcontractor proposed is also licensed or will become licensed. to work in Iowa

e. A statement identifying the bidder's federal tax identification number

f. A statement that the bidder will comply with all contract terms and conditions as indicated in this RFP

g. A statement that no attempt has been made or will be made by the bidder to induce any other person or firm to submit or not to submit a proposal

h. A statement of affirmative action that the bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap

i. A statement that no cost or pricing information has been included in this letter or the Technical Proposal

j. A statement identifying all amendments to this RFP issued by the state and received by the bidder. If no amendments have been received, a statement to that effect shall be included

k. A statement that the bidder certifies in connection with this procurement that:

    1. The prices proposed have been arrived at independently, without consultation, communication, or agreement, as to any matter relating to such prices with any other bidder or with any competitor for the purpose of restricting competition; and

    2. Unless otherwise required by law, the prices quoted have not been knowingly disclosed by the bidder prior to award, directly or indirectly, to any other bidder or to any competitor.

l. A statement that the person signing this proposal certifies that he or she is the person in the bidder's organization responsible for or authorized to make decisions regarding the prices quoted and that he or she has not participated and will not participate in any action contrary to item k

m. If the use of subcontractors is proposed, a statement from each subcontractor must be appended to the transmittal letter signed by an individual authorized to legally bind the subcontractor stating:
   1. The general scope of work to be performed by the subcontractor;
   2. The subcontractor's willingness to perform the work indicated; and
   3. The subcontractor's assertion that it does not discriminate in employment practices with regard to race, color, religion, age (except as provided by law), sex marital status, political affiliation, national origin, or handicap.

n. Any request for confidential treatment of information shall also be identified in the transmittal letter, in addition to the specific statutory basis supporting the request and an explanation why disclosure of the information is not in the best interest of the public.

o. The name, address and telephone number of the individual authorized to respond to the Department about the confidential nature of the information.

7.2.3 Checklist and Cross-References (Tab 3)

Bidders will complete three exhibits in each Technical Proposal to confirm their responsiveness to requirements:

- 7.2.3.1 Bid Proposal Mandatory Requirements Checklist
- 7.2.3.2 General Requirements Cross-Reference
- 7.2.3.3 Professional Services Requirements Cross-Reference

7.2.3.1 Bid Proposal Mandatory Requirements Checklist

Bidders will complete a checklist of the mandatory submittal requirements. The Department will use this checklist to confirm that bidders have produced and submitted bid proposals according to Department specifications. The Mandatory Requirements Checklist form appears in RFP Attachment L Bid Proposal Mandatory Requirements Checklist.

7.2.3.2 General Requirements Cross-Reference

The Department requests that bidders complete a General Requirements Cross-Reference for each Technical Proposal under consideration using the sample RFP cross-reference form in RFP Attachment M Sample Cross-Reference. In Column A, bidders will list requirements by reference number from Section 6.1 General Requirements in the RFP (such as 6.1.3.3.c). In Column B, bidders will list the location within the Technical Proposal where the bidder's response to this requirement can be found (such as Tab 5, Page 5).

7.2.3.3 Professional Services Requirements Cross-Reference

The Department requests that bidders develop a Professional Services Requirements Cross-Reference for each Technical Proposal under consideration based upon the sample RFP cross-reference form in RFP Attachment M Sample Cross-Reference. In Column A, bidders will list requirements by reference number (such as 7.2.3.3). In Column B, bidders will list the location within the Technical Proposal where the bidder's response to this requirement can be found (such as Tab 3, page 32).

7.2.4 Executive Summary (Tab 4)

The bidder shall submit an executive summary that provides the evaluation committees and state management with a collective understanding of the contents of the entire bid proposal. The Executive Summary should briefly summarize the strengths of the bidder and the key features of its proposed approach to meet the requirements of the RFP component toward which the individual bid proposal is targeted.

The Department expects bidders to provide a comprehensive overview of the services that they are proposing to provide to the state. For bidders who have submitted bid proposals for multiple RFP components, this overview provides an opportunity to discuss how the services integrate with one another. Bidders may also articulate other added-value services that are relevant to the scope of services for the submitted bid proposals.

Due to the complex nature of this procurement, the Department requests that bidders describe within the Executive Summary their understanding of the Iowa Medicaid Enterprise (IME). The Department is looking for evidence that bidders understand how multiple contractors work together in a common, integrated environment, operating a unified Iowa Medicaid Program from a single location.

This section shall also include a summary of the bidder's project management plans for all phases of the resulting contract. In addition, it is expected that bidders will identify the risks inherent in the IME and identify the strategies that the bidder will use to mitigate each risk.

7.2.5 General Requirements (Tab 5)

In the General Requirements section, bidders will explain their approach to Section 6.1 General Requirements for All Components. For the General Requirements section of the Technical Proposal, the Department expects bidders to list the requirement numbers for addressed requirements above the paragraph or set of paragraphs that addresses them.

7.2.6 Operational Requirements (Tab 6)

The bidder shall address each contract function (such as third-party liability) within the Professional Services component (such as Revenue Collections) that the bidder is addressing in the bidder proposal. Bidders also will explain in detail how they plan to approach each contractor responsibility and operational requirement for the contract function.

This section should provide a comprehensive integrated narrative that describes how the contractor will meet the requirements, including a description of the bidder's processes, control procedures, and quality assurance procedures for each function. In addition, the bidder may provide process flow diagrams to supplement the narrative.

For the Professional Services Requirements section of the Technical Proposal, the Department expects bidders to list the requirement numbers for addressed requirements above the paragraph or set of paragraphs that addresses them. The Department also expects that bidders will format the Professional Services Requirements section of the Technical Proposal in a manner similar to the following outline:

Figure 6: Section 6 Organization

Section 6 Numbering	Section 6 Content
6.x	RFP component introduction
6.x.1	Name of contract function 1
6.x.2	Name of contract function 2
6.x.3	Name of contract function 3
6.x.4	Name of contract function 4
6.x.5	Name of contract function 5
6.x.6	Name of contract function 6
6.y	etc.

Bidders are free to organize subsections about each contract function as they see fit. Bidders are also given wide latitude in the degree of detail they offer or the extent to which they reveal plans, designs, examples, processes, and procedures.

Bid proposals must be fully responsive to the service requirements. Merely repeating the requirement statement will be considered nonresponsive and disqualify the bidder. Bid proposals must identify any deviations from the requirements of this RFP or requirements that the bidder cannot satisfy.

7.2.7 Project Plan (Tab 7)

The Department requires that bidders produce a project plan for each phase of the contract: transition phase, operations phase, and turnover phase. If bidding on multiple components, bidders must include a project plan for each contract phase in each individual component proposal.

Bidders should include their proposed approach for communication management, quality management, risk management, and time management as part of their overall project plan. The Department will need to consider this approach in determining the overall master project plan for the IME.

In addition to task lists and corresponding start and end dates, the project plans for each phase will include a calendar-year-based schedule for all tasks (including operational

tasks), specify the allocation of resources by job for those tasks, and identify the timeframes in which the tasks will occur (expressed in weeks during transition and turnover and in quarters during operations). The bidder must be capable of updating and maintaining this information systematically throughout the contract.

7.2.8 Project Organization (Tab 8)

The proposed organization and staffing must meet the requirements of RFP Section 6.1.1 Staffing. Bidders respond to the project organization requirements for the Professional Services contractors supporting the IME in this section. This section of the proposal is the bidder's opportunity to describe the merits of its planned approach to the following topics:

- 7.2.8.1 Organization Charts
- 7.2.8.2 Staffing
- 7.2.8.3 Key Personnel
- 7.2.8.4 Subcontractors

7.2.8.1 Organization Charts

For each phase of the project, the bidder will provide a narrative description of the proposed organization, roles and responsibilities of key personnel, and representative job descriptions for all positions within the organization for all phases of the contract. Bidders will include an organization chart of proposed key personnel and counts of full-time equivalent (FTE) workers in each staff position in each organizational unit during each project phase.

Organization charts must identify the percentage of allocation of key personnel to the IME. Bidders may include separate charts for the transition phase to reflect staff loading in the individual tasks but must provide the FTE counts on each one for each organizational unit.

7.2.8.2 Staffing

Bidders are expected to propose sufficient staff who have the requisite skills to meet all requirements in this RFP and who can attain a satisfactory rating on all Performance Standards. Unless otherwise specified by the bidder and approved in advance by the Department, staff positions are effective for the entire duration of the project phase.

The Department encourages bidders to describe their approaches to acquiring qualified staff with experience in the IME. Special attention should be paid to retaining expertise that exists within the IME today.

7.2.8.3 Key Personnel

The bidder must provide resumes and references for all identified key personnel, including the bidder's project manager who will be involved in providing the services contemplated by this RFP. Resumes and references must meet the requirements of section 6.1.1 Staffing. All staff identified as key personnel must be employees of the bidder, unless specified otherwise by the key personnel subsections of the RFP.

7.2.8.4 Subcontractors

The bidder shall disclose the planned use of another company or individual staff member with which the bidder will contract to perform the services described in this RFP. The information that the bidder must provide includes:

a. Subcontractor name and address

b. Subcontractor qualifications

c. Work that the subcontractor will perform

d. The estimated percentage of total contract dollars for each subcontract

The prime contractor for this contract must perform at least 60 percent of the work awarded as a result of this RFP. Special services project staff members that are hired on a retainer or as-needed basis (such as physicians, attorneys, and similar professional staff) are excluded from subcontractor percentage calculations.

7.2.9 Corporate Qualifications (Tab 9)

Information about contractor qualifications includes the following topics:

- 7.2.9.1 Corporate Organization
- 7.2.9.2 Corporate Experience
- 7.2.9.3 Corporate References
- 7.2.9.4 Felony Disclosures
- 7.2.9.5 Certifications and Guarantees

7.2.9.1 Corporate Organization

The bidder must provide an organization chart for the firm that is submitting the proposal. If the firm is a subsidiary of a parent company, the organization chart should be that of the subsidiary firm. The chart should display the firm's structure and the organizational placement of the oversight for the IME project. The bidder must identify the name of the person who will be responsible for signing the contract and indicate the signing person's relationship with the firm. The bidder must include the following information in the proposal:

a. History of the organization

b. Description of the executive, management and any other staff assigned to oversight of this project, their roles on this project, their expertise and experience in providing the services described in the RFP, and their tenure with the organization

c. Legal structure of the organization, names and credentials of the owners and executives, and state in which the organization is registered

d. Evidence of an Iowa business license and any necessary applicable professional license required by law

e. Any established partnership relationships with the community

f. Other projects in which the bidder is currently providing or has provided services similar to the services described in this RFP with names and contact information for the clients' contract administrators

g. Other contracts or projects currently undertaken by the bidder with names and contact information for the clients' contract administrators

7.2.9.2 Corporate Experience

Bidders will describe all relevant experience within the last five years, including all Medicaid contracts. As appropriate, bidders also will specify their participation as primary contractor or subcontractor on each project. Bidders will include projects that demonstrate at a minimum:

a. Relevant governmental experience with the functional areas and proposed requirements of the RFP component considered by the bid proposal

b. Relevant commercial experience with the functional areas and proposed requirements of the RFP component considered by the bid proposal

c. Other experience with governmental healthcare programs

d. For up to five projects in each category, the bidder shall provide the following items in the project summaries:

    1. Project title
    2. Client organization name
    3. Client reference contact name, title, and current telephone number
    4. Original contract start and end dates
    5. Total contract value to the bidder's organization
    6. Average staff hours in FTEs during operations
    7. Workload statistics
    8. Brief description of scope of work that demonstrates relevance to this contract

Project summaries are limited to one project per page. The state reserves the right to contact other references on the project.

7.2.9.3 Corporate References

The bidder shall provide letters of reference from three existing or previous clients knowledgeable of the bidder's performance in providing services similar to the services described in this RFP and a contact person and telephone number for each reference

7.2.9.4 Felony Disclosures

The bidder must state whether it or any owners, officers, or primary partners have ever been convicted of a felony. Failure to disclose such matters may result in rejection of the bid proposal or in termination of any subsequent contract. This disclosure must continue for the life of the contract. Any such matter commencing after submission of a bid

proposal, and with respect to the successful bidder after the execution of a contract, must be disclosed in a timely manner in a written statement to the Department.

7.2.9.5 Certifications and Guarantees

The bidder must include a statement that indicates the bidder's agreement to the certifications and guarantees that appear in RFP Section 9 Attachments.

7.3 Cost Proposal

The Cost Proposal will consist of the following sections in the order listed below and separated by tabs.

Figure 7: Cost Proposal Sections

Section Title	Tab Number
Table of Contents	1
Bid Proposal Security	2
Pricing Schedules	3

7.3.1 Table of Contents (Tab 1)

The Table of Contents will identify all sections (which are separated by tabs), all subsections contained therein, and the corresponding page numbers. The Table of Contents found at the beginning of this RFP provides a representative example of what is expected for the Technical Proposal Table of Contents.

7.3.2 Bid Proposal Security (Tab 2)

Each bidder's original copy of the Cost Proposal shall be accompanied by the original proposal bid bond payable to the Department or original letter of credit equal to five percent of the total costs listed in the pricing schedules in the Cost Proposal. Copies of the Cost Proposal can include copies of the bond or letter. If the bidder elects to use a bond, a surety licensed to do business in Iowa must issue the bond in a form acceptable to the Department.

The submitted Bid Proposal Security shall guarantee the availability of the services as described throughout the bid proposal. The Bid Proposal Security shall be forfeited if the bidder chosen to receive the contract withdraws its bid proposal after the Department issues a Notice of Intent to Award, does not honor the terms offered in its bid proposal, or does not negotiate contract terms in good faith. The Bid Proposal Security should remain in force and in the Department's possession until the firm-terms period for bid proposals expires (which is 120 days).

Upon the signing of contracts and approval of the contracts by CMS, the Bid Proposal Securities will be returned to unsuccessful bidders. In the event that all bid proposals are rejected or the RFP is cancelled, Bid Proposal Securities will be returned to the bidders.

7.3.3 Pricing Schedules (Tab 3)

The pricing schedules in RFP Attachment N (which includes parts N-1, N-2 and N-3) n include specific format and content instructions.

7.4 Company Financial Information

The bidder must submit the following documents to be used in the evaluation of financial viability:

a. Audited financial statements (annual reports) for the last three years

b. A minimum of three financial references (such as letters from creditors, letters from banking institutions, Dunn & Bradstreet supplier reports)

c. A description of other contracts or projects currently undertaken by the bidder

d. A summary of any pending or threatened litigation, administrative or regulatory proceedings or similar matters that could affect the ability of the bidder to perform the required services

e. A disclosure of all contracts during the preceding three-year period in which the bidder or any subcontractor identified in the bid proposal has defaulted, including a brief description of the incident, the name of the contract, a contact person and telephone number for the other party to the contract

f. A disclosure of all contracts during the preceding three-year period in which the bidder or any subcontractor identified in the bid proposal has terminated a contract prior to its stated term or has had a contract terminated by the other party prior to its stated term, including a brief description of the incident, the name of the contract, a contact person and telephone number for the other party to the contract

g. The company's five-year business plan that would include the award of the state's contract as part of the plan

The company financial information must be submitted in a separate sealed envelope and will be opened only for those bid proposals that are selected as apparent successful bidders for each component during the proposal evaluation. This information will be used in the screening for financial viability. After contracts have been signed for all components or if the Department elects not to award any components, the sealed corporate financial information will be returned unopened to unsuccessful bidders.

8 EVALUATION PROCESS

This section describes the evaluation process that will be used to determine which bid proposal provides the greatest benefits to the Department. The evaluation process is designed to award the contract to the bidder with the best combination of attributes to perform the required services. Request for Proposal (RFP) Section 7 Proposal Format and Content describes the content that the committee will evaluate. The evaluation process will ensure the selection of the best overall solution for the Iowa Medicaid Enterprise (IME). The evaluation process includes the following components:

- 8.1 Evaluation Committees
- 8.2 Mandatory Requirements
- 8.3 Technical Proposals
- 8.4 Points and Evaluation Criteria
- 8.5 Cost Proposals
- 8.6 Bid Proposal Security
- 8.7 Combined Score
- 8.8 Oral Presentations
- 8.9 Best and Final Offers
- 8.10 Financial Viability Screening
- 8.11 Recommendation
- 8.12 Notice of Intent to Award
- 8.13 Acceptance Period
- 8.14 Federal Approvals

8.1 Evaluation Committees

The Department intends to conduct a comprehensive, fair, and impartial evaluation of all bid proposals received in response to the component contract awards designated by this RFP. In making its award determinations, the Department will be represented by a set of evaluation committees; subject matter experts from Department staff, the project management office (PMO) and the technical assistance contractor will be assigned to the individual RFP components. Finally, an evaluation committee that may consist of members from the Department's Division of Fiscal Management will evaluate the financial stability and viability of the bidder.

8.2 Mandatory Requirements

As part of its initial screening, the Department will assess all bid proposals submitted in response to this RFP to assure that proposals have satisfied the mandatory requirements. Any one mandatory requirement that a proposal does not meet will cause

the Department to declare a bid proposal nonresponsive and return it to the bidder. The mandatory requirements checklist form appears in RFP Attachment L Bid Proposal Mandatory Requirements Checklist.

8.3 Technical Proposals

Members of the appropriate evaluation committees will evaluate independently each proposal that passes the mandatory submittal criteria. Committee members will score each proposal using criteria established by the Department and using the point values that appear in the technical proposal scoring table.

The evaluation committees will meet at the completion of their evaluation process to address any technical questions raised by their respective reviews and discuss the relative merits of each bidder's bid proposal. At the conclusion of this discussion, the evaluation committee members may independently reevaluate and rescore any section of any proposal.

8.3.1 Scoring Technical Proposals

Technical Proposal volumes meeting all mandatory requirements will be evaluated and scored by an evaluation committee. A weighted scoring system will be used. The weighted scoring system will provide numerical scores that represent the committee's assessment of the relative merits of the technical bid proposals. The Technical Proposal will be evaluated first and a minimum score of 4,500 points out of the maximum of 7,500 points must be accumulated for the Technical Proposal to be considered competitive and determines whether the Cost Proposal will be evaluated. If the Technical Proposal receives less than 4,500 points, the Cost Proposal will not be considered.

Figure 8: Technical Proposal Scoring

Section	Points	Weight	Maximum Points
Executive Summary	150	1-5	750
General Requirements	300	1-5	1,500
Professional Services Requirements	500	1-5	2,500
Project Management	300	1-5	1,500
Corporate Qualifications	100	1-5	500
Oral Presentations	150	1-5	750
Total	**1,500**		**7,500**

After the first round of scoring, the Department will hold oral presentations with designated finalists. Following oral presentations, the evaluation committees may independently reevaluate and rescore any section of any proposal. After the final rescore, each evaluation committee will convene and average the bidder's scores (from each of its members) for each section of the bidder's technical proposal to facilitate a composite and final technical proposal score for each bidder.

8.3.1 Executive Summary

Each evaluation committee will review the proposal's executive summary, the overall quality of the proposal (including appendices), and the general qualifications of the bidder. It will also include a review of subcontracting or joint venture arrangements and how these may affect the overall contract.

Also in the executive summary, each evaluation committee will evaluate the bidder's understanding of the IME and the roles of the stakeholders, including the responsibilities of the Department and other agencies that are involved in administration of the Iowa medical assistance programs. In addition, each evaluation committee will evaluate the overview of the proposed services and solutions to meet the Department's needs.

8.3.2 General Requirements

The evaluation committees will evaluate how well the bidder explains their approach to RFP Section 6.1 General Requirements. In addition, the evaluation committees will evaluate the bidder's response to other general requirements that are identified in each component's operational requirements subsection from RFP Section 6 Professional Services Requirements.

8.3.3 Professional Services Requirements

The evaluation committees will assess the bidder's approach to meeting all the functional, operational, and technological requirements of the RFP. The bidder's response will be evaluated based upon the functional description of the bidder's solution and how their proposal meets or exceeds the requirements listed in this RFP.

8.3.4 Project Management

The evaluation committees will assess the bidder's approach to project management and evaluate the bidder's work plan and approach to the transition and operations phases. Also of interest to the committee will be the bidder's organization of the project teams and approach to quality control in all phases of the contract.

The committee will review proposed staffing levels at each phase of the project, job descriptions, roles, and responsibilities. The evaluation committees will examine closely the resumes of all key personnel and verify references. Reference checking may not be limited to those references supplied by the bidder. Special attention will be given to the bidder's intended use of existing IME contractor staff.

8.3.5 Corporate Qualifications

The corporate background, organization, and relevant experience of the bidder and any subcontractors are significant factors in the evaluation process. The experience and reputation of the bidder in managing large projects of this nature and how the bidder's corporate local teams interact with its clients is important. Experience in Medicaid, large health care delivery systems, managed care operations, and recent technological

advancements in the arena of healthcare systems will carry significant weight in the evaluation of submitted proposals.

8.4 Points and Evaluation Criteria

For the purposes of evaluation, points will be assigned for each component of the evaluation criteria as follows:

5 – Exceeds all requirements

4 – Exceeds many requirements

3 – Meets all requirements

2 – Meets most requirements

1 – Does not meet requirements

8.5 Cost Proposals

A separate committee will review and score the cost proposals from all bidders meeting the mandatory requirements. This committee will note any bidder-imposed cost limitations that could prevent the Department from achieving the objectives of the procurement and report these limitations to the State Medicaid Director for a decision on the proposal.

8.5.1 Scoring Cost Proposals

Cost proposal points for each RFP component (except the Estate Recovery Services and Revenue Collections components) are allocated and determined as follows:

Figure 9: Cost Proposal Scoring

Factor	Percentage of Points
Transition costs	500
Fixed Price Operations costs	2,000
Estate Recovery Services only:	
Operations percentage contingency fee for recoveries: 2,000	
Revenue Collections only:	
Fixed Operations Cost: 1,000	
Operations percentage contingency fee for recoveries: 1,000	
Total	**2,500**

The bidder with the lowest price will receive the maximum points of 2,500.

To calculate every other bidder's score (other than the bidder who received the maximum points) for each Cost Proposal will be divided into the corresponding value of

the lowest bidder and then multiplied by the maximum points. The formula for each is expressed as follows:

Bidder's cost score = (lowest cost / bidder cost) x maximum points

In the case of the Estate Recovery Services component, a maximum of 2,000 points is available for the operation's costs that will be applied to the bidder's proposed contingency fee for recoveries. In the case of the Revenue Collections component a maximum of 1,000 points each is available for the fixed cost and contingency fee.

For all incumbent contractors, there will be no transition price as changes to the components have not significantly changed. For scoring purposes only, each incumbent contractor will be given the point score equal to the lowest bidder for the transition price.

8.6 Bid Proposal Security

The bid proposal security is evaluated on a pass/fail basis as part of the mandatory submittal requirements and is not considered in the scoring.

8.7 Combined Score

Technical and cost proposal scores will be combined to establish a final score for each bidder. The maximum total score is 10,000 points. Proposals will be ranked according to total score to facilitate a recommendation from the evaluation committees.

8.8 Oral Presentations

The Department is likely to request oral presentations and a subsequent "best and final offer" (BAFO) from those bidders that have demonstrated to the evaluation committee their ability to satisfy the requirements of the RFP. Through the issuing officer, the evaluation committee will notify each bidder of their selection as a finalist and arrange for a presentation of their respective services.

Oral presentations will take place at a location to be determined and bidders are expected to have all designated key personnel on hand. The determination order and schedule for the presentations is at the sole discretion of the Department.

The presentation may include slides, graphics and other media selected by the bidder to illustrate the bid proposal. The presentation should not materially change the information contained in the bid proposal. At its option, the Department may require site visits by select Department staff to a bidder's current client site to view current operations.

Upon completion of oral presentations, individual evaluation committee members may re-score bidder's Technical Proposal score based on any clarifications received during that bidder's oral presentation.

8.9 Best and Final Offers (BAFO)

The Department may request a subsequent best and final offer from those bidders that have demonstrated to the evaluation committee their ability to satisfy the requirements of the RFP. At the end of each oral presentation, the presenting bidder will receive any

debriefing instructions regarding the BAFO process if the Department requests any BAFOs. Bidders will have five business days after their individual oral presentations to develop and submit their best and final offers. Thus, a bidder presenting on Tuesday will deliver a its BAFO on the following Tuesday, while a bidder who presents on Thursday will deliver its BAFO on the following Thursday.

Best and final offers must be submitted via delivery service (such as UPS, FedEx, or USPS Priority Mail) by 3:00 p.m. Central Time on the requisite business day. The BAFO must be in writing, accompanied by a transmittal letter binding the bidder to the financial terms described therein. BAFOs are to be sent to the issuing officer of this RFP at the same address identified in RFP Section 2.11 Proposal Submission.

8.10 Financial Viability Screening

The Department's Division of Fiscal Management will evaluate the financial stability and viability of the bidder. The committee will review the bidder's financial stability to ensure that the State of Iowa will be fully covered against any financial difficulties that the company may experience during any period of the contract. After the oral presentations and the bidder's Technical and Cost proposal scores are combined, the bid proposal that receives the most points for each component will be reviewed for the bidder's financial stability and viability to sustain the operation and to assume the ongoing enterprise. This will include a review of the requested corporate financial information. The bidder's financials will be evaluated on a pass/fail basis.

8.11 Recommendation

Following the financial viability screening process, the evaluation committees will forward their final recommendations to the State Medicaid Director for a final decision and contracts award, if appropriate. The recommendations shall be based on all information received through the evaluation process and shall provide the evaluation committee's assessment of bidders that will provide the greatest benefit to the Department. The evaluation committees will recommend the bidder with the greatest total point value or a recommendation that no bidder be selected.

The Department reserves the right to take any additional steps deemed necessary in determining the final awards, which may include negotiations with the selected bidders. The State Medicaid Director may accept or reject the recommendation of the evaluation committees. If the State Medicaid Director rejects the recommendation of any of the evaluation committees, that component or the RFP may be cancelled or rebid at the sole discretion of the Department.

The State Medicaid Director's decision is final for purposes of Iowa Administrative Code Chapter 17A.

8.12 Notice of Intent to Award

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

8.13 Acceptance Period

Negotiation and execution of the contracts shall be completed by the date specified in RFP Section 2.1 Procurement Timetable. If the apparent successful bidder fails to negotiate and execute a contract, the Department (in its sole discretion) may revoke the award and award the contract to the next highest ranked bidder or withdraw the RFP. The Department further reserves the right to cancel the award at any time prior to execution of a written contract or receiving federal approval.

8.14 Federal Approvals

The contract award is subject to federal approval. The Department will make every effort to obtain and expedite federal approval. The Department reserves the right to not award a contract if federal approval is not obtained or does not receive enhanced federal financial participation (FFP).

9 ATTACHMENTS

This section includes the attachments to the RFP as listed in the following table.

Figure 10: IME Professional Services RFP Attachments

Identifier	Title of Attachment
A	Glossary of Acronyms and Terms
B	Proposal Certification
C	Certification of Independence and No Conflict of Interest
D	Certification Regarding Debarment Suspension Ineligibility and Voluntary Exclusion
E	Authorization to Release Information
F	Certification Regarding Registration, Collection and Remission of State Sales and Use Taxes
G	Certification of Compliance with Pro-Children Act of 1994
H	Certification Regarding Lobbying
I	Business Associate Agreement
J	Proposal Certification of Available Resources
K	Resource Library Content
L	Mandatory Requirements Checklist
M	Sample Cross-Reference
N	Pricing Schedule
O	Check Stock Specifications
P	Payment File Definitions
Q	Check Extract Layout
R	Sample RCF Letter
S	EFT Layout
T	Sample Contract

Attachment A: Glossary of Acronyms and Terms

Acronym	Definition
AAA	Area Agencies on Aging
ACH	Automated clearing house
AEA	Area education agency
AFSCME	American Federation of State, County and Municipal Employees
AI	American Indian
AIDS	Acquired immune deficiency syndrome
AN	Alaskan Native
APC	Ambulatory payment classifications
APG	Ambulatory patient groups
A/R system	Accounts receivable system that was instituted to track county financial obligations for support of the Medicaid program. County governments in Iowa are responsible for the nonfederal share of certain Medicaid service costs for persons age 18 and older. These services include ICF/MR, MR and BI waivers, and adult rehabilitation.
ARNP	Advanced Registered Nurse Practitioner
ARO	Adult rehabilitation option for individuals with chronic mental illness.
ASAP-AP	A PC-based EMC submission software package for submitting claims and claim adjustments.
AVR or AVRS	Automated voice response system
AWP	Average wholesale price, which is part of a calculation for one of the state's four pharmacy reimbursement methods.
BCBS	Blue Cross Blue Shield
BCCT	Breast and Cervical Cancer Treatment Program
BEF	Bureau of Economic Fraud
BENDEX	Beneficiary and Earnings Data Exchange System
BI	Brain-injured
Buy-in	See Medicare buy-in
CAC	Critical advisory committee
CCI	Correct coding initiative
CD	Compact disc
CDAC	Consumer-directed attendant care
CD-ROM	Compact disc with read-only memory
CFR	Code of Federal Regulations

Acronym	Definition
CHAMPUS	Civilian Health and Medical Programs of the Uniformed Services (Now TRI-CARE)
CHIP	Children's Health Insurance Program
CHSC	Child health specialty clinic
CICS	Customer Information Control System
CLIA	Clinical Laboratory Improvement Amendments
CMAP	Children's Medical Assistance Program
CMHC	Community mental health center
CMS	Centers for Medicare and Medicaid Services
CMS 64 report	The report that provides the state's Medicaid financial statistics tables to the federal government.
COLD	Computer output to laser disk, which is a form of image storage
COTS	Commercial, off-the-shelf
County of legal settlement	A status defined in Iowa law as being acquired by a person when a specific county is identified as having a financial responsibility for that person
County of residence	The county where the person is currently living, which the courts have interpreted broadly and which can be established without regard to length of time
CP	Client participation
CPAS	Claims Processing Assessment System
CPC	Central point of coordination
CPT-4	Current Procedural Terminology, Version 4
CPU	Central processing unit
CSR	Change service request, which is the process used when the Department or a contractor requests a change to the MMIS that may include production of a special report, modification to a system process, or a new requirement from the MMIS.
Crossover claims	Claims for members with both Medicare and Medicaid coverage
DAS	*See IDAS*
DDI phase	Design, development, and implementation phase of contract
DDM	Division of Data Management
DEA	Drug Enforcement Administration
DESI	Drug Efficacy Study Implementation
DHS	*See IDHS*
DHHS	Department of Health and Human Services
DIA	*See IDIA*
DIP	Document import processor
DME	Durable medical equipment
DO	Doctor of Osteopathy

Acronym	Definition
DPH	*See IDPH*
DRF	*See IDRF*
DRG	Diagnosis related groups
DSH	Disproportionate share hospital
DSS	Decision support system
DUA	Data use agreement
DUR	Drug utilization review
DW/DS	Data warehouse/decision support
EAC	Estimated acquisition cost
EDB	Enrollment database
EDI	Electronic data interchange
EEP	Extended enrollment period
EFT	Electronic funds transfer
EIN	Employer identification number
ELVS	Eligibility Verification System
EMC	Electronic media claim
EOB	Explanation of benefit
EPP	Extended participation period
EPSDT	Early and periodic screening, diagnosis, and treatment
EQRO	External quality review organization
ESLIMB or ESLMB	Expanded specified low-income Medicare beneficiaries
FACS	Family And Children's Services System, which is the payment and tracking system for protective services in Iowa, including family-centered, family foster care, foster group home care and family preservation services
FDA	Food and Drug Administration
FEIN	Federal employer identifying number
FFP	Federal financial participation
FFS	Fee for service
FIP	Family Investment Program, which is Iowa's TANF program
FIPS	Federal Information Processing Standards
FMAP	Family Medical Assistance Program
FPL	Federal poverty level
FQHC	Federally qualified health center
FTE	Full-time equivalent

Acronym	Definition
FUL	Federal upper limit
GAAP	Generally accepted accounting principle
GSD	General systems design
GUI	Graphical user interface
hawk-i	Healthy and Well Kids In Iowa, which is the name of the nonMedicaid portion of Iowa's Title XXI state children's health program.
HCBS	Home and community-based services waivers, of which Iowa has six for these situations: ill and handicapped, elderly, mentally retarded, physically disabled, brain injury, and AIDS/HIV.
HCFA-1500	Health Care Financing Administration Form 1500, which is the form that CMS requires for claims from physicians and suppliers except for ambulance services
HCPCS	Healthcare Common Procedure Coding System
HEDIS®	Healthcare Effectiveness Data and Information Set, which is a set of standardized performance measures designed to ensure that purchasers and members have the information they need to reliably compare the performance of managed health care plans.
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPDB	Health integrity protection data base
HIPP	Health insurance premium payment
HIT	Health information technology
HIV	Human immunodeficiency virus
HMO	Health maintenance organization
HRSA	Health Resource Services Administration
IABC	Iowa Automated Benefit Calculation System
IAC	Iowa Administrative Code
I-CAR	Individual Collections and Reporting
ICBS	Iowa County Billing System
ICD-9-CM	International Classification of Diseases, Ninth Edition, Clinical Modification
ICF	Intermediate care facility
ICF/MR	Intermediate care facility for the mentally retarded
ICN	Iowa Communications Network
ID	Identification (number)
IDAS	Iowa Department of Administrative Services *See DAS*
IDEA	Individual Disabilities Education Act
IDHS	Iowa Department of Human Services *See DHS*
IDIA	Iowa Department of Inspection and Appeals *See DIA*
IDPH	Iowa Department of Public Health
IDRF	Iowa Department of Revenue and Finance

Acronym	Definition
IFAS	Iowa Financial Accounting System
IFMC	Iowa Foundation for Medical Care
IGT	Intergovernmental transfer
IME	Indirect medical education
I-MERS	Iowa Medicaid Electronic Record System
IMW	Income maintenance worker (referred to as eligibility worker in some states)
Iowa Plan	The Iowa Plan for Behavioral Health (Iowa Plan), which is Iowa's statewide, managed behavioral health plan for mental health and substance abuse treatment services.
IPIA	Improper Payments Information Act of 2002
IandSS	Implementation and support services
ISIS	Individualized Service Information System
ITE	Information technology enterprise
IV-E	Title IV-E that provides federal funding for FIP foster care and adoption subsidy
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LAN	Local area network
LEA	Local education agency
LI or lock-in	A special program administered by the Department for Medicaid members who have overutilized Medicaid services and who are issued a special identification card and assigned to a select group of lock-in providers to control claims
LOC	Level of care
LOS	Length of stay
LSO	Limited service organization
LTC	Long-term care
MAC	Maximum allowable cost
MAR	Management and administrative reporting
MARS	Management and Administrative Reporting Subsystem
MCO	Managed care organization, which the Department uses to describe HMOs and MediPASS providers
MD	Doctor of Medicine
MDC	Multiple description coding
MDS	Minimum data set
Medically needy	The program that provides medical assistance to individuals who meet the categorical but not the financial criteria for Medicaid eligibility and who may be responsible for a portion of their medical expenses in the amount referenced as their spend-down obligation
Medicare buy-in	Premium payments made to CMS on behalf of Iowa Medicaid members who are eligible for Medicare
MediPASS	Medicaid Patient Access to Service System, which is Iowa's PCCM program

Acronym	Definition
MEPD	Medicaid for employed people with disabilities
MEQC	Medicaid eligibility quality control
MEVS	Medicaid Eligibility Verification System
MFCU	Medicaid Fraud Control Unit, which is the Iowa business unit responsible for conducting federally-required Medicaid Provider Fraud Control Unit (MPFCU) activities as well as state-sponsored member fraud control activities
MHC	Managed health care
MHCAC	Managed health care advisory committee
MHEP	Member Health Education Program
MHI	Mental health institution
MIG	Medicaid integrity group
MIPS	Medicaid IowaCare Premium System
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information System
MQC	Medicaid quality control program
MQUIDS	Medicaid Quality Utilization and Improvement Data System
MR	Mentally retarded (developmentally disabled)
MSIS	Medicaid Statistical Information System
MVM	Medicaid Value Management
NABP	National Association of Boards of Pharmacy
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NF	Nursing facility
NF-MI	Nursing facility for the mentally ill *See Specialty NF-MI*
NIPS	Noninpatient services
NOD	Notice of decision
NPI	National provider identifier number
NPDB	National provider data base
OCR	Optical character recognition
OIG	Office of the Inspector General, which is the federal authority for identifying and investigating instances of fraud and abuse for state Medicaid programs
Online	Accessible via a computer system or computer network
Operations phase	The contract phase in which contractors assume and maintain live operation of a Medicaid function from a current contractor or the state and in which incumbent contractors begin operation of newly implemented enhancements, services or features
OTC	Over the counter

Acronym	Definition
PA	Prior authorization
PACE	Program of All-Inclusive Care for the Elderly
PASRR	Preadmissions Screening and Resident Review
Pay and chase	The portion of funds paid to a provider for member services that are recoverable from liable third parties
PC	Personal computer
PCCM	Primary care case management, which is MediPASS in Iowa, in which providers are paid on a fee-for-service basis with an addition premium paid for care management
PCP	Primary care physician
PDD	Procedure, drug, and diagnosis
PDDDA	Procedure, drug, diagnosis, DRG and APG file
PDL	Preferred drug list
PERM	Payment error rate measurement
PIN	Personal identification number
PMIC	Psychiatric medical institutions for children
PMF	Provider master file
POS	Point-of-sale
PRO	Peer review organization
ProDUR	Prospective drug utilization review
P and T	Pharmaceutical and therapeutics
QA/UR	Quality assurance/utilization review
QDWP	Qualified disabled working person
QIO	Quality improvement organization
QMB	Qualified Medicare beneficiary
RA	Remittance advice
RBRVS	Resource-based relative value scale
RCF	Residential care facility
RCF/MR	Residential care facility for the mentally retarded
REOMB	Recipient explanation of Medicaid benefit *See EOB*
RetroDUR	Retrospective drug utilization review
REVS	Recipient Eligibility Verification System
RFI	Request for information
RFP	Request for proposal
RHC	Rural health clinic
RHEP	See MHEP

Acronym	Definition
RTS	Rehabilitative treatment services
RUG	Resource utilization group
RVS	Relative value scale (or schedule)
SCHIP	See CHIP.
SDX	State data exchange
SFY	State fiscal year
SID	State identification number
SIQ	Supplemental insurance questionnaire
SLA	Service-level agreement
SLIMB or SLMB	Specified low-income Medicare beneficiary
SLTF	Senior living trust fund
SMAC	State maximum allowable cost
SNF	Skilled nursing facility
SQL	Structured (or system) query language
Specialty NF-MI	Specialty nursing facilities for the mentally ill
Spend-down amount	The portion of their medical expenses that individuals must pay themselves if they meet the categorical but not the financial criteria for Medicaid eligibility
SSA	Social Security Administration
SSBI	Social Security Buy-In
SSI	Supplemental security income
SSN	Social Security number
Supplemental DSH	Supplemental disproportionate share hospitals, which is a reimbursement program that makes supplemental payment adjustments to qualifying DSH facilities in addition to the standard base payments for the purpose of further assisting hospitals that treat a disproportionate share of Iowa Medicaid members and other low-income families
Supplemental IME	Supplemental indirect medical education, which was created in the Balanced Budget Act of 1997 to provide supplemental payment to teaching hospitals for operating indirect medical education to help cover the increased operating or patient care costs that are associated with approved intern and resident programs
SUR	Surveillance and utilization review
SURS	Surveillance and Utilization Review Subsystem
TANF	Temporary Aid for Needy Families Program
TCM	Targeted case management
TCN	Transaction control number that is used to uniquely identify documents
TDD	Telecommunications device for the deaf
Title XIX	Title XIX of the Social Security Act, which established the state Medicaid programs
Title XVIII	Title 18 of the Social Security Act, which established the Medicare program

Acronym	Definition
Title XXI	Title XXI of the Social Security Act, which provides funds to states to initiate and expand the provision of child health assistance to uninsured, low-income children
TPA	Third-party administrator
TPL	Third-party liability
Turnover phase	The final phase of a contract in which the incumbent contractor turns over operations to a new contractor
UB-92	Universal Billing Form 92 that CMS requires institutional and other selected providers to use to bill for inpatient services.
UPIN	Universal provider identification number
UPL	Upper payment limit
UR	Utilization review
USPS	United States Postal Services
Usual and Customary	The amount that a provider typically bills for a particular drug or service
WAC	Wholesale acquisition cost
Waiver programs	*See HCBS*
Work plan	The tasks and subtasks, duration, resources, milestones, deliverables, and their associated estimated and actual start and finish dates
X12 270/271	ANSI ASC X12 270/271 transaction, which refers to the HIPAA healthcare eligibility benefit inquiry and response transactions
X12 275	ANSI ASC X12 275 transaction, which refers to the HIPAA claims attachment transaction
X12 276/277	ANSI ASC X12 276/277 transaction, which refers to the HIPAA healthcare claims status request and response transactions
X12 278	ANSI ASC X12 278 transaction, which refers to the HIPAA referral certification and prior authorization requests transaction
X12 820	ANSI ASC X12 820 transaction, which refers to the HIPAA premium payment transaction
X12 834	ANSI ASC X12 834 transaction, which refers to the HIPAA HMO enrollment and disenrollment transaction
X12 835	ANSI ASC X12 835 transaction, which refers to the HIPAA claims payment and remittance advice transaction
X12 837	ANSI ASC X12 837 transaction, which refers to the HIPAA healthcare claim or encounter transaction

Attachment B: Proposal Certification

PROPOSAL CERTIFICATION

BIDDERS – SIGN AND SUBMIT CERTIFICATION WITH PROPOSAL.

I certify that I have the authority to bind the bidder indicated below to the specific terms, conditions and technical specifications required in the Department's Request for Proposal (RFP) and offered in the bidder's proposal. I understand that by submitting this bid proposal, the bidder indicated below agrees to provide services described in the Iowa Medicaid Enterprise 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.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

Attachment C: Certification of Independence and No Conflict of Interest

CERTIFICATION OF INDEPENDENCE AND NO CONFLICT OF INTEREST

By submission of a bid proposal, the bidder certifies (and in the case of a joint proposal, each party thereto certifies) that:

a. the bid proposal has been developed independently, without consultation, communication or agreement with any employee or consultant of the Department who has worked on the development of this RFP, or with any person serving as a member of the evaluation committee;

b. the bid proposal has been developed independently, without consultation, communication or agreement with any other bidder or parties for the purpose of restricting competition;

c. unless otherwise required by law, the information in the bid proposal has not been knowingly disclosed by the bidder and will not knowingly be disclosed prior to the award of the contract, directly or indirectly, to any other bidder;

d. no attempt has been made or will be made by the bidder to induce any other bidder to submit or not to submit a bid proposal for the purpose of restricting competition;

e. no relationship exists or will exist during the contract period between the bidder and the Department that interferes with fair competition or is a conflict of interest.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

Attachment D: Certification Regarding Debarment Suspension Ineligibility and Voluntary Exclusion

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION -- LOWER TIER COVERED TRANSACTIONS

By signing and submitting this Proposal, the bidder is providing the certification set out below:

1. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the bidder knowingly rendered an erroneous certification, in addition to other remedies available to the federal government the Department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
2. The bidder shall provide immediate written notice to the person to whom this Proposal is submitted if at any time the bidder learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.
3. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principle, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this Proposal is submitted for assistance in obtaining a copy of those regulations.
4. The bidder agrees by submitting this Proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the Department or agency with which this transaction originated.
5. The bidder further agrees by submitting this Proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
6. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it

determines the eligibility of its principals. A participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Nonprocurement Programs.

7. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
8. Except for transactions authorized under paragraph 4 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the federal government, the Department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND/OR VOLUNTARY EXCLUSION--LOWER TIER COVERED TRANSACTIONS

(1) The bidder certifies, by submission of this Proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.

(2) Where the bidder is unable to certify to any of the statements in this certification, such bidder shall attach an explanation to this Proposal.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

Attachment E: Authorization to Release Information

AUTHORIZATION TO RELEASE INFORMATION

_____ (name of bidder) hereby authorizes any person or entity, public or private, having any information concerning the bidder's background, including but not limited to its performance history regarding its prior rendering of services similar to those detailed in this RFP, to release such information to the Department.

The bidder acknowledges that it may not agree with the information and opinions given by such person or entity in response to a reference request. The bidder acknowledges that the information and opinions given by such person or entity may hurt its chances to receive contract awards from the Department or may otherwise hurt its reputation or operations. The bidder is willing to take that risk. The bidder agrees to release all persons, entities, the Department, and the Department of Iowa from any liability whatsoever that may be incurred in releasing this information or using this information.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

Attachment F: Certification Regarding Registration, Collection and Remission of State Sales and Use Taxes

CERTIFICATION REGARDING REGISTRATION, COLLECTION, AND REMISSION OF STATE SALES AND USE TAX

By submitting a proposal in response to this Request for Proposal (RFP), the undersigned certifies the following: (check the applicable box):

☐ _____ [name of vendor] is registered or agrees to become registered if awarded the contract, with the Iowa Department of Revenue, and will collect and remit Iowa Sales and use taxes as required by Iowa Code chapter 423; or

☐ _____ [name of vendor] is not a "retailer" or a "retailer maintaining a place of business in the state" as those terms are defined in Iowa Code §§ 423.1(42) & (43) (2005).

_____ [name of vendor] also acknowledges that the Department may declare the Vendor's bid or resulting contract void if the above certification is false. The Vendor also understands that fraudulent certification may result in the Department or its representative filing for damages for breach of contract.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

Attachment G: Certification of Compliance with Pro-Children Act of 1994

CERTIFICATION OF COMPLIANCE WITH PRO-CHILDREN ACT OF 1994

The Contractor must comply with Public Law 103-227, Part C Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act). This Act requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees, and contracts. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities (other than clinics) where WIC coupons are redeemed.

The Contractor further agrees that the above language will be included in any subawards that contain provisions for children's services and that all subgrantees shall certify compliance accordingly. Failure to comply with the provisions of this law may result in the imposition of a civil monetary penalty of up to $1000 per day.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

Attachment H: Certification Regarding Lobbying

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

a. No federal appropriated funds have been paid or will be paid on behalf of the Sub-Grantee to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of the Congress, an officer or employee of the Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan or cooperative agreement.

b. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of the Congress, or an employee of a Member of Congress in connection with this Contract, grant, loan, or cooperative agreement, the applicant shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

c. The Contractor shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C.A. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

Attachment I: Business Associate Agreement

BUSINESS ASSOCIATE AGREEMENT

THIS Attachment supplements and is made a part of the Iowa Department of Human Services ("Department") Contract (hereinafter, the "Underlying Agreement") between the Department and the Contractor ("the Business Associate"). This Attachment, when accepted by the Department, establishes the terms of the relationship between the Department and the Business Associate.

Whereas, the Department and the Business Associate are parties to the Underlying Agreement pursuant to which the Business Associate provides or performs certain services on behalf of or for the Department. The Department discloses to the Business Associate certain Protected Health Information (“PHI”) (as defined in 45 C.F. R. § 164.501), related to the services performed by the Business Associate for the relationship and, in connection with the provision of those services. This PHI is subject to protection under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

Whereas, the Department is a "Covered Entity" as that term is defined in the HIPAA implementing regulations, 45 C.F.R. Part 160 and Part 164, Subparts A and E, the Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule");

Whereas, the Contractor, provides or performs certain services on behalf of or for the Department which require the disclosure of PHI from the Department, and is, therefore a "Business Associate" as that term is defined in the Privacy Rule; Whereas, pursuant to the Privacy Rule and the Security Rule, all Business Associates of Covered Entities must agree in writing to certain mandatory provisions regarding the use and disclosure of PHI; and

Whereas, the purpose of this Attachment is to comply with the requirements of the Privacy Rule and the Security Rule, including, but not limited to, the Business Associate’s contract requirements at 45 C.F.R. §164.504(e) and 45 C.F.R. §164.314.

NOW, THEREFORE in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

1. **Definitions**. Unless otherwise provided in this Attachment, capitalized terms have the same meanings as set forth in the Privacy Rule and the Security Rule.
2. **Scope of Use and Disclosure by Business Associate of Protected Health Information**.
   A. The Business Associate shall be permitted to use and disclose PHI that is disclosed to it by the Department as necessary to perform its obligations under the Underlying Agreement.
   B. Unless otherwise limited herein, in addition to any other uses and/or disclosures permitted or authorized by this Attachment or required by law, the Business Associate may:
      (a) Use the PHI in its possession for its proper management and administration and to fulfill any legal responsibilities of DHS;

(b) Disclose the PHI in its possession to a third party for the purpose of proper management and administration or to fulfill any legal responsibilities of DHS; provided, however, that the disclosures are required by law or Business Associate has received from the third party written assurances that:

(i) The information will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the third party; and

(ii) The third party will notify the Business Associate of any instances of which it becomes aware in which the confidentiality of the information has been breached;

and

(c) Disclose or use any PHI created or received by DHS under this Attachment, for other purposes, so long as it has been de-identified and the de-identification conforms to the requirements of the Privacy Rule.

3. **Obligations of Business Associate**. In connection with its use and disclosure of PHI, the Business Associate agrees that it will:

A. Use or further disclose PHI only as permitted or required by this Attachment or as required by law.

B. Use reasonable and appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Attachment;

C. To the extent practicable, mitigate any harmful effect that is known to the Business Associate of a use or disclosure of PHI in violation of this Attachment.

D. Promptly report to the Department any use or disclosure of PHI not provided for by this Attachment of which the Business Associate becomes aware.

E. Require contractors or agents to whom the Business Associate provides PHI to agree to the same restrictions and conditions that apply to the Business Associate pursuant to this Attachment.

F. Make available to the Secretary of Health and Human Services the Business Associate’s internal practices, books and records relating to the use and disclosure of PHI for purposes of determining the Business Associate's compliance with the Privacy Rule, subject to any applicable legal privileges.

G. Obtain consents, authorizations and other permissions from all individuals necessary or required by laws applicable to the Business Associate to fulfill its obligations under the Underlying Agreement and this Attachment.

H. Promptly comply with any changes in, or revocation of, permission by an Individual for the Business Associate or the Department to use or disclose PHI, after receiving written notice by the Department.

I. Promptly comply with any restrictions on the use and disclosure of PHI about Individuals that the Department has agreed to, after written notice by the Department.

J. Within 15 days of receiving a request from the Department, make available the information necessary for the Department to make an accounting of disclosures of PHI about an individual.

K. Within 10 days of receiving a written notice from the Department about a request from the Individual, make available PHI necessary for the response to individuals' requests for access to PHI about them in the Business Associate's possession which constitutes part of the Department's Designated Record Set.

L. Within 15 days of receiving a written notice from the Department to amend or correct an Individual's PHI in accordance with the Privacy Rule, make the amendments or corrections to PHI in Business Associate's possession which constitutes part of the Department's Designated Record Set.

M. Implement administrative, physical, and technical safeguards that protect the confidentiality, integrity, and availability of the electronic PHI that it creates, maintains, or transmits on behalf of the Department. This security requirement is effective April 20, 2005.

N. Promptly report to the Department any security incident of which the Business Associate becomes aware. This security requirement is effective April 20, 2005.

4. **Obligations of the Department**. The Department agrees that it:

A. Has included, and will include, in the Department's required Notice of Privacy Practices that the Business Associate may disclose PHI for health care operations purposes.

B. Has obtained, and will obtain, from Individuals authorizations and other permissions necessary or required by laws applicable to the Department and the Business Associate to fulfill their obligations under the Underlying Agreement and this Attachment.

C. Will promptly notify Business Associate in writing of any restrictions on the use and disclosure of PHI about Individuals that the Department has agreed to that may affect Business Associate's ability to perform its obligations under the Underlying Agreement or this Attachment.

D. Will promptly notify the Business Associate in writing of any changes in, or revocation of, authorization by an Individual to use or disclose PHI, if such changes or revocation may affect the Business Associate's ability to perform its obligations under the Underlying Agreement or this Attachment.

5. **Termination**.

A. Termination for Cause. The Department may terminate this Attachment for cause if the Department determines that the Business Associate, or any of its subcontractors, etc. has breached a material term of this Attachment. The Department will allow the Business Associate an opportunity to cure the breach. The Department shall provide written notice to the Business Associate requesting that the breach be remedied within the period of time specified in the notice. If the breach is not remedied by the date specified to the satisfaction of the Department, the Department may immediately terminate this Attachment and the Underlying Agreement.

B. Automatic Termination. This Attachment will automatically terminate upon the termination or expiration of the Underlying Agreement.

C. Effect of Termination.

(a) Termination of this Attachment will result in termination of the Underlying Agreement.

(b) Upon termination of this Attachment or the Underlying Agreement, unless specially required by the Department for the business associate to retain the protected health information, the Business Associate will return or destroy all PHI received from the Department, or created or received by the Business Associate on behalf of the Department, that the Business Associate still maintains and retain no copies of such PHI. If such return or destruction is not feasible, the Business Associate will extend the protections of this Attachment to the PHI and limit any further uses and disclosures. The Business Associate will provide the Department in writing the reason that will make the return or destruction of the information infeasible.

6. **Amendment**. The Department and the Business Associate agree to take such action as is necessary to amend this Attachment from time to time as is necessary for the Business Associate to comply with the requirements of the Privacy Rule and/or the Security Rule.
7. **Survival**. The obligations of the Business Associate under section 5.C. (b) of this Attachment shall survive any termination of this Attachment.
8. **No Third Party Beneficiaries**. Nothing express or implied in this Attachment is intended to confer, nor shall anything herein confer, upon a person other than the parties and their respective successors or assigns, an rights, remedies, obligations or liabilities whatsoever.
9. **Effective Date**. This Attachment shall be effective on _____ .

_____	**Department of Human Services**
Contractor	
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

Attachment J: Proposal Certification of Available Resources

PROPOSAL CERTIFICATION OF AVAILABLE RESOURCES
BIDDERS – SIGN AND SUBMIT CERTIFICATION WITH PROPOSAL.

I certify that the bidder organization indicated below has sufficient personnel resources available to provide all services proposed by this Bid Proposal. I duly certify that these personnel resources for the contract awarded will be available on and after July 1, 2010.

In the event that we, the bidder, have bid more than one component contract specified by this RFP, my signature below also certifies that the personnel bid for this component Bid Proposal are not personnel for any other component Bid Proposal. If my organization is awarded more than one component, I understand that the State may agree to shared resource allocation if the bidder can prove feasibility of shared resource.

_____

Name Date

_____

Title

_____

Name of Bidder Organization

Attachment K: Resource Library Content

The documents listed below are available in the Iowa Medicaid Enterprise resource library located at *www.ime.state.ia.us*

a. RFP MED 04-015 Systems and Professional Services for the Iowa Medicaid Enterprise
   1. IME Bidders Proposals
   2. IME Contracts
   3. Quarterly Reports (SFY 06, 07, 08, 09)

b. RFP MED 04-034 Medical Services with Preferred Drug List
   1. IME Bidders Proposals
   2. IME Contract
   3. Quarterly Reports (SFY 06, 07, 08, 09)

c. RFP MED 04-037 Implementation and Support Services
   1. IME Bidders Proposals
   2. IME Contract
   3. Quarterly Reports (SFY 06, 07, 08, 09)

d. RFP MED 04-085 Medicaid Claims Payment Support Services
   1. IME Bidders Proposals
   2. IME Contract

e. RFP MED 09-010 Iowa Plan for Behavioral Health
   1. IME Bidders Proposals
   2. IME Contract

f. RFP MED 09-006 Technical Assistance and Support for Iowa Medicaid Enterprise Services Procurement
   1. IME Bidders Proposals
   2. IME Contracts

g. RFP MED 09-016 Claims Editing and Correct Coding Initiative (CCI)
   1. IME Bidders Proposals
   2. IME Contract

h. IME Policies
   1. Iowa Administrative Code
   2. State Medicaid Plan

i. IME Operational Procedures

1. Provider Services
2. Member Services
3. Pharmacy Medical Services
4. Medical Services
5. Pharmacy POS
6. Revenue Collections (includes Estate Recovery currently)
7. Data Warehouse
8. Core MMIS
9. SURS
10. Provider Cost Audits and Rate Setting (PCA)

j. IME Operational Tools:
   1. OnBase
   2. Mailroom-verification/scanning
   3. MQUIDS
   4. Data Warehouse
   5. Decision Support Documentation
   6. MMIS Valid Values Booklet (Iowa Medicaid Guide)

k. Provider Manuals

l. Provider Information Releases

m. Workflow Process Maps

n. System Interface Diagram

o. Iowa Department of Human Services, Division of Medical Services, Iowa Medicaid Enterprise Table of Organization

p. Iowa Medicaid Workload Statistics

q. Consumer Directed Attendant Care (CDAC) Memorandum of Understanding (MOU)

r. Quarterly Revenue Summary Reports (SFY 06, 07, 08, 09)

Attachment L: Bid Proposal Mandatory Requirements Checklist

The Department has provided the following template to submit with the Technical Proposal. Bidders are expected to confirm compliance by marking the "Yes" box in the "Bidder Check" column. Upon receipt of bid proposals, the Department will confirm compliance by marking "Yes" in the "DHS Check" column. Bidders' failure to complete mandatory requirements will result in the bidders' disqualification for this procurement as described in RFP Section 2.15 Disqualification.

Figure 11: IME Professional Services RFP Attachments Mandatory Requirements Checklist

Bidder Check	Requirement	Confirmed by DHS
☐ Yes ☐ No	1. Did the issuing officer receive the bid proposal by 3:00 p.m., Central Time, on the date specified in RFP Section 2.1 Procurement Timetable?	☐ Yes ☐ No
☐ Yes ☐ No	2. Does each bid proposal consist of three distinct parts?	☐ Yes ☐ No
☐ Yes ☐ No	a. Technical Proposal	☐ Yes ☐ No
☐ Yes ☐ No	b. Cost Proposal	☐ Yes ☐ No
☐ Yes ☐ No	c. Company Financial Information	☐ Yes ☐ No
☐ Yes ☐ No	3. Is each bid proposal sealed in a box (or boxes), with the Cost Proposal and Company Financial Information volumes sealed in separate, labeled envelopes inside the same box or boxes?	☐ Yes ☐ No
☐ Yes ☐ No	4. Are packing boxes numbered in the following fashion: 1 of 4, 2 of 4, and so forth for each bid proposal that consists of multiple boxes?	☐ Yes ☐ No
☐ Yes ☐ No	5. Are all boxes containing bids labeled with the following information?	☐ Yes ☐ No
☐ Yes ☐ No	a. Bidder's name and address	☐ Yes ☐ No
☐ Yes ☐ No	b. Issuing officer and department's address as identified by RFP Section 7.1.d.2	☐ Yes ☐ No
☐ Yes ☐ No	c. RFP title (Iowa Medicaid Enterprise Procurement) and RFP reference number (MED-10-001)	☐ Yes ☐ No

Bidder Check	Requirement	Confirmed by DHS
☐ Yes ☐ No	d. RFP component for which the bid proposal is being submitted for consideration (such as Medical Services or Provider Services)	☐ Yes ☐ No
☐ Yes ☐ No	6. Are separate boxes utilized for each bid proposal if submitting bid proposals for more than one of the individual contract awards?	☐ Yes ☐ No
☐ Yes ☐ No	7. Are all bid proposal materials printed on 8.5" x 11" paper (two-sided)?	☐ Yes ☐ No
☐ Yes ☐ 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.)	☐ Yes ☐ No
☐ Yes ☐ 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)	☐ Yes ☐ No
☐ Yes ☐ 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)	☐ Yes ☐ No
☐ Yes ☐ No	11. Is one sanitized copy of the proposal volumes included if any bid proposal information is designated as confidential? (Note: Bidders cannot designate their entire proposal as confidential or proprietary.)	☐ Yes ☐ No
☐ Yes ☐ No	12. Does each Technical Proposal package include:	☐ Yes ☐ No
☐ Yes ☐ No	a. One original	☐ Yes ☐ No
☐ Yes ☐ No	b. Eight copies	☐ Yes ☐ No
☐ Yes ☐ No	c. One sanitized copy (if applicable) in a separate binder (or set of binders)	☐ Yes ☐ No
☐ Yes ☐ No	d. Are the original, copies, and sanitized copy correctly marked?	☐ Yes ☐ No
☐ Yes ☐ No	13. Does each Cost Proposal package include: (Note: This status will be determined when Cost Proposals are opened after Technical Proposals have been evaluated.)	☐ Yes ☐ No
☐ Yes ☐ No	a. One original	☐ Yes ☐ No
☐ Yes ☐ No	b. Eight copies	☐ Yes ☐ No

Bidder Check	Requirement	Confirmed by DHS
☐ Yes ☐ No	c. One sanitized copy of Cost Proposal in separate, sealed envelope	☐ Yes ☐ No
☐ Yes ☐ No	d. Are the original, copies and sanitized copy correctly marked?	☐ Yes ☐ No
☐ Yes ☐ 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.)	☐ Yes ☐ No
☐ Yes ☐ No	15. Are all bid proposals also submitted on CD ROM copies per bid proposal?	☐ Yes ☐ No
☐ Yes ☐ No	16. Does one submitted CD-ROM contain one full version of each bid proposal part and the other submitted CD contain one sanitized version of each bid proposal part?	☐ Yes ☐ No
☐ Yes ☐ No	17. Are all electronic files in PDF format or in Microsoft Word 2000 format (or a later version)?	☐ Yes ☐ No
☐ Yes ☐ No	18. Are all electronic files individually identified by:	☐ Yes ☐ No
☐ Yes ☐ No	a. Component name	☐ Yes ☐ No
☐ Yes ☐ No	b. Bid proposal part (technical, cost, or company financial information)	☐ Yes ☐ No
☐ Yes ☐ No	c. Version	☐ Yes ☐ No
	Technical Proposal Content	
☐ Yes ☐ No	19. Does each Technical Proposal consist of the following sections separated by tabs with associated documents and responses presented in the following order?	☐ Yes ☐ No
☐ Yes ☐ No	a. Table of Contents (Tab 1)	☐ Yes ☐ No
☐ Yes ☐ No	b. Transmittal Letter (Tab 2)	☐ Yes ☐ No
☐ Yes ☐ No	c. Checklists and Cross-References (Tab 3)	☐ Yes ☐ No
☐ Yes ☐ No	d. Executive Summary (Tab 4)	☐ Yes ☐ No
☐ Yes ☐ No	e. General Requirements (Tab 5)	☐ Yes ☐ No
☐ Yes ☐ No	f. Professional Services Requirements (Tab 6)	☐ Yes ☐ No

Bidder Check	Requirement	Confirmed by DHS
☐ Yes ☐ No	g. Project Plan (Tab 7)	☐ Yes ☐ No
☐ Yes ☐ No	h. Project Organization (Tab 8)	☐ Yes ☐ No
☐ Yes ☐ No	i. Corporate Qualifications (Tab 9)	☐ Yes ☐ No
☐ Yes ☐ No	20. Does the Table of Contents in Tab 1 of the Technical Proposal identify all sections, subsections, and corresponding page numbers?	☐ Yes ☐ No
☐ Yes ☐ No	21. Does the Transmittal Letter in Tab 2 include the following?	☐ Yes ☐ No
☐ Yes ☐ No	a. The bidder's mailing address	☐ Yes ☐ No
☐ Yes ☐ No	b. Electronic mail address, fax number, and telephone number for both the authorized signer and the point of contact designated by the bidder	☐ Yes ☐ No
☐ Yes ☐ No	c. A statement indicating that the bidder is a corporation or other legal entity	☐ Yes ☐ No
☐ Yes ☐ No	d. Identification of all subcontractors and a statement included that indicates the exact amount of work to be done by the prime contractor (not less than 60 percent) and each subcontractor, as measured by a percentage of the total work?	☐ Yes ☐ No
☐ Yes ☐ No	e. No actual price information	☐ Yes ☐ No
☐ Yes ☐ No	f. A statement confirming that the prime contractor is registered or agrees to register to do business in Iowa and providing the corporate charter number (if currently issued), along with assurances that any subcontractor proposed is also licensed or will become licensed to work in Iowa	☐ Yes ☐ No
☐ Yes ☐ No	g. A statement identifying the bidder's federal tax identification number	☐ Yes ☐ No
☐ Yes ☐ No	h. A statement that the bidder will comply with all contract terms and conditions as indicated in this RFP	☐ Yes ☐ No
☐ Yes ☐ No	i. A statement that no attempt has been made or will be made by the bidder to induce any other person or firm to submit or not to submit a proposal	☐ Yes ☐ No
☐ Yes ☐ No	j. A statement of affirmative action that the bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap	☐ Yes ☐ No
☐ Yes ☐ No	k. A statement that no cost or pricing information has been included in this letter or the Technical Proposal	☐ Yes ☐ No
☐ Yes ☐ No	l. A statement identifying all amendments to the RFP issued by the state and received by the bidder. (Note: If no amendments have been received, a statement to that effect shall be included.)	☐ Yes ☐ No

Bidder Check	Requirement	Confirmed by DHS
☐ Yes ☐ No	m. A statement that the bidder certifies in connection with this procurement that:	☐ Yes ☐ No
☐ Yes ☐ No	n. The prices proposed have been arrived at independently, with consultation, communication, or agreement, as to any matter relating to such prices with any other bidder or any competitor for the purpose of restricting competition; and	☐ Yes ☐ No
☐ Yes ☐ 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	☐ Yes ☐ No
☐ Yes ☐ No	p. A statement that the person signing this proposal certifies that he/she is the person in the bidder's organization responsible for or authorized to make decisions regarding the prices quoted and that he/she has not participated and will not participate in any action contrary to items m, n and o	☐ Yes ☐ No
☐ Yes ☐ No	22. If the use of subcontractors is proposed, a statement from each subcontractor must be appended to the transmittal letter signed by an individual authorized to legally bind the subcontractor stating:	☐ Yes ☐ No
☐ Yes ☐ No	a. The general scope of work to be performed by the subcontractor	☐ Yes ☐ No
☐ Yes ☐ No	b. The subcontractor's willingness to perform the work indicated; and	☐ Yes ☐ No
☐ Yes ☐ No	c. The subcontractor's assertion that it does not discriminate in employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap	☐ Yes ☐ No
☐ Yes ☐ No	23. Any request for confidential treatment of information shall also be identified in the transmittal letter, in addition to the specific statutory basis supporting the request and an explanation why disclosure of the information is not in the best interest of the public	☐ Yes ☐ No
☐ Yes ☐ No	24. The name, address and telephone number of the individual authorized to respond tothe Department about the confidential nature of the information (if applicable)	☐ Yes ☐ No
☐ Yes ☐ No	25. Is a completed copy of the Checklist and Cross-References included in Tab 3?	☐ Yes ☐ No
☐ Yes ☐ No	a. Mandatory Requirements Checklist	☐ Yes ☐ No
☐ Yes ☐ No	b. General Requirements Cross-Reference	☐ Yes ☐ No
☐ Yes ☐ No	c. Professional Services Requirements Cross-Reference	☐ Yes ☐ No
☐ Yes ☐ No	26. Is a General Requirements Cross-Reference in Tab 5 included for each Technical Proposal under consideration based upon the sample provided in RFP Section 9?	☐ Yes ☐ No
☐ Yes ☐ No	27. Is a Professional Requirements Cross-Reference in Tab 3 included for each Technical Proposal under consideration based upon the sample provided in RFP Section 9?	☐ Yes ☐ No

Bidder Check	Requirement	Confirmed by DHS
☐ Yes ☐ No	28. Are requirements numbers listed above the paragraph or set of paragraphs for all addressed requirements in?	☐ Yes ☐ No
☐ Yes ☐ No	29. Does information in Tab 9 (Contractor Qualifications) include the following?	☐ Yes ☐ No
☐ Yes ☐ No	a. Description of the Contractor Organization (Section 7.2.9.1)	☐ Yes ☐ No
☐ Yes ☐ No	b. Description of the Contractor Experience (Section 7.2.9.2)	☐ Yes ☐ No
☐ Yes ☐ No	c. Contractor References (Section 7.2.9.3)	☐ Yes ☐ No
☐ Yes ☐ No	d. Signed Felony Disclosures (Section 7.2.9.4)	☐ Yes ☐ No
☐ Yes ☐ No	e. A signed copy of Attachment E (Authorization to Release Information) which authorizes the release of information to the Department	☐ Yes ☐ No
☐ Yes ☐ No	f. A signed copy of Attachment D (Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion – Lower Tier Covered Transactions) which certifies that the bidder is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal, department or agency	☐ Yes ☐ No
☐ Yes ☐ No	g. A signed copy of Attachment C (Certification of Independence and No Conflict of Interest) which certifies that the bid proposal was developed independently, and also certifiers that no relationship exists or will exist during the contract period between the bidder and the Department that interferes with fair competition or is a conflict of interest.	☐ Yes ☐ No
☐ Yes ☐ No	h. A signed copy of Attachment B (Proposal Certifications and Declarations) which certifies that the contents of the bid proposal are true and accurate.	☐ Yes ☐ No
☐ Yes ☐ No	i. A signed copy of Attachment J (Proposal Certification of Available Resources) which certifies that the bidder has sufficient available resources to provide the services proposed in the bid proposal.	☐ Yes ☐ No
☐ Yes ☐ No	j. A statement that stipulates that, with the submitted bid proposal, the bidder acknowledges the acceptance of all terms and conditions stated in the RFP. (Note: If the bidder objects to any term or condition, a specific reference to the RFP page, section, paragraph, and line numbers must be made. Objections or responses that materially alter the RFP shall be deemed nonresponsive and disqualify the bidder.)	☐ Yes ☐ No
☐ Yes ☐ No	k. A written guarantee regarding the availability of the services offered and that all bid proposal terms, including price, will remain firm for at least 120 days after the date set for completion of contract negotiations and execution of the contract.	☐ Yes ☐ No
	Cost Proposal Content	
☐ Yes ☐ No	30. Does the Cost Proposal include the following sections:	☐ Yes ☐ No

Bidder Check	Requirement	Confirmed by DHS
☐ Yes ☐ No	a. Table of Contents (Tab 1)	☐ Yes ☐ No
☐ Yes ☐ No	b. Bid Proposal Security (Tab 2)	☐ Yes ☐ No
☐ Yes ☐ No	c. Pricing Schedules (Tab 3)	☐ Yes ☐ No
☐ Yes ☐ No	31. Does Tab 1 include a Table of Contents of the Cost Proposal?	☐ Yes ☐ No
☐ Yes ☐ No	32. Does the Table of Contents identify all sections, subsections, and corresponding page numbers?	☐ Yes ☐ No
☐ Yes ☐ No	33. Is a proposal bid bond or proposal guarantee in the form of a cashier's check, certified check, bank draft, treasurer's check, bond or a original letter of credit payable to DHS in an amount equal to five percent of the total implementation and operations costs identified by Pricing Schedule A of the Cost Proposal included in Tab 2?	☐ Yes ☐ No
☐ Yes ☐ No	34. Are photocopies of the proposal bid bond included in Tab 2 in all other copies of the Cost Proposal submitted by the bidder?	☐ Yes ☐ No
☐ Yes ☐ No	35. If a bond is used, is it issued by a surety licensed to do business in Iowa?	☐ Yes ☐ No
☐ Yes ☐ No	36. Are pricing schedules as specified in the RFP included in Tab 3?	☐ Yes ☐ No
	COMPANY FINANCIAL INFORMATION	
☐ Yes ☐ No	37. Does the Company Financial Information include audited financial statements (annual reports) for the last 3 years?	☐ Yes ☐ No
☐ Yes ☐ No	38. Does the Company Financial Information include at least three financial references (such as letters from creditors, letters from banking institutions, Dun & Bradstreet supplier reports)?	☐ Yes ☐ No
☐ Yes ☐ No	39. Does the Company Financial Information include a description of other contracts or projects currently undertaken by the bidder?	☐ Yes ☐ No
☐ Yes ☐ No	40. Does the Company Financial Information include a summary of any pending or threatened litigation, administrative or regulatory proceedings or similar matters that could affect the ability of the bidder to perform the required services?	☐ Yes ☐ No
☐ Yes ☐ No	41. Does the Company Financial Information include a disclosure of any contracts during the preceding three year period, in which the bidder or any subcontractor identified in the bid proposal has defaulted? Does it list all such contracts and provide a brief description of the incident, the name of the contract, a contact person and telephone number for the other party to the contract?	☐ Yes ☐ No

Bidder Check	Requirement	Confirmed by DHS
☐ Yes ☐ No	42. Does the Company Financial Information include a disclosure of any contracts during the preceding three-year period in which the bidder or any subcontractor identified in the bid proposal has terminated a contract prior to its stated term or has had a contract terminated by the other party prior to its stated term.?	☐ Yes ☐ No
☐ Yes ☐ No	43. Does the Company Financial Information include the company's five-year business plan that would include the award of the state's contract as part of the work plan?	☐ Yes ☐ No

Attachment M: Sample Cross-Reference

The following table provides a sample of the necessary cross-reference for general and professional services requirements. The bidder is expected to produce a similar table with the same column headings.

Figure 12: RFP Cross-Reference

RFP Requirement	Location of Response in Bid Proposal
6.1.1.1, item a	Section 5.x, pg. yyy
6.2.3.2, item k, number 2	Section 6.y, pg. zzz

Attachment N: Pricing Schedules

This section includes the following pricing schedules for this procurement.

Figure 13: IME Professional Services RFP Attachments

Identifier	Title of Pricing Schedule
N-1	Pricing Schedule Except for Revenue Collections and Estate Recovery Services
N-2	Pricing Schedule for Revenue Collections
N-3	Pricing Schedule for Estate Recovery Services

Attachment N-1

Figure 14: Pricing Schedule, except for Revenue Collections and Estate Recovery Services

Component: _____

Line Item Description	Year 1	Year 2	Year 3	Opt 1	Opt 2	Opt 3	Total
Salaries and Benefits	$	$	$	$	$	$	$
Administrative Overhead	$	$	$	$	$	$	$
Other Costs (itemized in the following rows)	$	$	$	$	$	$	$
Grand Total	$	$	$	$	$	$	$

Attachment N-2

Figure 15: Pricing Schedule for Revenue Collections

Line Item Description	Year 1	Year 2	Year 3	Opt 1	Opt 2	Opt 3	Total
Salaries and Benefits	$	$	$	$	$	$	$
Administrative Overhead	$	$	$	$	$	$	$
Other Costs (itemized in the following rows)	$	$	$	$	$	$	$
Total Fixed Price	$	$	$	$	$	$	$
Contingency	%	%	%	%	%	%	%

NOTE: Please indicate the dollar (threshold) amount of collections to which the contingency fee applies. Contingency fee depends upon an increase of cost avoidance that is double the percentage increase of collections above the threshold. Cost avoidance cannot include those types of costs that are outside this contractor's scope of work, such as Medicare cost avoidance.

Attachment N-3

Figure 16: Pricing Schedule for Estate Recovery Services

Line Item Description	Year 1	Year 2	Year 3	Opt 1	Opt 2	Opt 3	Total
Salaries and Benefits	$	$	$	$	$	$	$
Administrative Overhead	$	$	$	$	$	$	$
Other Costs (itemized in the following rows)	$	$	$	$	$	$	$
Contingency Fee %	%	%	%	%	%	%	%

Attachment O: Sample Contract

The following pages provide a sample of the actual contract that the Department will use with the successful bidders.