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**Technical Proposal
Sanitized Version
Electronic Copy**

Response to Request for Proposal
RFP MED-10-001

**Iowa Medicaid Enterprise
Professional Services**

Medical Services Component

December 10, 2009



FEIN: 42-0992483



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TAB 2 – TRANSMITTAL LETTER (7.2.2)

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1776 West Lakes Parkway
West Des Moines, Iowa 50266-8239
(515) 223-2900
www.ifmc.org

December 10, 2009

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

Subject: IFMC Response to Request for Proposal for Iowa Medicaid Enterprise Professional Services (RFP MED-10-001), Medical Services Component

Dear Ms. Tavegia:

IFMC is submitting the enclosed proposal in response to the Medical Services component of Iowa Medicaid Enterprise Professional Services Request for Proposal, RFP MED-10-001. Our mailing address is 1776 West Lakes Parkway, West Des Moines, Iowa 50266-8239.

The proposal is presented in three volumes:

1. Technical Proposal (original, eight copies and one electronic copy on CD-ROM)
2. Cost Proposal (original, eight copies and one electronic copy on CD-ROM)
3. Company Financial Information (original)

One sanitized version of each volume is also presented, along with a CD-ROM containing an electronic copy of each sanitized version.

I () am an authorized signer for the IME Medical Services contract and I am authorized to make representations, commitments and obligations for IFMC:
, Group Vice President

Electronic Mail Address:
Telephone Number: 515-
Fax Number: 515-

The designated point of contact for the IME Medical Services contract is Andi Dykstra, Senior Director, Medicaid Quality Improvement. Please direct any questions regarding this proposal to
at:

, Senior Director, Medicaid Quality Improvement
Electronic Mail Address:
Telephone Number: 515-
Fax Number: 515-

IFMC is a 501(c)(6) nonprofit corporation, incorporated in the State of Iowa in 1971.

IFMC does not intend to partner with subcontractors for Medical Services.



IFMC affirms it is registered to do business in Iowa. IFMC's corporate charter number is 59194.

IFMC's federal tax identification number is .

IFMC accepts all contract terms and conditions as specified in the RFP. IFMC will comply with said terms and conditions. Our proposal is predicated on acceptance of all terms and conditions stated in the RFP.

IFMC affirms no attempt has been made or will make no attempt to induce any other person or firm to submit or not submit a proposal.

IFMC 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.

IFMC affirms no cost or pricing information has been included in this letter or in IFMC's Technical Proposal.

IFMC has received the following amendments to the RFP issued by the state:

- Amendment 1 – September 30, 2009
- Amendment 2 – October 2, 2009
- Amendment 3 – October 16, 2009
- Amendment 4 – November 12, 2009
- Amendment 5 – November 19, 2009

IFMC affirms 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 any competitor for the purpose of restricting competition. IFMC also affirms 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.

By signing this letter, I () certify that I am authorized to make decisions regarding the prices quoted and have not participated and will not participate in any action contrary to the items listed above.

IFMC's Bid Proposal Security guarantees the availability of the services as described throughout the bid proposal.

IFMC respectfully requests that certain information be considered for confidential treatment. Our request for consideration of confidentiality is being made under Iowa Code Chapter 22.7, Paragraph 6 and Freedom of Information Act (FOIA) Exemption 4 (5 U.S.C. §552(b)(4)). One copy (sanitized version) of each proposal volume is being submitted from which confidential information has been excised.

IFMC Transmittal Letter
 Medical Services

Our request to consider confidential treatment of information, which has been exercised, is based on the following grounds: the information marked confidential pursuant to Iowa Code Section 22.7(6) as contains IFMC proprietary and confidential information, which if released, would give advantage to competitors and serve no public purpose.

IFMC respectfully requests that the following sections be treated as confidential and these sections are marked as containing confidential information in IFMC's response to this RFP:

Section/Pages	Grounds	Explanation
Cost Proposal		
Tab 2 – Bid Proposal Security/all pages	Section 22.7(6)	IFMC Proprietary Information
Tab 3 – Pricing Schedule/all pages	Section 22.7(6)	IFMC Proprietary Information
Company Financial Information		
Audited Financial Statements/pages 3-27	Section 22.7(6)	IFMC Proprietary Information
Financial References/pages 29-32	Section 22.7(6)	IFMC Proprietary Information
Litigation/page 36	Section 22.7(6)	IFMC Proprietary Information
Contract Default/page 36	Section 22.7(6)	IFMC Proprietary Information
Contract Termination/page 36	Section 22.7(6)	IFMC Proprietary Information
IFMC Five Year Business Plan/pages 36-39	Section 22.7(6)	IFMC Proprietary Information
Technical Proposal		
Tab 2/pages 2-5	Section 22.7(6)	IFMC Proprietary Information
Tab 5/pages 32-46, 48, 74	Section 22.7(6)	IFMC Proprietary Information
Tab 7/pages 155, 157, 158, 160-162	Section 22.7(6)	IFMC Proprietary Information
Tab 8/pages 166-190	Section 22.7(6)	IFMC Proprietary Information
Tab 9/pages 195-199, 202-218, 227	Section 22.7(6)	IFMC Proprietary Information

is IFMC's contact person regarding the confidential nature of this information:

IFMC Transmittal Letter
Medical Services

may be reached as follows:

Senior Director, Contracts and Compliance
Electronic Mail Address:
Telephone Number: 515-
Fax Number: 515-

IFMC appreciates the opportunity to continue our successful relationship with the State of Iowa.

Sincerely,

A handwritten signature in black ink that reads "Peg Mason". The signature is written in a cursive, flowing style.

Group Vice President



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TAB 3 - CHECKLIST AND CROSS-REFERENCES (7.2.3)

Bid Proposal Mandatory Requirements Checklist (7.2.3.1)

Bidder Check	Requirement	Confirmed by DHS
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	1. Did the issuing officer receive the bid proposal by 3:00 p.m., Central Time, on the date specified in RFP Section 2.1 Procurement Timetable?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	2. Does each bid proposal consist of three distinct parts?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. Technical Proposal	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. Cost Proposal	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	c. Company Financial Information	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	3. Is each bid proposal sealed in a box (or boxes), with the Cost Proposal and Company Financial Information volumes sealed in separate, labeled envelopes inside the same box or boxes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	4. Are packing boxes numbered in the following fashion: 1 of 4, 2 of 4, and so forth for each bid proposal that consists of multiple boxes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	5. Are all boxes containing bids labeled with the following information?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. Bidder's name and address	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. Issuing officer and department's address as identified by RFP Section 7.1.d.2	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	c. RFP title (Iowa Medicaid Enterprise Professional Services Procurement) and RFP reference number (MED-10-001)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	d. RFP component for which the bid proposal is being submitted for consideration (such as Medical Services or Provider Services)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6. Are separate boxes utilized for each bid proposal if submitting bid proposals for more than one of the individual contract awards?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	7. Are all bid proposal materials printed on 8.5" x 11" paper (two-sided)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	8. Is Technical Proposal presented in a spiral, comb, or pasteboard binder separate from the sealed Cost Proposal and Company Financial Information volumes? (Note: Technical Proposals in 3-ring binders will not be accepted.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	9. Is each Cost Proposal in a spiral, comb, or pasteboard binder separate from the sealed Technical Proposal and Company Financial Information volumes? (Note: This status will be determined when Cost Proposals are opened after Technical Proposals have been evaluated. 3-ring binders will not be accepted.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	10. Is each Company Financial Information in a spiral binder, or comb, or pasteboard binder separate from the sealed Technical Proposal and Cost Proposal volumes? (Note: This status will be determined when Company	<input type="checkbox"/> Yes <input type="checkbox"/> No



	Financial Information volumes are opened for the financial viability screening. (3-ring binders will not be accepted)	
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	11. Is one sanitized copy of the proposal volumes and Company Financial Information included if any bid proposal information is designated as confidential? (Note: Bidders cannot designate their entire proposal as confidential or proprietary.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	12. Does each Technical Proposal package include:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. One original	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. Eight copies	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	c. One sanitized copy (if applicable) in a separate binder (or set of binders)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	d. Are the original, copies, and sanitized copy correctly marked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	13. Does each Cost Proposal package include:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. One original	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. Eight copies	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	c. One sanitized copy of Cost Proposal in separate, sealed envelope	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	d. Are the original, copies and sanitized copy correctly marked?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	14. Does each Company Financial Information package contain one original of Company Financial Information (in a separate sealed envelope)? (Note: This status will be determined when Company Financial Information volumes are opened for the financial viability screening.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	15. Are all bid proposals also submitted on CD ROM copies per bid proposal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	16. Does one submitted CD-ROM contain one full version of the Technical and Cost Proposal and the other submitted CD contain one sanitized version of the Technical and Cost Proposal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	17. Are all electronic files in PDF format?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	18. Are all electronic files individually identified by:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. Component name	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. Bid proposal part (technical, cost, or company financial information)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	c. Status (original, copy or sanitized)	<input type="checkbox"/> Yes <input type="checkbox"/> No



Technical Proposal Content		
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	19. Does each Technical Proposal consist of the following sections separated by tabs with associated documents and responses presented in the following order?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. Table of Contents (Tab 1)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. Transmittal Letter (Tab 2)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	c. Checklists and Cross-References (Tab 3)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	d. Executive Summary (Tab 4)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	e. General Requirements (Tab 5)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	f. Professional Services Requirements (Tab 6)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	g. Project Plan (Tab 7)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	h. Project Organization (Tab 8)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	i. Corporate Qualifications (Tab 9)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	20. Does the Table of Contents in Tab 1 of the Technical Proposal identify all sections, subsections, and corresponding page numbers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	21. Does the Transmittal Letter in Tab 2 include the following?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. The bidder's mailing address	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. Electronic mail address, fax number, and telephone number for both the authorized signer and the point of contact designated by the bidder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	c. A statement indicating that the bidder is a corporation or other legal entity	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	d. Identification of all subcontractors and a statement included that indicates the exact amount of work to be done by the prime contractor and each subcontractor, as measured by a percentage of the total work?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	e. No actual price information	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	f. A statement confirming that the prime contractor is registered or agrees to register to do business in Iowa and providing the corporate charter number (if currently issued), along with assurances that any subcontractor proposed is also licensed or will become licensed to work in Iowa	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	g. A statement identifying the bidder's federal tax identification number	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	h. A statement that the bidder will comply with all contract terms and conditions as indicated in this RFP	<input type="checkbox"/> Yes <input type="checkbox"/> No



Medical Services – Technical Proposal
 IFMC Response to the Iowa Department of Human Services
 Iowa Medicaid Enterprise Professional Services – RFP MED-10-001

<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	i. A statement that no attempt has been made or will be made by the bidder to induce any other person or firm to submit or not to submit a proposal	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	j. A statement of affirmative action that the bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	k. A statement that no cost or pricing information has been included in this letter or the Technical Proposal	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	l. A statement identifying all amendments to the RFP issued by the state and received by the bidder. (Note: If no amendments have been received, a statement to that effect shall be included.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	m. A statement that the bidder certifies in connection with this procurement that:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	n. The prices proposed have been arrived at independently, with consultation, communication, or agreement, as to any matter relating to such prices with any other bidder or any competitor for the purpose of restricting competition; and	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	o. Unless other wise required by law, the prices quoted have not been knowingly disclosed by the bidder prior to award, directly or indirectly, to any other bidder or to any competitor	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	p. A statement that the person signing this proposal certifies that he/she is the person in the bidder's organization responsible for or authorized to make decisions regarding the prices quoted and that he/she has not participated and will not participate in any action contrary to items m, n and o	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	q. A statement that the submitted Bid Proposal Security shall guarantee the availability of the services as described throughout the bid proposal.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	r. A statement that the bidder acknowledges the acceptance of all terms and conditions stated in the RFP.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	22. If the use of subcontractors is proposed, a statement from each subcontractor must be appended to the transmittal letter signed by an individual authorized to legally bind the subcontractor stating:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. The general scope of work to be performed by the subcontractor	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. The subcontractor's willingness to perform the work indicated; and	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	c. The subcontractor's assertion that it does not discriminate in employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	23. Any request for confidential treatment of information shall also be identified in the transmittal letter, in addition to the specific statutory basis supporting the request and an explanation why disclosure of the information is not in the best interest of the public	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	24. The name, address and telephone number of the individual authorized to respond to the Department about the confidential nature of the information (if applicable)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	25. Is a completed copy of the Checklist and Cross-References included in Tab 3?	<input type="checkbox"/> Yes <input type="checkbox"/> No



<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. Mandatory Requirements Checklist	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. General Requirements Cross-Reference	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	c. Professional Services Requirements Cross-Reference	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	26. Is a General Requirements Cross-Reference in Tab 3 included for each Technical Proposal under consideration based upon the sample provided in RFP Section 9?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	28. Are requirements numbers listed above the paragraph or set of paragraphs for all addressed requirements in?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	29. Does information in Tab 9 (Contractor Qualifications) include the following?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. Description of the Contractor Organization (Section 7.2.9.1)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. Description of the Contractor Experience (Section 7.2.9.2)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	c. Contractor References (Section 7.2.9.3)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	d. A signed copy of each of Attachments B through J inclusive of signature from an individual authorized to bind the company.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cost Proposal Content		
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	30. Does the Cost Proposal include the following sections:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	a. Table of Contents (Tab 1)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	b. Bid Proposal Security (Tab 2)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	c. Pricing Schedules (Tab 3)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	31. Does Tab 1 include a Table of Contents of the Cost Proposal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	32. Does the Table of Contents identify all sections, subsections, and corresponding page numbers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	33. Is a proposal bid bond or proposal guarantee in the form of a cashier's check, certified check, bank draft, treasurer's check, bond or a original letter of credit payable to DHS in an amount equal to five percent of the total implementation and operations costs identified by Pricing Schedule N of the Cost Proposal included in Tab 2?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	34. Are photocopies of the proposal bid bond included in Tab 2 in all other copies of the Cost Proposal submitted by the bidder?	<input type="checkbox"/> Yes <input type="checkbox"/> No



<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	35. If a bond is used, is it issued by a surety licensed to do business in Iowa?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	36. Are pricing schedules as specified in the RFP included in Tab 3?	<input type="checkbox"/> Yes <input type="checkbox"/> No
COMPANY FINANCIAL INFORMATION		
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	37. Does the Company Financial Information include audited financial statements (annual reports) for the last 3 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	38. Does the Company Financial Information include at least three financial references (such as letters from creditors, letters from banking institutions, Dun & Bradstreet supplier reports)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	39. Does the Company Financial Information include a description of other contracts or projects currently undertaken by the bidder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	40. Does the Company Financial Information include a summary of any pending or threatened litigation, administrative or regulatory proceedings or similar matters that could affect the ability of the bidder to perform the required services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	41. Does the Company Financial Information include a disclosure of any contracts during the preceding three year period, in which the bidder or any subcontractor identified in the bid proposal has defaulted? Does it list all such contracts and provide a brief description of the incident, the name of the contract, a contact person and telephone number for the other party to the contract?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	42. Does the Company Financial Information include a disclosure of any contracts during the preceding three-year period in which the bidder or any subcontractor identified in the bid proposal has terminated a contract prior to its stated term or has had a contract terminated by the other party prior to its stated term.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	43. Does the Company Financial Information include the company's five-year business plan that would include the award of the state's contract as part of the work plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No



General Requirements Cross-Reference (7.2.3.2)

RFP Requirement	Location of Response in Bid Proposal
6.1, item f, g, h, j, k	Tab 5, Pages 25 – 26
6.1, item a	Tab 5, Page 26
6.1, item b, c, o, p	Tab 5, Pages 26 – 28
6.1, item d, e, l, q	Tab 5, Pages 28 – 29
6.1.1	Tab 5, Page 30
6.1.1.1, item a, b, c, d	Tab 5, Pages 30
6.1.1.1.2	Tab 5, Page 32 – 42
6.1.1.1.3	Tab 5, Page 32 – 42
6.1.1.1.4, item a, b, c, d	Tab 5, Page 43 – 45
6.1.1.1.5, item a	Tab 5, Page 43 – 45
6.1.1.2, item a, b, c, d	Tab 5, Page 45 – 46
6.1.2	Tab 5, Pages 46
6.1.2.1	Tab 5, Pages 46 – 47
6.1.2.1.2, item a, b, c, d	Tab 5, Page 47 – 48
6.1.2.2, item a, b	Tab 5, Page 48
6.1.3	Tab 5, Page 49
6.1.3.1, item a, b	Tab 5, Pages 49 – 50
6.1.3.3, item s	Tab 5, Pages 49 – 50
6.1.3.1, item c	Tab 5, Pages 50 – 55
6.1.3.3, item a, b, c	Tab 5, Page 55
6.1.3.3, item d, e	Tab 5, Pages 55 – 56
6.1.3.3, item e, f	Tab 5, Page 56
6.1.3.3, item g, h, i	Tab 5, Page 56 – 57
6.1.3.3, item q, r	Tab 5, Pages 57 – 58
6.1.3.3, item j	Tab 5, Pages 58 – 59
6.1.3.3, item k, l, m, n, o, p	Tab 5, Pages 50 – 55
6.1.3.4	Tab 5, Page 59 – 65
6.1.3.4.1, item a	Tab 5, Pages 59 – 65
6.1.3.4.2, items a, b, c	Tab 5, Pages 59 – 65
6.1.3.4.3, items a & b	Tab 5, Pages 59 – 65
6.1.3.4.3.1, items a & b	Tab 5, Pages 59 – 65
6.1.4, item a, b, c	Tab 5, Pages 65 – 67
6.1.5, item a, b, c, d	Tab 5, Page 67
6.1.6, item a, b, c, d	Tab 5, Pages 67 – 69
6.1.7, item a, b	Tab 5, Page 69
6.1.8, item a, b, c	Tab 5, Page 70
6.1.9, item a, b	Tab 5, Pages 70 – 71
6.1.10, item a	Tab 5, Page 71
6.1.12, item a	Tab 5, Page 72
6.1.13, item a, b, c, d	Tab 5, Page 72 – 73
6.1.14, item a, b	Tab 5, Page 73



Professional Services Requirements Cross-Reference (7.2.3.3)

RFP Requirement	Location of Response in Bid Proposal
6.2	Tab 6, Page 74
6.2.1	Tab 6, Page 74
6.2.1.2 , items a, 1, 2, 3, 4	Tab 6, Pages 74 – 75
6.2.1.2, item b	Tab 6, Pages 75 – 76
6.2.1.2, item c	Tab 6, Pages 76 – 77
6.2.1.2, item d	Tab 6, Page 77 – 80
6.2.1.2, item e	Tab 6, Page 80
6.2.1.2, item f	Tab 6, Page 80
6.2.1.2, item g	Tab 6, Page 81
6.2.1.2, item h	Tab 6, Page 81
6.2.1.2, item i	Tab 6, Page 81
6.2.1.2, items j, 1, 2, 3, 4, 5, 6, 7, 8, 9 , 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 21,23, 24, 25, 26, 27, 28, 29, 30, 31	Tab 6, Page 82
6.2.1.2, item k	Tab 6, Pages 83 – 84
6.2.1.2, item l	Tab 6, Page 84
6.2.1.2, item m	Tab 6, Page 84
6.2.1.2, item n	Tab 6, Page 84
6.2.1.2, item o	Tab 6, Page 85
6.2.1.2, item p	Tab 6, Page 85 – 86
6.2.1.2, item q	Tab 6, Page 86 – 87
6.2.1.2, item r	Tab 6, Page 87
6.2.1.2, item s	Tab 6, Page 87
6.2.1.2, item t	Tab 6, Pages 88
6.2.1.2, item u	Tab 6, Page 88 - 89
6.2.1.2, item v	Tab 6, Pages 89 – 90
6.2.1.2, item w	Tab 6, Page 91 – 92
6.2.1.2, item x	Tab 6, Pages 92
6.2.1.2, item y	Tab 6, Page 93 – 94
6.2.1.2, items z, 1, 2, 3, 4, 5	Tab 6, Pages 94 – 95
6.2.1.2, item aa	Tab 6, Page 96
6.2.1.2, item bb	Tab 6, Page 96
6.2.1.2, item cc	Tab 6, Page 96
6.2.1.3	Tab 6, Pages 96
6.2.1.3, item a	Tab 6, Pages 96 – 97
6.2.1.3, item b	Tab 6, Page 96 – 97
6.2.1.3, item c	Tab 6, Page 97
6.2.2	Tab 6, Page 97
6.2.2, item a	Tab 6, Page 98



RFP Requirement	Location of Response in Bid Proposal
6.2.2, item b	Tab 6, Page 98
6.2.2.2	Tab 6, Page 98
6.2.2.2, items a, 1, 2, 3, 4	Tab 6, Pages 98 – 99
6.2.2.2, items b, 1, 2, 3, 4, 5	Tab 6, Page 100
6.2.2.2, item c	Tab 6, Page 101
6.2.2.2, item d	Tab 6, Pages 101 – 102
6.2.2.2, item e	Tab 6, Pages 102 – 103
6.2.2.2, item f	Tab 6, Pages 102 – 103
6.2.2.2, item g	Tab 6, Pages 103 – 104
6.2.2.2, item h	Tab 6, Page 104
6.2.2.2, item i	Tab 6, Pages 103 – 104
6.2.2.2, item j	Tab 6, Page 104
6.2.2.2, item k	Tab 6, Page 104
6.2.2.2, item l	Tab 6, Page 105
6.2.2.3	Tab 6, Page 105
6.2.2.3, item a	Tab 6, Page 105
6.2.2.3, item b	Tab 6, Page 105
6.2.2.3, item c	Tab 6, Page 105
6.2.2.3, item d	Tab 6, Page 105
6.2.2.3, item e	Tab 6, Page 106
6.2.2.3, item f	Tab 6, Page 106
6.2.3, items a, b, c, d	Tab 6, Page 106
6.2.3	Tab 6, Page 106
6.2.3.2, items a, 1, 2, 3, 4	Tab 6, Page s 106 – 107
6.2.3.2, item b	Tab 6, Page 107
6.2.3.2, item c	Tab 6, Page 108
6.2.3.2, item d	Tab 6, Pages 108 – 109
6.2.3.2, item e	Tab 6, Page 109
6.2.3.2, item f	Tab 6, Page 109
6.2.3.2, item g	Tab 6, Page 109
6.2.3.2, item h	Tab 6, Pages 109 – 110
6.2.3.2, item i	Tab 6, Page 110
6.2.3.2, item j	Tab 6, Page 110
6.2.3.2, item k	Tab 6, Page 110
6.2.3.2, item l	Tab 6, Pages 110 – 111
6.2.3.2, item m	Tab 6, Pages 110 – 111
6.2.3.2, item n	Tab 6, Page 111
6.2.3.2, item o	Tab 6, Page 111
6.2.3.2, item p	Tab 6, Page 111
6.2.3.2, item q	Tab 6, Page 111
6.2.3.2, item r	Tab 6, Page 111



RFP Requirement	Location of Response in Bid Proposal
6.2.3.2, item s	Tab 6, Pages 111
6.2.3.2, item t	Tab 6, Page 111 – 112
6.2.3.2, items u, 1, 2, 3, 4, 5, 6, i, ii, iii, iv, vi, vii, viii, ix, x, xi, xii, xiii, xiv, xv, xvi, 7	Tab 6, Pages 112 – 113
6.2.3.2, item v	Tab 6, Page 113
6.2.3.2, items x, 1, 2, 3, 4	Tab 6, Pages 1113 – 114
6.2.3.3	Tab 6, Page 114
6.2.3.3, item a	Tab 6, Page 115
6.2.3.3, item b	Tab 6, Page 115
6.2.3.3, item c	Tab 6, Page 115
6.2.4	Tab 6, Page 116
6.2.4.2, items a, 1, 2, 3, 4	Tab 6, Pages 116 – 117
6.2.4.2, item b	Tab 6, Pages 117 – 118
6.2.4.2, item c	Tab 6, Pages 118 – 121
6.2.4.2, item d	Tab 6, Pages 121 – 122
6.2.4.2, item e	Tab 6, Page 122
6.2.4.2, item f	Tab 6, Pages 122 – 123
6.2.4.2, items g, 1, 2, 3, 4, 5	Tab 6, Pages 123 – 127
6.2.4.2, items h, 1, 2	Tab 6, Pages 128 – 129
6.2.4.2, items i, 1, 2, 3, 4	Tab 6, Pages 129 – 130
6.2.4.2, item j	Tab 6, Page 130
6.2.4.2, item k	Tab 6, Page 131
6.2.4.2, items l, 1, 2, 3, 4, 5, 6	Tab 6, Pages 131 – 132
6.2.4.2, item m	Tab 6, Page 132
6.2.4.2, items n, 1, 2, 3, 4, 5, 6	Tab 6, Page 133
6.2.4.2, items o, 1, 2, 3, 4, 5	Tab 6, Page 134
6.2.4.2, item p	Tab 6, Page 135
6.2.4.2, items q, 1, 2, 3, 4	Tab 6, Pages 135 – 136
6.2.4.2, item r	Tab 6, Page 136
6.2.4.2, item s	Tab 6, Page 136
6.2.4.2, item t	Tab 6, Page 136
6.2.4.3	Tab 6, Page 137
6.2.4.3, item a	Tab 6, Page 137
6.2.4.3, item b	Tab 6, Page 137
6.2.4.3, item c	Tab 6, Page 137
6.2.4.3, items e, 1, 2, 3	Tab 6, Pages 137 – 139
6.2.4.3, items f, 1, 2, 3	Tab 6, Pages 137 – 139
6.2.5	Tab 6, Page 140
6.2.5.2, items a, 1, 2, 3	Tab 6, Page 140 – 141
6.2.5.2, items b, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11	Tab 6, Pages 141 – 142



RFP Requirement	Location of Response in Bid Proposal
6.2.5.2, item c	Tab 6, Page 142
6.2.5.2, item d	Tab 6, Page 142
6.2.5.2, item e	Tab 6, Page 143
6.2.5.2, items f, 1, 2, 3, 4, 5, 6, 7, 8, 9	Tab 6, Pages 143 – 144
6.2.5.2, item g	Tab 6, Page 144
6.2.5.2, item h	Tab 6, Page 145
6.2.5.2, item i	Tab 6, Page 145
6.2.5.2, item j	Tab 6, Page 145 – 146
6.2.5.2, item k	Tab 6, Page 145 – 146
6.2.5.2, item l	Tab 6, Page 146
6.2.5.3, items a, b	Tab 6, Page 146
6.2.6	Tab 6, Page 146
6.2.6.2, item a	Tab 6, Pages 146 – 147
6.2.6.2, item b	Tab 6, Pages 147 – 148
6.2.6.2, item c	Tab 6, Page 149
6.2.6.2, item d	Tab 6, Page 149
6.2.6.2, item e	Tab 6, Page 149
6.2.6.2, item f	Tab 6, Page 150



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TAB 4 - EXECUTIVE SUMMARY (7.2.4)

Collective Overview

IFMC is pleased to present this proposal in response to the Medical Services component of the Department's Iowa Medicaid Enterprise (IME) Professional Services Request for Proposal (MED-10-001). We are excited about the opportunity to continue our work with the Department as the IME Medical Services contractor.

IFMC has been involved in Medicaid medical review activities since 1979. We have been a trusted partner with the Department for over 30 years. These activities, while traditionally focused on utilization management and oversight programs, have expanded over the years to include a wide variety of care management and quality improvement efforts. We have established a good working relationship with Department policy specialists, IME vendors, other state agencies, and stakeholder organizations. In addition, we have become a trusted source of information and help for Medicaid members throughout the state. In 2008 we expanded our Medicaid work to serve Medicaid members in Oklahoma. Our work there includes comprehensive care management and quality improvement programs.

IFMC is in the process of seeking URAC accreditation for our IME activities. Nationwide, many federal and state agencies recognize the value of URAC accreditation in the deployment of standardized best practices, promotion of cost-efficient review procedures, and ensuring quality health care.

IFMC continually monitors trends in medical management and evaluates new approaches for suitability in the programs we manage. We have identified several organizations that provide information relevant to Medicaid population health management, which have proven to be particularly useful in identifying or stimulating innovative methods and ideas for program improvement. Examples of these resources include:

- The Center for Health Care Strategies
- National Association of State Medicaid Directors
- The Rand Corporation
- The Commonwealth Fund
- The Kaiser Family Foundation
- The National Governors' Association, Center for Best Practices
- Improving Chronic Illness Care

As the current Medical Services vendor, we have met or exceeded performance standards of our current contract and are committed to continuing high quality work for the Department. As an Iowa-based company, we are knowledgeable about the local environment and committed to improving the quality of health care for all Iowa residents. Our efforts to monitor trends in medical management and innovate the programs we manage combined with our institutional knowledge regarding Iowa health care and Iowa Medicaid provides the Department with a framework for success. The ROI provided to the State of Iowa under the current Medical Services contract demonstrates this success:



IFMC – IME Medical Services ROI			
SFY	State Savings	State Costs	Dollars Saved per Dollar Spent
2006	\$6,783,312	\$1,597,039	\$4.25
2007	\$9,785,720	\$1,562,194	\$6.26
2008	\$17,201,311	\$2,183,559	\$7.88
2009	\$28,644,415	\$2,613,031	\$10.96

Monitoring industry trends and continuous innovations in programs provides the Department with a framework for success.

The programs we have proposed for the new contract period will continue this trend.

Our IME Medical Services management team has more than 30 years of combined experience with developing, implementing and operating Medicaid utilization and quality management programs. Our knowledgeable and tenured staff have well-established working relationships with Department personnel and other IME vendors. Our experience with the Department’s Medicaid Management Information System (MMIS), OnBase workflow, OnBase Workview, Individualized Services Information System (ISIS), and Cisco telephone systems will help ensure a smooth transition to the new contract without the need for a protracted learning curve.

As the Medical Services contractor, we have worked with members, physicians, hospitals, nursing facilities, Intermediate Care Facilities for Mental Retardation (ICF/MR) and other providers to ensure members get the right care, at the right time, and at the right place. Our programs help safeguard the integrity of the Medicaid program by ensuring payment is made only for medically necessary services.

Features and Benefits

IFMC offers a comprehensive program for providing IME Medical Services. Our proposed approach includes many unique operational features that will directly benefit the Department. A summary of the features and benefits is provided below:

Features offered by IFMC	Benefits to DHS
➤ Long term highly experienced vendor with full understanding of IME operations and objectives	➤ Seamless implementation of new contract and effective program operations
➤ Experienced tenured staff	➤ Demonstrated collaborative, effective contractor in the complex IME environment
➤ Comprehensive clinical management tool (CaseNet TruCare™)	➤ Application of evidence based guidelines to inform appropriate care determinations
➤ ClearCoverage program	➤ Application of evidence-based guidelines to authorize high cost medical imaging
➤ Comprehensive end-to-end program with no subcontractors	➤ Minimizes operational risk



Features offered by IFMC	Benefits to DHS
➤ Predictive modeling	➤ Improved targeting of program interventions for members most in need
➤ Stable and tenured leadership team in place	➤ Minimal transition costs; preservation of institutional knowledge
➤ Consistently meet or exceed performance standards specified by the state	➤ Effective program operations, increased program impact
➤ Long history of adding value to IME Operations beyond basic program requirements	➤ Positive ROI resulting from program activities
➤ Established approaches to ensure operational processes stay current with best practices	➤ Continuous quality improvement in program activities
➤ Medicare QIO	➤ Enhanced Federal match for program operating costs

Overview of Services

We are proposing a comprehensive end-to-end program for the Medical Services component of the IME contract, without the need for any subcontractors.

We have demonstrated experience in managing the operational programs included in the Medical Services contract which has been demonstrated by meeting or exceeding all performance measures. Our utilization and quality management programs are evidence-based to ensure appropriate care in the appropriate setting. Nurse reviewers use established national criteria and Department approved criteria to make initial review determinations. An experienced physician assistant makes level of care determinations and provides pre-procedure approval. This clinical assistant to our medical director also conducts research for the medical director for use in evaluation denials. Our medical director, as well as our panel of medical peer reviewers, will provide final denial determinations and provide expert testimony at appeal hearings when necessary.

Over the past five years, IFMC has been a partner with the Department working on numerous medical assistance programs. We have a comprehensive understanding of the complexity of medical assistance programs and eligibility requirements. We interact with the Medicaid policy staff, personnel in other Department divisions and other IME vendors. We have established positive working relationships with all entities.

IFMC has brought efficiencies and innovative changes to the IME Medical Services program. These enhancements have supported continuing increases in costs savings and also ensure appropriate, quality health care for Iowa’s Medicaid members. We will continue to monitor industry trends and best practices to further add value to IME.



Examples of enhancements implemented in the current contract period follow:

Program Component	Enhancement/Innovation
Prior Authorization (PA) Imagery	Implementation of a web-based approval software to decrease response time for imagery PAs
Remedial Progress Note Review	After several years of quality review and provider education, implemented a recoupment program based on documented non-compliance, returning \$66,968 to the Department from October 2008 through June 2009
Institutional Quality Review	Implemented requirements of 42 CFR 456 to ensure Department compliance with federal mandates
All-inclusive Care for the Elderly (PACE)	Developed and implemented PACE level of care criteria and quality review to ensure compliance with CMS waiver requirements
Long Term Care (LTC)	Developed and implemented a level of care certification form to ensure accurate and appropriate information for assessment is collected in the initial level of care (LOC) determination request which eliminated the frequent need to conduct provider follow-up which resulted in delays in establishing LOC

In preparation for the new contract, IFMC has developed a comprehensive project plan that identifies all responsibilities including deliverables and milestones. This plan includes the transition plan, operations plan, and turnover plan. As the current contractor, there will be minimal tasks included in the transition phase.

Integration with Member Services

IFMC is submitting proposals for both the Medical Services and Member Services components of the IME contract. The institutional and program knowledge of our Medical Services leadership team will be leveraged to benefit Member Service activities and help provide a more efficient and coordinated program for the Department.

Coordination and integration of these two components will provide several operational advantages:

- Shared knowledge among our leadership teams in both Medical Services and Member Services will be leveraged to mitigate risks during the transition phase of the contract as well as during program operations.
- Our Medical Services staff will benefit from a close affiliation with Member Services staff. Following identification of utilization concerns of Medicaid members, we can seamlessly refer to Member Services care management and/or lock-in programs.
- The quality of care program conducted by Medical Services and member enrollment activities managed by Member Services will provide opportunities for collaboration and enhancement of the quality of care received by Medicaid members through the MediPASS program.



- Both units will share use of the IFMC's comprehensive care management system as well as our predictive modeling application. Sharing software and resources to manage these applications will increase the efficiency of both the Medical Services and Member Services units.

Value Adds

Over the past five years, IFMC has worked closely with the Department on numerous medical assistance programs. We have a thorough understanding of the complexity of medical assistance programs and eligibility requirements. We have a track record of providing high quality assistance to the Department on special projects such as the Foster Care study group, Medicaid Integrity Group (MIG) audits, and identification of complex care needs of Medicaid members with a diagnosis of intellectual disability.

We have tenured staff, particularly in management, and a track record of being below industry norms for staff turnover. Our 2009 corporate employee turnover was 20.9 percent, which is significantly below the rate of health services organizations.

Quality improvement is embedded in the culture of IFMC. All staff are proactive in identifying opportunities for improvement in program operations. The efficiencies our staff have identified and implemented through our process improvement model include reductions in paper and postage for the Department as well as decreased costs related to specific procedure utilization review. In compliance with URAC standards, we maintain no less than two quality improvement projects at all times focusing on the quality of care received by Medicaid members.

IFMC will use the CaseNet TruCare™ Care Management system for all care management activities. The real-time reporting and analysis tools in the system will allow the Department to perform state-initiated queries within the database using an easy-to-use point-and-click interface designed for non-technical users. This will help the Department ensure that members are receiving optimum quality of care in the most cost-effective manner. To enable real-time visibility, data is captured within the system in a structured format that ensures extensive clinical and operational reporting.

IFMC will use the ClearCoverage system for prior authorization of medical imaging. This system allows providers to request imagery PA through a web portal which eliminates provider hassle and streamlines the authorization process. Utilizing evidence-based criteria and a question and answer-style decision support system allows for approval of authorizations within minutes.

Understanding of IME

IME is a complex, interconnected system of contractors, state staff, information technology and communications infrastructure all working together to manage the health care needs of Medicaid members in the State of Iowa. The structure of the current procurement separates IME functions into two basic groups – systems and professional services.



In terms of service delivery, many of Iowa’s Medicaid members receive their care under a fee-for-service program yet the IME is based on a managed care model. This approach provides the Department with the ability to effectively manage the health and the costs of healthcare for the Medicaid population in Iowa. IME provides a framework that helps the State achieve significant cost savings and measurable changes in health outcomes. These advantages result from:

- Improved efficiency – system-side coordination of vendors working together using common and integrated tools to improve program activities, operational efficiency and program coordination
- Improved effectiveness – the Department receives state-of-the-art programs from “best of breed” vendors

Improved health status – effectively managing the health of the Medicaid population results in improved health status for individual members. A healthier population uses fewer and more appropriate healthcare resources and is less expensive over time.

As seven IME vendors and the Department co-located in common work space, we learned to effectively work together to get things done. Along the way, many processes were established that improved operational efficiency and program impact. All vendors learned early on that even small changes in the process used by one vendor could have unforeseen consequences for another vendor.

The Department focuses on the larger picture of member, provider and stakeholder needs and directs the policies and operations of IME. Policy Specialists for each program determine the parameters for vendor activities. IFMC has effectively worked with Department representatives and other state agencies for many years including the last five years at IME. IFMC has formed many partnerships and collaborative relationships with other state government departments and stakeholder organizations. Selected partnerships are highlighted in the following table:

Partner	Activities and Collaborations
Iowa Department of Inspections and Appeals	<ul style="list-style-type: none"> ➤ Cooperation between 42 CFR 456 and licensure and certification ➤ Quarterly meetings with DIA, the Department, and Medical Services
Iowa Department of Public Health	<ul style="list-style-type: none"> ➤ Collaboration on maternal health care management programs (Title V and Title XIX) ➤ Quarterly meetings
University of Iowa	<ul style="list-style-type: none"> ➤ HEDIS to compare quality data for MVM and other quality and utilization reviews
Des Moines University	<ul style="list-style-type: none"> ➤ Evaluation of care management programs
Iowa Health Care Association	<ul style="list-style-type: none"> ➤ Collaboration on accountability measures.
Wellmark	<ul style="list-style-type: none"> ➤ Collaboration on PMIC criteria

Medical Services Project Management

Our approach to project management is based on our extensive experience and incorporates the proven strengths of our project team. This formula provides the highest level of service to our clients and ensures successful project implementation and smooth program operations. We incorporate five proven strategies in our project management plan:

- Our management team is empowered to make rapid and deliberate operational decisions in the field.
- Our team of technical advisors is available for “on-call” assistance with any clinical, operational, organizational, and developmental function throughout the life of the contract. Our technical advisors are among the most experienced individuals in the state in their designated specialties.
- At the foundation of our management approach is a commitment to flexibility and responsiveness that ensures “seamless” operations and project administration. Our work plan is a “living document” designed to accommodate changes as the project unfolds.
- We have made strong philosophical and operational commitments to a process of continuous quality improvement in all operational programs. IFMC will apply this focus on process improvement to all components of the Medical Services contract.
- Successful project management relies on close communication with the client. We will work with the Department as a partner in our project management activities.

We have included project plans for transition, operations, and turnover phases in our proposal. All project plans include detailed steps with timelines and are specific to Medical Services functions. Each project plan addresses:

- Required proficiencies
- Deliverables
- Milestones
- Timelines
- Barriers/risks

The details of our project management plans are provided in Tab 7 of this proposal.

Risk Identification and Mitigation

The Department embarked on a risky adventure five years ago when it established an enterprise composed of the Department and multiple vendors, some of whom were competitors. Although IME has proven itself since then, some of the same start up risks will be evident in this next transition. Risks increase with the selection of new vendors who are not familiar with IME operations and the complex and subtle interactions required to maintain efficient processes. Some current vendors may be leaving, there will likely be contractors entirely new to the IME environment, and some vendors will be taking over operations of former collaborative partners. We will all need to learn how to effectively collaborate with new partners.



As an Iowa based company, we are aware of the operational, financial, and political challenges faced by IME. Our existing relationship with the Department, combined with our long history of working with Iowa health care providers, will enable us to act quickly and appropriately in all situations. Our experience helps reduce the administrative and logistical problems that might otherwise occur.

IFMC’s detailed operational procedures will also mitigate risks. Our tenured processes for Medical Services will avoid interruption of services to members and providers who have established relationships with us.

IFMC considers the regular status meeting with the Department as the most appropriate time to review project operations and discuss problems, accomplishments, and planning issues. We will continue to collaborate with other vendors as needed to discuss relevant issues when they arise. For each status meeting, we will create and distribute a status report document containing “action items” identified at the previous meeting with assigned responsibilities and a summary report of project accomplishments, issues and next steps.

Other potential risks and our proposed mitigation strategies include:

Risks	Mitigation Strategy
<ul style="list-style-type: none"> ➤ System failure; unable to obtain access to health care management system 	<ul style="list-style-type: none"> ➤ Business continuity plans developed as part of each function’s operational procedures ➤ Staff ability to construct access data base and spreadsheet tools for manual tracking
<ul style="list-style-type: none"> ➤ Inability to hire sufficient staff to support all aspects of the program 	<ul style="list-style-type: none"> ➤ Corporate resources focus on intensifying recruitment ➤ Support for non-essential tasks obtained from corporate resources ➤ Re-deployment of staff to address crucial functions
<ul style="list-style-type: none"> ➤ Change in IME vendors 	<ul style="list-style-type: none"> ➤ Experienced account manager and tenured staff to assist in the implementation, operations, and defining interfaces in collaboration with any new vendor for IME



TAB 5 - GENERAL REQUIREMENTS (7.2.5)

General Requirements for all Components (6.1.f, g, h, j, k)

IFMC was established in 1972 to work with healthcare providers, businesses, and federal and state governments to promote the availability of high quality, cost-effective healthcare. The Iowa Department of Human Services (the Department) has contracted directly with IFMC to conduct utilization management, quality management, and care management since 1979. IFMC has formed partnerships and collaborative relationships with Department policy staff, other state government agencies (i.e., Iowa Department of Inspections and Appeals, Iowa Department of Public Health [IDPH]) and private organizations (i.e., Iowa Healthcare Collaborative, Des Moines University, Wellmark) to support the objectives of the Iowa Medicaid program.

Our proposed Medicaid management team has more than 30 years of combined experience developing, implementing, and operating Medicaid utilization, quality, and care management programs. This knowledgeable and tenured team has established highly effective working relationships with numerous Department staff and other IME vendor staff. IFMC has routinely met or exceeded performance standards established by the Department within our current IME contracts.

In our role as the Medical Services vendor, we will continue to manage both general requirements and medical services requirements using formal project plans, including detailed time lines, well-defined communication protocols, documented and regular quality management, and risk management. These components of our proposed solution ensure our ability to meet all contractual requirements in a timely manner. Project management, communication protocols and quality and risk management are defined in detail later in this section and in Tabs 6 and 7 of this proposal.

Providing timely and accurate management reporting is embedded within these various project plans. Reports regarding our activities and performance will be developed to provide both the Department and our IME management team with information critical to monitoring and improving our performance. We will provide suggested reporting formats and data elements to the Department, and will negotiate final format, content and frequency with Department representatives.

We will also develop and maintain records of our performance and activities as required by state and federal regulation and the Medical Services contract. The Department, its representatives and/or designated state and federal auditors will be provided access to these records upon request.

We assure the Department of our continued flexibility and adaptability to changing and unexpected needs. We will respond to Department requests for information and other requests for assistance within the timeframe specified by the Department. Because IFMC's corporate



office is located in West Des Moines, we are able to readily access a broad range of corporate resources when needed to meet the defined and evolving needs of the IME program.

Our corporate staff of approximately 800 employees includes a broad array of care management, quality management and information management professionals. Specific examples include certified project management professionals, health informatics, statistical/data analysis, business requirements planning, information management development, quality assurance, health information technology, implementation and operations, systems security, communication systems, compliance specialist, communications and marketing. All of these resources are available to the Department and the IME management team.

Common IME Location (6.1.a)

IFMC's Medicaid Medical Service's team has co-located at the IME state location for the past five years. The co-location has proved to be immensely valuable in promoting collaboration among vendors and Department staff in all aspects of Medicaid operations and in providing the best quality services for Medicaid members. Because we so clearly understand the inherent value of this seamless delivery, we are fully engaged in continuing the arrangement of common location with other IME vendors and Department administrators and staff.

For example, we noted a consistent increase in the number of provider inquiries received each quarter. This was due to a newly designated provider inquiry process that was not readily available prior to IME implementation. The process of assigning the inquiries to review coordinators based on their area of expertise became time-consuming because of the volume. Due to the familiarity with other vendors gained through our common location, we were able to quickly identify the best points of contact and sources of data to investigate the increasing levels of inquiries. We collaborated with Provider Services staff to better understand the level of resolution they perform prior to routing an inquiry to Medical Services. We then worked with Core and Provider Services to add a provider inquiry type to the case. Provider Services adds this inquiry type before routing the case to Medical Services. This allows our review coordinator to easily respond to inquiries in their area of expertise. This has resulted in a decreased response time for providers.

Another example of efficiencies achieved related to delays in initiating Lock-in restrictions. When this delay was identified, we worked in collaboration with DDM to develop a protocol allowing appropriate Medical Services staff access to SSNI. Our staff members now access SSNI to initiate lock-in restrictions, eliminating the need for another unit to complete data entry.

Coordination and Communication (6.1.b, c, o, p)

IFMC has cooperated and collaborated with all IME vendors and state staff for the past five years to implement and operate the IME. The common location for all IME vendors drastically reduces travel time and meeting expenses. This in turn allows maximum time to focus on essential tasks and enhances our communication with state staff and other IME vendors. The



common workflow process management system also supports effective and efficient communication, as we are able to readily forward all related correspondence and case/inquiry history to state staff or other vendors when necessary. This paperless system eliminates the need for repeated copying of correspondence and documentation.

The communication between Department staff and the other vendors is and will continue to be a priority. As the current Medical Services contractor, we have established communications protocols. Our team members are educated regarding these protocols, and follow established processes and lines of communication for discussions internal to our team, with other vendors and with state staff. This allows all team members to resolve any issues or information needs in as timely a manner as possible. Our management team and staff are fully aware that all interactions must be based on open communication.

All communications protocols and established lines of communication will be reviewed at the onset of the new contract period. As necessary, we will work with the Department and other vendors to ensure that our processes are collaborative and support the open communication needs of all IME parties. Any revisions to protocols and process will be reviewed with our full Medical Services team.

IFMC's Medical Services team will continue to use OnBase to support workflow between our unit, state staff and other IME vendors. All new personnel will receive comprehensive training related to the appropriate use of the OnBase system during their first week of employment.

Our management team will actively participate in routine meetings between vendors and Department staff. We will actively support discussion and sharing of information to review performance, offer suggestions for improvement and resolve issues. Examples of the meetings we will actively support include:

- Bimonthly Pharmacy, Medical Services, and Policy meetings to discuss division of medication PAs.
- Weekly vendor meetings with OnBase staff to discuss changes/concerns in a collaborative effort.
- Monthly account manager and policy staff meetings to discuss new work, performance standards, legislative actions, and other concerns.

During the past five years IFMC has demonstrated our cooperative approach to our work at IME through numerous projects and activities with other vendors, all units, and other stakeholders. Some examples follow:

- Member Services – provision of member educational materials regarding H1N1, vaccines, mammograms, and choice of a primary care provider; implementing a seamless process in Lock-in member enrollment and disenrollment in managed care.
- Provider Services – writing and editing information letters and providing face-to-face provider training resulting in a better understanding of utilization management processes.



- Core – reviewing and updating codes and edits to ensure current coding and edit accuracy through an established process completed on an annual basis.
- SURs - audits of suspected provider misconduct related to waiver certification and data provision for provider feedback.
- Pharmacy Medical – coordinating criteria for similar PAs.
- Point of Sale – co-creating timely override process for providers serving Lock-in members.
- Provider Cost Audits and Rate Setting - assisting in determining medical necessity for specific procedure codes to determine if the provider had billed claims appropriately with regard to home health cost settlements and establishing fees for specific procedures.
- Revenue Collections – pursuit of pay and chase opportunity for recovery of claims paid for Early Periodic Screening, Diagnosis, and Treatment (EPSDT).
- DW/DS – queries and analysis regarding quality improvement opportunities for Medicaid members and Medicaid Value Management.
- Iowa Department of Public Health – maternal health task force and development of maternal health care management program; facilitating claim reports for well child periodicity notifications; smoking cessation.
- Iowa Department of Education – facilitating eligibility reports for Medicaid school based services.
- Wellmark – collaborating on psychiatric medical institution for children (PMIC) and PA activities.
- Des Moines University – implementation of a tele-health program for Medicaid members
- University of Iowa Hospitals and Clinics – HIE exchange, IowaCare activities, routine collaboration on billing issue.
- Broadlawn Medical Center – IowaCare activities.

Data Systems Interface and Support (6.1.d, e, l, q)

During the past five years as the IME Medical Services contractor, IFMC has met all interface requirements with IME data systems. During the implementation phase of IME operations, IFMC collaborated with the Core vendor to develop an effective process flow in OnBase for medical prior authorization. IFMC has continued to enhance processes to make the best use of the OnBase workflow management system. We have implemented numerous additional OnBase workflows, directly interacted with multiple MMIS files and have effectively utilized COLD reports. IFMC staff have effectively communicated with the Core vendor and Department policy specialists to ensure that the IME data systems are accurate and efficient. Since the second year of operations, at the suggestion of the Core vendor, IFMC staff have had direct access to MMIS to support the annual update of procedure codes.



As the Medical Services contractor we intend to continue the necessary interfaces with all Department systems. Anticipated data interfaces and methods for supporting the interface are highlighted in the following table:

System	Data	Method
CaseNet	Data warehouse – Claims, Eligibility, Providers	Secured ftp
CareAnalyzer	Data warehouse – Claims, Eligibility, Providers	Secured ftp
Clear Coverage	MMIS – Eligibility, Prior Authorizations	Manual updates
ISIS	Prior Authorizations	Manual updates
IMERS	Claims	View Only
SSNI	Case information	View Only
MMIS	Claims, Prior Authorizations	Manual updates

IFMC has a strong understanding and a wealth of experience in securely managing and transferring healthcare data, based on our past experiences working with the Department and other IME vendors as well as a number of other federal, state and commercial clients. For example, we currently hold the CMS Physician Quality Reporting Initiative (PQRI) contract. Leveraging our past experience, we will continue to meet IME’s data transfer requirements and standards, and are prepared to support any future initiatives to further advance direct electronic interfaces. IFMC has a robust health data processing engine designed to process, validate, and store data within our system, as well as route data to external systems as needed.

Under our current Medical Services contract, we have used the wealth of information in the IME DW/DS system to enhance our ability to add value to IME. We have worked with DW/DS staff to create data extracts for analytical and reporting needs. Our requests are coordinated by a designated primary contact who has been with IFMC’s Medicaid team for more than 15 years. This designated primary contact will serve as our primary contact for developing queries and requesting assistance from the DW/DS system manager. This primary contact will have access to our broad corporate resources in the event subject matter expertise is required to define data queries and/or conduct statistical or complex analysis.

We will work cooperatively with the Department to proactively identify system changes and to provide notice of system problems. We have, and will continue to designate a single point of contact for all system action memos (SAMs), and change management requests (CMRs). This single point of contact, one of our experienced program managers, has more than eight years experience with Iowa Medicaid and has been a part of our Medical Services team for more than five years. She has a comprehensive understanding of IME systems and data, and will ensure that CMRs and SAMs are appropriate, accurate and complete when submitted to the Department.



STAFFING AND KEY PERSONNEL (6.1.1)

Named Key Personnel (6.1.1.1)

The proposed account manager, transition manager and operations managers are current members of IFMC’s Medical Services management team.

The account manager for Medical Services is _____, RN, CPHQ. With more than 20 years experience with Medicaid programs, _____ is the current Medical Services account manager and has had management and fiscal responsibility for IFMC’s Iowa Medicaid contracts since 1998. She reports directly to _____, group vice president of Quality Management at IFMC and will be responsible for ensuring all contractual obligations are met.

Under _____ leadership as the current account manager, ROI attributable to the Medical Services program has increased from \$5 million in SFY 2006 to \$14 million in SFY 2008.

The role of transition manager and our first operations manager will be filled by _____, LISW. _____ has more than seven years of Medicaid management experience and has been a member of IFMC’s Medical Services management team since the inception of the program. _____ currently manages a significant number of Medical Services programs and supervises all associated staff, including member health education and lock-in, rehabilitative treatment, psychiatric medical institutions for children, claims pre-pay, PA, quality of care, EPSDT, and other medical support services.

The second operations manager position will be filled by an existing member of the IFMC management team. This role will be filled by _____ management team (a group of _____). _____ have been members of our Medical Services team since the inception of IME. This group’s average experience is nearly four years experience with IME Medical Services and more than eight years average Medicaid experience.

_____, MS, CPHQ, is currently an operations manager on our Medical Services management team. _____ has been proposed as the account manager in IFMC’s Member Services proposal. In the event IFMC’s bid for Member Services is unsuccessful, _____ will fill the role of the second operations manager for Medical Services. She has over 11 years of experience working with Medicaid review and quality management programs and has had management and fiscal responsibility for IFMC’s Iowa Medicaid programs since 1998. She served as IFMC’s implementation manager for Medical Services in 2004-2005 and has been an integral part of our IME management team since that time. The experience and qualifications of our second tier management team is highlighted later in this proposal Tab.



Our proposed medical director, _____, MD, FAAP, has committed to join IFMC by contract start date. He will be oriented and trained by _____, DO, IFMC’s current IME Medical Services medical director. _____ has committed to joining IFMC’s Member Services team and has been proposed as the medical director in our Member Services proposal. _____ will provide medical leadership for Medical Services and the IME. He received his MD from the University of Iowa, is board certified in general pediatrics by the American Board of Pediatrics and is a Fellow of the American Academy of Pediatrics. _____ will have the opportunity to work with _____, the current IME medical director for at least 60 days prior to the start of the operations phase of the contract.

Summarized qualifications and other key data regarding proposed key personnel follow:

Key Role and Named Resource	Qualifications	Start Date	Special Requirements
Account Manager	RN, CPHQ 15 years management of Medicaid contracts	Currently employed in position	100 percent dedicated to IME
Transition Manager Operations Manager	LISW 5 years management of Medicaid programs	Currently employed in position	100 percent dedicated to IME
Operations Manager	MS, CPHQ or RN Minimum 2 years IME Medical Services experience	Currently employed by IFMC	100 percent dedicated to IME
Medical Director	MD, FAAP Board Certified in Pediatrics	Currently committed to IFMC; will begin employment a minimum of 60 days prior to start date for the operations period	100 percent dedicated to IME
Medical Director - trainer	DO 6 years experience as medical director for IME	Currently employed in position but will transition to Member Services as of July 1, 2010	100 percent dedicated to Medical Services during 60-day orientation period for

IFMC affirms that its key personnel are committed to the project through at least the first six months of operation. Key personnel will not be reassigned or replaced during this period except in cases of resignation or termination from IFMC, or in the case of death of the named individual.



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EDUCATION

ADDITIONAL TRAINING/CERTIFICATIONS

1998, Certified Professional in Healthcare Quality (CPHQ)

REFERENCES



EMPLOYMENT HISTORY

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EDUCATION

REFERENCES:



EMPLOYMENT HISTORY







EDUCATION

ADDITIONAL TRAINING/CERTIFICATIONS

REFERENCES



EMPLOYMENT HISTORY



EDUCATION

ADDITIONAL TRAINING/CERTIFICATIONS

2008, American Heart ECC Instructor – PALS Instructor Training via University of Iowa
Emergency Medical Services Learning Resource Center

2007, Midwest Regional Children’s Advocacy Center, Basic Medical Training Academy

2007, The Happiest Baby, Certified Educator Program

2006, Society of Developmental and Behavioral Pediatrics, Pediatric Hypnosis Workshop

2003, American Board of Pediatrics

Basic Life Support

Advanced Cardiac Life Support

Pediatric Advanced Life Support, PALS Instructor

Neonatal Resuscitation Program



PROFESSIONAL AFFILIATIONS

REFERENCES

Approval of Key Personnel and Key Personnel Changes (6.1.1.1.4 and 6.1.1.1.5)

All proposed key personnel are existing IFMC Medical Services staff or, in the case of _____, have been interviewed and approved by the Department. As the current Medical Services contractor, we are familiar with and accept the Department's right of prior approval for all proposed key personnel.

IFMC acknowledges any changes in key personnel and/or in the number or distribution of key personnel may only take place with prior approval of the Department.

We also accept the Department's right to approve replacement of key personnel if needed. Our local corporate recruitment team is available to provide direct assistance in the event we need to



replace a key team member. Our corporate recruitment team uses a variety of tools and processes for identifying critical team members including employee referrals, print media, electronic job boards and corporate web page postings. Under this comprehensive approach, we agree to the 45-day timeframe stipulated by the Department for replacement of key personnel.

We will provide periodic status reports to the Department when actively recruiting key personnel. If IFMC is unable to locate a satisfactory replacement for a key personnel position within the 45-day timeframe, we will request an extension from the Department before the end of the 45-day period. The extension request will provide details regarding the plan of action to ensure a qualified and acceptable replacement is quickly identified.

We agree to the Department's right to meet and/or interview all final candidates for named key positions prior to assignment to IME. This meeting will be scheduled at the IME location in Des Moines, Iowa. A resume(s) and references for proposed replacement key personnel will be provided to the Department's representative as well.

When changes in key personnel are required, replacement staff will possess comparable training, experience, and ability to the person(s) originally designated for the position. We will provide a comprehensive orientation program to ensure adequate training for the new key team member. To the greatest extent possible, transition and phase-in of replacement personnel will be supported by the exiting key team member; replacement personnel approved by the Department will be in place and demonstrating competency prior to the departure of the key personnel being replaced.

IFMC will notify the Department at least 15 days prior to any proposed transfer or replacement of key personnel. The notification will be provided in writing to the unit manager. If there are reasons beyond our control where the approval cannot be requested prior to the transfer or termination of the key personnel (such as termination, death or resignation), the account manager will request a waiver from the Department. The account manager and current key personnel team will ensure appropriate training and orientation of replacement personnel in such situations.

When we provide the written notification of a proposed transfer or replacement, we will provide the project director or contract administration with the resume and references for proposed replacement personnel. As requested by the Department, we will schedule an interview/meeting with replacement finalists within a 10-day period after providing information on candidates for the key position.

Additional Staffing Information

IFMC will have _____ for this contract. These program managers are current IFMC employees and are members of the current IME Medical Services management team. As program managers, they hire, train, manage, motivate, and evaluate professional and support staff.



The program managers include:

Program Manager	IME and Medicaid Experience
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A clinical assistant is also employed as part of the IFMC Medical Services team. _____, _____ has worked for IFMC in this capacity for three years and will continue to serve as _____ . _____ is responsible for the first line peer review for all utilization review programs for IME Medical Services. This model provides for an efficient and consistent review for approvals and communication to the medical director for any potential denial.

IFMC’s staffing also includes:

FTEs	Title



Whenever we have vacant positions on the Medical Services team, we will recruit other IME staff who may be displaced by vendor turnover, as well as Department staff who may be displaced as a result of State budget constraints.

All staff are fully trained and/or certified and/or licensed with the skills required to complete their day-to-day responsibilities. Additional training required to complete Medical Service review will be completed timely with ongoing retraining, mentoring, and coaching as needs are identified.

Special Staffing Needs (6.1.1.2)

IFMC policy requires that all professional Medical Services staff carry current licensure for Iowa. Established policy and procedures ensure that appropriate licensure/certification is in place for all appropriate personnel.

We review all medical staff credentials and licensure prior to hiring. Recredentialing is completed every two years and encompasses the same credentialing process. Items requested for validation by the IFMC compliance officer include:

- Curriculum vitae,
- Copy of current license(s),
- Copy of board certification(s) or board eligibility,
- Signed confidentiality statement,
- Signed conflict of interest form,
- W-9 form,
- Copy of liability, and
- Data bank query.

IFMC certifies that it carries sufficient professional liability insurance to meet the requirement for professional medical staff.

IFMC has an established and comprehensive system of cross-training and job rotation that builds a level of redundancy to its operations. Our IME team/staff are familiar with and competent in multiple roles within Medical Services operation. We leverage cross-training and job rotation to ensure all Medical Services functions are fully and consistently executed during the absence of any individual staff member. The job rotation program is targeted not only at providing adequate coverage during vacations and absences, but also promoting understanding of the overall workflow and improving work processes.

Our turnover rate is significantly lower than the national healthcare industry average. We attribute our success in employee retention to a wide variety of benefits and programs designed to meet a diverse workforce. In addition, we promote continued learning, job rotation, and cross-training.



IFMC will provide the Department with names and contact information for IME team members who will perform the functions of time-sensitive positions (i.e., emergent preprocedures, emergent PAs). The designated staff will be fully trained and able to competently and professionally address the responsibilities of the time-sensitive positions they are supporting. In addition there will be assigned, fully trained backup staff for these positions.

The account manager, medical director, and management team will meet weekly (or more often when warranted) to share information to promote continuity and consistency in all IME activities. The meetings include discussion regarding:

- Project activities, problems, and solutions
- Upcoming activities
- Coverage

FACILITIES (6.1.2)

IME Permanent Facilities (6.1.2.1)

As mentioned earlier, we recognize the significant value of co-locating with other vendors and Department staff at the permanent IME facility. This arrangement has proved to be immensely valuable in promoting collaboration among vendors and Department staff in all aspects of Medicaid operations and in providing the best quality services for Medicaid members. Our full Medical Services team, with the exception of field staff, will be located at the permanent facility during the Operations and Turnover phases of the contract. As the current Medical Services vendor, our team will also be located at this facility during transition.

Our estimated staffing for the Medical Services component is as follows:

Position description	Number of staff

We understand that the Department will provide the following accommodations at no cost to the IME professional services vendors:

- Office space for all IME staff (except Medical Services field staff)
- Desks, chairs, and cubicles (except Medical Services field staff)
- Network infrastructure and network connections



- Personal computers
- Telephones and facsimile (fax) machines (except Medical Services field staff, who will receive a voice mailbox)
- Access to photocopiers and copier paper (except Medical Services field staff)
- Access to network printers (except Medical Services field staff)
- Staff licenses as needed for MMIS, OnBase, replacement for Siemens HiPath ProCenter v7.0, Pharmacy POS, and DW/DS applications; standard Microsoft Office packages; and other standard software packages (such as Visio or MS Project) necessary and required based upon job function
- Access to shared conference rooms for meetings among contractor personnel, state staff, providers, and other stakeholders

Other Software, Equipment and Supplies (6.1.2.1.2.a)

IFMC will be using CaseNet TruCare™, a commercially available software product, to conduct utilization and quality management programs for Medical Services. This system has been approved for use by the Medicaid Director. The system will store demographic and clinical information obtained during review, as well as review results and other pertinent information. The Department will have easy access to the electronic data stored in CaseNet TruCare™.

At the time of initial IME operations, IFMC provided personal workstation printers to our staff as needed and signed over ownership to the Department. IFMC will continue this process as required and dictated by business needs.

IFMC provides all general office supplies for its IME personnel, excluding copier paper and envelopes. Office supply needs are supported by IFMC's corporate purchasing staff. Corporate purchasing agreements ensure cost management and on-time provision of supplies.

All special needs equipment, for ergonomics or other purposes, required by Medical Services staff will be provided by IFMC. During the past five years, we have provided ergonomic equipment to Medical Service's staff at no cost to the Department. The ergonomic equipment used by IME Medical Services staff includes, but is not limited to:

- Desk chairs
- Specialized keyboards
- Specialized computing mouse

Courier and Mail Services (6.1.2.2)

We understand that 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.



IFMC will utilize the courier service provided by the Core MMIS contractor. During the past five years we have collaborated with the Core MMIS staff to arrange a pick-up process from Medical Services to ensure necessary documents and materials are delivered to the Capitol complex and the US Post Office in a timely manner. In addition, a process for courier services of PA documents and materials such as dental study models and x-rays, as well as audiology PA documents, are delivered and picked-up at peer reviewer offices two days per week by the Core MMIS courier service. This process decreases the costs for the Department related to postage and ensures timely completion of PAs.

In addition, IFMC has contracted with a delivery service to provide daily courier service between IME and the IFMC corporate office at no direct expense to the Department. This allows for expedited delivery of documents/materials that are mistakenly sent to the corporate office which are needed at IME.

IFMC uses the IME mailroom for all daily mail and small-volume mailings. We have established an effective process that includes routine scheduled small volume mailings and alerts for timely completion of non-routine mailings. We will continue this process in the next contract period.

IFMC Medical Services has collaborated with the IME mailroom to schedule large-volume mailings with identified entities (i.e., MediPASS quality of care mailings to patient managers for utilization, and referral validations). IFMC will continue to work with the Department to identify the most cost-effective way to print and mail large volume mailings.

IFMC will provide a print-ready copy of all documents for printing to the entity selected by the Department for large-volume printing. We currently provide print-ready education materials and brochures to the Hoover print shop for large volume printing.

IFMC understands that the Department pays for all postage and external mailing costs. IFMC does/will not direct charge any mailing costs to the Department.

CONTRACT MANAGEMENT (6.1.3)

We recognize the State of Iowa has mandated performance-based contracts and that payment for our professional services provided as the Medical Services contractor will be tied to meeting performance standards identified in the contract awarded through this RFP. During the past five years, IFMC has routinely submitted monthly, quarterly and annual report cards as tools for oversight by the Department. These reports demonstrate our commitment to providing results to the State of Iowa and the Department.

Performance Reporting (6.1.3.1.a, b and 6.1.3.3.s)

IFMC understands that performance standards outlined in this RFP clearly define the expectations of the Department. During the past five years, IFMC has consistently reported performance results compared to standards defined in the current Medical Services contract.



These performance standards include measured timeliness, accuracy and completeness of numerous operational functions. Our performance standards report card has been submitted within the time frames determined by the Department.

Medical Services Quarterly Scorecard by Functional Area – 4th Quarter SFY 2009

Performance Measurement	Scoring Rules	Possible Points	Points Received
Professional Services			
Report on a quarterly basis to DHS the per member per month and total cost of all services and of each service for each cohort.	Award 5 points if Medical Services reports to Unit Manager by the fifth business day of each quarter that data is or is not available. Otherwise, 0 points are received.	5	5
Provide monthly contract management report within three business days of the end of the reporting period.	Award 95 points if the public report card is submitted to the Medicaid Director on or prior to the date requested. Otherwise, deduct 5 points for each business day submitted late.	95	95
Medical Support		100	100
Notify the provider within three business days of receipt of a claims appeal of incomplete or missing information.	Award 10 points if providers are notified within 5 business days or receipt of a claims inquiry with missing or incomplete information. Otherwise, deduct 1 percentage point for each notification that is sent late, after 95 percent.	10	10
Send the final determination letter on a claims inquiry to the provider within 10 business days of receipt of complete documentation.	Award 25 points if provider is notified with 10 business days. Otherwise, if < 90 percent are completed within 5 business days, then start deducting 2 points for every 1 percent notification is late after 90 percent.	25	25
Process requests for Exception to Policy within 10 business days of receipt unless additional information is requested.	Award 35 points if the ETP is processed within 10 business days once additional information is received. Otherwise, deduct 1 point for each percentage point less than 95 percent.	35	35
Complete retrospective reviews based on criteria developed by the department.	Award 15 points if 90 percent of initial retrospective outpatient reviews are completed within 30 days. Otherwise, deduct 1 point for each day late.	15	15
Complete retrospective reviews based on criteria developed by the department.	Award 15 points if 90 percent of initial retrospective inpatient reviews are completed within 30 days. Otherwise, deduct for each day late.	15	15
Quality of Care		100	100
Provide Quarterly reports within 10 business days of the end of the reporting period.	Award 100 points for providing quarterly reports to DHS within 3 business days of the end of the reporting period after receipt of data. Otherwise, deduct 10 points for every business day after 3 days and receipt of data.	100	100
Overall Totals:		300	300

As demonstrated by the reported results, IFMC successfully met all Performance Standards.

During the initial year of IME operations, we met with the Department to ensure that the performance standards were quantifiable and automated as much as possible. This collaborative effort assisted understanding of requirements and measurement methodologies. Currently, all performance measures are reported either monthly, quarterly and/or annually on report cards and in the quarterly activities report. We will work with the Department and/or its representatives under the new contract to ensure our proposed methodology for measurement and reporting completion of contract requirements and attainment of performance standards meets Department expectations.



In the future contract period of performance, automated reports will be produced through OnBase and CaseNet TruCare™. Again, we will provide suggested reporting formats, data elements and measurement methods to the Department. IFMC will collaborate and negotiate with the Department to ensure final format, content and frequency meet Department needs. We understand the Department may select a subset of the standards for reporting purposes; we will provide all performance reports as requested by the Department. We will maintain complete records documenting our measurement and reporting methodologies and the data and calculations that are the basis for reported performance. These records will be available to the Department upon request.

Our long-term experience with Iowa Medicaid will be a benefit to the Department as we work towards establishing the measures to inform the Department and the public of our performance in key service areas. We apply a continuous quality improvement focus to our work to ensure all expected performance standards are met (this IQC focus is discussed further below).

IFMC understands after the first full year of operations, the Department may apply liquidated damages as a result of the failure to meet the standards. We understand 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. IFMC has never experienced liquidated damages as a result of failure to meet standards with our Iowa Medicaid contracts.

Quality Assurance (6.1.3.1.c and 6.1.3.3.k, l, m, n, o, p)

IFMC is a QIO and quality improvement is a major component of the work we do. A continuous quality improvement focus is part of our organizational culture. We pride ourselves on building proactive improvement into all operations.

We apply an improvement focus to our internal activities and the services we provide to our customers. We continuously measure our performance to validate results, identify the need for corrective actions and identify opportunities for improvement based on analysis of the performance data. We then implement changes designed to achieve and exceed performance standards. This approach to quality improvement is reinforced by our participation in the Malcolm Baldrige National Quality Program for the past three years. The program is globally recognized for organizational performance excellence.

Quality Control

The values that drive IFMC as a leader in health care management also drive our commitment to continuous quality improvement. We continuously measure our own performance, identify opportunities for improvement based on analysis of performance data and implement changes designed for improvement. This approach to ongoing performance monitoring and improvement will be rigorously applied to all activities included in the Medical Services contract.



During the program Transition Phase, we will submit a Project Work Plan that details our quality monitoring and corrective action processes. During the Operations Phase, we will operate under this plan. The information below details our quality assurance and improvement programs.

IFMC Quality Assurance Program

Our quality management policies and procedures provide a systematic approach to addressing quality assessment and process improvement at all levels of our organization to support the IME Medical Services contract. Our procedures outline processes for:

- Annual development of quality management program goals and objectives
- Development of quality indicators for administrative and contract requirements
- Compliance to URAC standards, state and federal regulations
- Data measurement plans for ongoing evaluation and tracking of performance
- Implementation of quality improvement projects or corrective action plans
- Reporting mechanisms and timelines
- Communication plans

We propose to use standardized clinical and administrative performance measures when available, which will enable the Department to compare our performance to that of other programs. We will collaborate with the Department on the final selection of the performance measures.

Categories of suggested measures may include the following:

- Review of medical material submitted for timely utilization determination
- Clinical outcomes including improved health status based on disease-specific evidence-based guidelines
- Financial indicators such as cost avoidance, changes in service utilization including ER services and total claims cost

We will establish and monitor baseline measurements over time for each performance measure. IFMC's Internal Quality Control (IQC) plan includes information on the source of data, time period of baseline measurement, re-measurement period, frequency of measurement, the analysis plan and reporting frequency. When appropriate and to assist in monitoring, we may develop proxy measures to track performance over time. Analysis of performance data will be completed weekly, monthly or quarterly, depending on the measure. We will look for trends to identify developing patterns that may adversely impact our ability to meet performance standards. We will address any problem trends immediately through process changes designed to reverse the trend and avoid a problem before it impacts our ability to meet the Department's expectations.

Workflow Analysis and Improvement Our IQC plan will include procedures for monitoring and analyzing workflow to identify opportunities for improving accuracy, efficiency and compliance with other contract requirements (such as privacy and security). Our procedure for monitoring and analyzing workflow will include workflow statistics, review of problems or issues encountered including patterns, and review of what activities or improvements have been



implemented previously. All staff will participate in this process by logging issues or problems as well as ideas for improvement and best practices.

The noted data and staff logs will be reviewed and analyzed by management and selected staff. Where opportunities for improvement are identified, we will work within the Medical Services unit as well as with the Department and other IME vendors to source and develop solutions.

The current workflow change processes (ISIS management, OBCR, SAM, and CMR) provide the Department and other vendors information about any proposed system changes. We find these processes efficient and are committed to continuing these protocols. Any changes to workflow will be submitted for Department approval prior to implementation.

Since the initiation of IME, we have submitted numerous workflow modifications to enhance efficiency of the PA OnBase workflow. Examples of Business Process Improvement (BPI) recently completed include:

- Enhance LTC lifecycle:
Collaborated with the OnBase team to build enhancements into the lifecycle to improve workflow.
- Streamline review path:
Streamlined acute retrospective review path of business by creating workflow process in OnBase.

Results of processes and workflow improvements will be reported to the Department.

Additional Quality Monitoring In accordance with URAC standards, we also have a monthly IQC process designed to measure compliance, accuracy, and inter-rater reliability. This process allows us to monitor the quality and accuracy of our daily production and supports early detection of performance concerns.

The IQC process is completed monthly using a statistically valid sample of completed reviews as determined by an IFMC statistician. Reviews from each reviewer are randomly selected by program managers and/or quality improvement coordinators. These individuals review prior results for accurate data entry, consistent criteria determinations, and appropriate referrals to physician review. Trends are identified and tracked. When concerns are noted, follow-up training or coaching is provided. Additional measures are taken and corrective action implemented as necessary.

All staff are proactive in identifying opportunities for quality improvement. We understand that all successful quality improvement activities are supported by measures. Quality improvement activities that impact member safety and care are priorities. All staff receive performance excellence training. Courses attended during the past year include:

- Propose, Deliver, Monitor and Improve (PDMI) [similar to Plan Do Study Act - PDSA],
- Coaching for Success,
- Introduction to Performance Improvement, and
- Performance Excellence Tools for Teams.



IFMC’s senior Medicaid management team was asked to participate in the National Medicaid Quality Framework Initiative. The initiative is an effort to develop a visionary, consensus-based document that serves as a roadmap for voluntary use by states to improve the quality and efficiency of care for all Medicaid members across the country. The groups have been asked to develop State goals and identify performance metrics. The accomplishment of this initiative will improve health care to Medicaid members nationwide through collaborative efforts and knowledge sharing. August 2008

All IFMC staff are required to participate in a process or quality improvement activity annually. As a result, staff frequently identify possible improvements in operational procedures to impact cost-effectiveness and improved customer service. During the past five years, 56 business process improvement (BPI) projects have been developed by IFMC Medical Services team members. The BPIs identify workflow concerns, action plans developed, objectives defined and measured, interim results, and BPI final documented results.

Examples of BPIs undertaken in the recent past include:

BPI	Result
Quality assurance letter automation	Access database developed for automation of letters previous completed manually by review staff, therefore allowing more professional staff time to complete additional reviews in a timely manner.
OnBase LTC lifecycle enhancement	Allowed for timely notification to case managers for rapid admission to waiver programs.
Care plan reference list	Provides member with community-based services that are available.

As the ongoing Medical Services contractor, we will continue to promote staff identification of potential opportunities for improvement.

Reporting and Corrective Action

Electronic reports of compliance findings and needed corrective actions will be submitted to the Department quarterly. Data regarding IQC activities is tracked and provided to IFMC’s compliance committee in accordance with URAC requirements.

As discussed above, IFMC develops internal “proxy measures” of performance with goal or target levels of the performance standards. Measurement systems are established to collect data about performance on the proxy measures throughout the contract. The proxy measures are designed to be “predictors of success” on the contractual performance standards. By evaluating



our performance with proxy measures which use real time data to measure work performance we are able to identify potential problem areas and take proactive action to promote improved performance. This IQC approach assures a high probability that we will meet or exceed the performance standards. As noted previously, we have met all performance standards under our current Medical Services contract.

Should any performance measure fall below state specified levels, we will clearly identify the situation and explain the problem to the Department, providing a detailed analysis. We will also create an action plan for correction of the sub-standard performance and to ensure performance is sustained at levels meeting expected standards in the future. The action plan will be provided to the Department within ten business days of discovery.

IFMC utilizes many process analysis tools to evaluate processes and improve them when concerns are noted. All IFMC staff are trained through our performance excellence curriculum to utilize tools such as Root Cause Analysis, PDSA, Cause and Effect Diagrams and Failure Mode and Effects Analysis. IFMC has created a corporate process to support internal process mapping and improvement PDMI, which is similar to the PDSA process. The management team will complete PDMI forms to implement performance improvement strategies, identify barriers in existing processes, develop possible solutions, and the results of interventions to mitigate barriers.

We will provide thorough and accurate documents to the Department that corrective action plans undertaken are complete and meet or exceed the Department's requirements within the required timeframes.

Other Contract Management Activities (6.1.3.3)

Records and Reporting (6.1.3.3.a, b, c)

We will develop and maintain records of our performance and activities as required by state and federal regulation as well as under the Medical Services contract. We maintain data regarding contract management activities within OnBase, a Department software system and our care management software CaseNet TruCare™. All reports to the Department will be supported by data from these systems. The Department, as well as state and federal auditors will have full access to all systems, as well as documentation of contract management activities.

As discussed previously, IFMC currently produces monthly, quarterly, and annual reports and scorecards describing compliance with all program performance standards and contract requirements. These reports are completed in a timely manner and according to the Department's needs and requests. We will apply our experience with current OnBase Workview and Cisco reporting capabilities to produce accurate and timely reports. We will also utilize CaseNet TruCare™ to provide detailed reports regarding long term care, habilitation, waiver, retrospective review, and claims pre-pay performance standards and requirements. These reports provide the information in an aggregate format with contract year-to-date activities including review results.



We will provide suggested reporting formats and data elements to the Department, and will negotiate final format, content and frequency with Department representatives.

Suggestions for Program Improvements (6.1.3.3.d, e)

Our in-depth knowledge of Medicaid programs, rules, and our cooperative and productive working relationship with the Department policy staff and IME vendors will continue to assist us in recognizing necessary system changes and relaying this information to the Department. As discussed earlier in this proposal Tab, we have, and will continue to designate a single point of contact for all OBCRs, CMRs and SAMs. This single point of contact, one of our experienced program managers, has more than eight years experience with Iowa Medicaid and has been a part of our Medical Services team for more than five years. She has a comprehensive understanding of IME systems and data, and will work with our Medical Services team to ensure that our suggestions are appropriate, accurate and complete when submitted to the Department. We will continue to use the established processes of OBCR, SAMs, and CMRs that suggest system enhancements to the Department. We have found these processes to be efficient tools to document requested changes.

During the past five years, IFMC has submitted more than 350 SAMs (i.e., updating UR file procedure numbers, changes to maximum units allowable) and 100 CMRs. Examples of SAMs include:

- Updating HCPC codes for wound VAC canisters and maximum allowable units for correct payment
- Changing fee schedule for Unna boot to be Medicare fee multiplied by 97 percent
- Updating place of service to include “home” for enteral formula

Examples of CMRs include:

- Updating edits for mammograms for individuals younger than 35 years of age
- Updating provider specialty codes

Procedure Manuals (6.1.3.3.e, f)

We currently maintain detailed operation procedure manuals in the format designated by the Department. These manuals are maintained and located on the IME universal drive. Operational procedures are reviewed for necessary updates on an annual basis or more frequently when circumstances require changes. For example, if routine workflow monitoring and analysis results in a change that impacts procedure, that change would be reflected immediately in a procedural update. Any necessary procedure updates will be forwarded to the Department for review and approval prior to finalizing the change. Once the change is approved, the manual on the IME universal drive will be updated.



We have consistently updated operational procedures in a timely manner. We have found that keeping operational procedures current is essential in maintaining efficiently trained staff, as well as program continuity, and will continue to follow these established protocols.

Communications and Activity Reports (6.1.3.3.g, h, i)

As noted previously, communication with Department staff and other IME vendors is and will continue to be a priority. As the current Medical Services contractor, we have established communications protocols. Our team members are educated regarding these protocols, and follow established processes and lines of communication for discussions internal to our team, with other vendors and with state staff. This allows all team members to resolve any issues or information needs in as timely a manner as possible. Our management team and staff are fully aware to support open communication.

All communications protocols and established lines of communication will be reviewed at the onset of the new contract period. As necessary, we will work with the Department and other vendors to ensure that our processes are collaborative and support the open communication needs of all IME parties. Any revisions to protocols and process will be reviewed with our full Medical Services team.

IFMC's Medical Services team will continue to use OnBase to support workflow between our unit, state staff and other IME vendors. All new personnel will receive comprehensive training related to the appropriate use of the OnBase system during their first week of employment.

Our management team will actively participate in routine meetings between vendors and Department staff. We will actively support discussion and sharing of information to review performance, offer suggestions for improvement and resolve issues.

For example, we respond openly and without hesitation to Department requests regarding program coverage criteria and vendor requests such as medical necessity questions from SURs, pricing questions from Provider Cost Audits and Rate Setting, and workflow development and testing requests from Core.

IFMC provides the Department with information about unit activities through required reports, open communication, and regular account manager/unit manager meetings. During the monthly account/unit manager meetings, discussions regarding progress on new activities aid in vendors' awareness of changes. For example, we have openly shared information and progress on projects such as the implementation of PA of high-tech imaging and implementation of DST CareAnalyzer to determine and predict the health status of Medicaid members.

Our leadership and support of Medicaid Value Management (MVM) is another clear example of the value we place on open communication and keeping the Department and other IME vendors apprised of our activities. Periodic status reports and update meetings were held with senior Department staff over the 90-day MVM development period. We also held information meetings with Department policy staff, other IME vendors and other stakeholders to explain



project objectives and approach and to obtain input from these other parties. This open approach to communications and activity reporting will continue into the next contract period.

Monthly account/unit manager meetings provide for discussions regarding progress on new activities and aid in vendors' awareness of changes. These meetings provide opportunities to seek and share input regarding suggestions for improvement and best practices. Our Medical Services team will continue active participation in these meetings.

Responding to the Department (6.1.3.3.q, r)

As part of our customer service orientation, IFMC will provide a written response to all Department requests and questions within two business days. IFMC has a process in place for Department policy specialists to route requests to specific IFMC staff for response. This process is completed through OnBase where it is monitored for timely completion. One recent example was a Department request for revision of family therapist qualifications within the CMH waiver program. Our experienced behavioral health staff, along with the medical director, were able to review national and state qualifications and provide rationale for revisions to the family therapist's qualifications of CMH waiver providers. All responses will include a description of the issue and resolution.

Emergency requests are generally received through OnBase and will be responded to within one business day.

Privacy and Security (6.1.3.3.j)

IFMC meets all federal and state privacy and security requirements. We understand the importance of protecting member and provider information and have processes in place to promote confidentiality and security. All staff have specialized and ongoing training relative to healthcare privacy and HIPAA mandates.

Protection of sensitive data is paramount at IFMC. Every contract we handle requires the proper protection, receipt, handling, transmission and storage of sensitive data. Security programs are established to protect the confidentiality, integrity and availability of that data, regardless of the type of data being protected. Appropriate controls are established based on the sensitivity of the data being protected. 'Least privilege' and 'need-to-know' are two guiding, fundamental principles we use in implementing controls.

The subject of protecting our customers' data is practiced and enforced through the following policies: Confidentiality Policy, E-mail Policy, Destruction of Confidential Information requirements, Building Access Policy, Visitor Policy, Remote Access Policy, Shipping of Confidential Information Policy, De-Identification Policy, and Breach Policy.

IFMC provides a continuing program of confidentiality awareness and training to all employees, temporary staff, and volunteers (collectively "staff") to understand how and why each individual is responsible for compliance of this policy. New employees learn the policies and procedures of



the company, as well as federal and state regulations that affect the work we do (e.g., HIPAA, Security). In addition to training provided upon hire or placement, training is also provided periodically thereafter and whenever policy or procedure changes require additional training. A quiz is completed at the end of the training to ensure understanding.

On the first day of work, all IFMC and consulting staff are required to sign the IFMC Confidentiality Policy. This policy binds them to protect all confidential data, including identifiable health information as well as business information. As a condition of continued employment or placement, all staff must annually sign the Statement of Confidentiality.

All suspected or confirmed privacy and security breaches must be reported to the IFMC Security Committee for appropriate management, analysis, and remedies, even when not resulting in damage or loss. Timely, accurate and complete reporting of all breaches is completed in accordance with the Breach Policy. This policy promotes a systematic approach when a privacy and security breach is suspected or confirmed to help management and staff quickly and efficiently respond and recover from security incidents and privacy breaches, minimizing loss or theft of information and/or disruption of critical business activities. We will also report breaches as required by Department processes and procedures and in accordance with our IME contract.

A variety of security audits are performed periodically to ensure staff members are following the policies and procedures. Audits are conducted using a checklist and using an audit team of senior staff members. The audits take place during and after working hours. Information and reports are provided to management regarding the status of compliance.

During work hours, the audit team will randomly check the follow items during work hours:

- Staff members are locking their PCs when away from their desks
- Personal Health Information is not being left out while staff members are away from their desks
- Medical Records being left on desks/carts and not locked up when staff are on break or at lunch
- Physical location of work stations and computer screens
- Track the number of computers that their displays/monitors are visible from doorway

After work hours, the audit team will randomly check the following items:

- Verify staff have not written down passwords and “hidden” them under keyboards, etc.
- Personal Health Information or other sensitive information is not left out over night
- Check to make sure that overhead bins are locked (Are keys kept in an obvious place?)
- Check trashcan for sensitive data
- Check printers, fax machines and copy room for unattended documents
- Check for media left out overnight

This comprehensive approach to confidentiality ensures compliance with HIPAA privacy and security requirements for IME. Additional information is provided in **Security and Confidentiality** (6.1.6) of this proposal Tab.



Performance Standards (6.1.3.4.1 through 6.1.3.4.3 and 6.1.3.4.3.1)

IFMC tracks all required reports to ensure timely submission to the Department. A screen print of our tracking document is below.

MEDICAL SUPPORT Description		2 nd Qtr	Jan	Feb	Mar	3 rd Qtr	Apr	May	Jun	4 th Qtr
Quarterly report of all appeal hearings, including status, disposition of case and policy changes resulting from appeals.	Due	1/15				4/14				7/15
	Sent	1/8				4/2				7/10
Monthly report of policy requests, including requestor, status, disposition of request and policy changes resulting from request.	Due		2/13	3/13	4/14		5/14	6/12	7/15	
	Sent		2/11	3/6	4/6		5/10	6/10	7/7	
CMS 64.96 Quarterly Abortion Report	Due	1/15				4/14				7/15
	Sent	1/9				4/14				7/10

EPSDT Description		2 nd Qtr	Jan	Feb	Mar	3 rd Qtr	Apr	May	Jun	4 th Qtr
Service breakdowns of the procedures that have occurred during the course of a Private Duty Nursing member's service.	Due		3/13	3/13	4/14		5/14	6/12	7/15	
	Sent		2/4	3/2	4/2		5/4	6/4	7/2	

While some detail has been deleted from this example for presentation purposes, note that the required reports under the current Medical Services contract were provided by the specified due date 100 percent of the time.

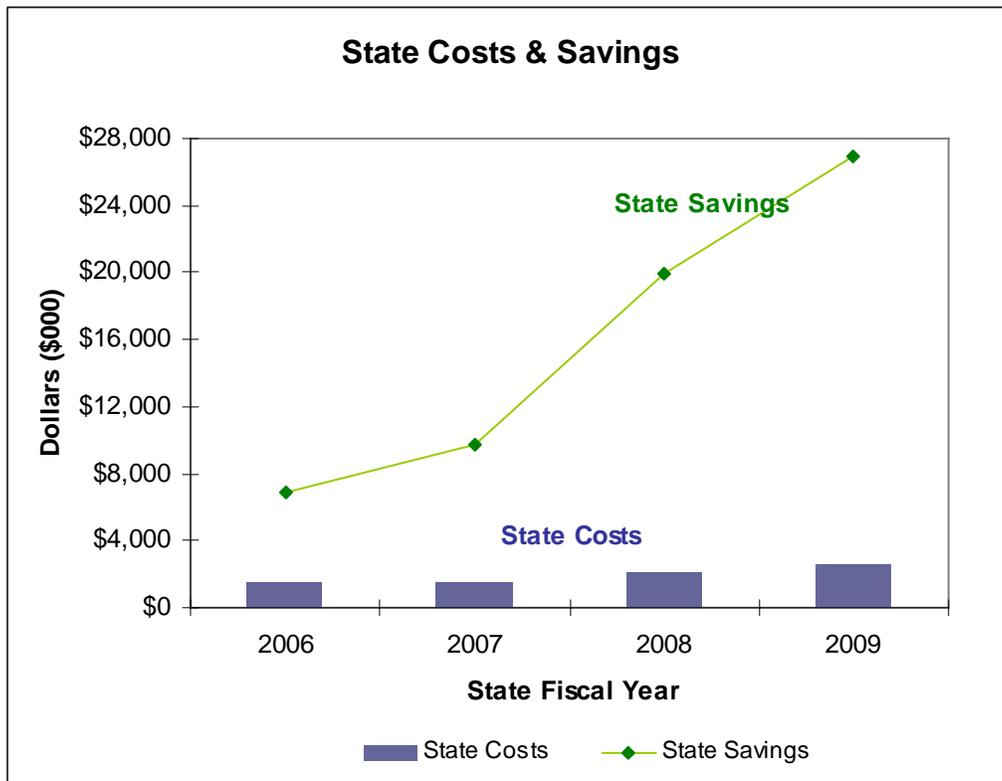
As noted earlier, IFMC maintains policy and procedure manuals that contain clear protocols regarding day-to-day operations on the IME Universal drive. We will update these manuals within 10 business days of when program changes occur, and also review and revise as needed on an annual basis (meeting URAC standards). Detailed process maps for operational procedures are also posted to the IME Universal drive. We also maintain desk level procedure manuals documenting processes and procedures. IFMC agrees to follow the Department's timelines, formats, and guidelines for documentation and revisions.

We continuously measure our performance to validate results, identify the need for corrective actions and identify other opportunities for improvement based on analysis of the performance data. We then implement changes designed to achieve and exceed performance standards. Our internal quality review process and methods for identifying deficiencies are presented in detail in the [Quality Assurance](#) section of this proposal Tab.



We will provide suggested reporting formats, data elements and measurement methodologies to the Department for all contract requirements and performance standards. Final format, content, measurement specifications and frequency will be negotiated with the Department and/or its representatives. IFMC will maintain and report on all requirements, identifying data sources as required by the Department. Sources of data will include OnBase reports, DW/DS queries, and CaseNet TruCare™ and will be specifically identified in documentation.

IFMC understands the goals of the IME to effectively manage the health and the costs of healthcare for Medicaid members in Iowa. IFMC assumes the Department intends to continue the current IME model which allows them to retain greater responsibility for the operation and direction of healthcare delivery to Medicaid members in Iowa. As IME is similar to the conceptual view of a managed care organization or health maintenance organization, there is a solid business case for contractual performance standards consistent with operation objectives one might see in these types of organizations. Contracting for results using best of breed vendors to ensure the most effective services available today is critical for the Department. As the current Medical Services vendor, we have consistently met all performance standards established by the Department and have provided the Department with significant ROI. A summary of our performance over the past four state fiscal years is presented in the following chart:



During IFMC's tenure as the IME Medical Services contractor we have consistently implemented new programs, efficiencies and innovations to provide the State a consistently increasing return on investment.



IFMC will continue to operate and manage the Medical Services contract in a manner that enables us to achieve all performance standards defined for the Medical Services component of the IME.

During the past five years IFMC has developed and submitted an annual report including cost savings and performance standards in a Department-approved format. The format provides the Department with aggregate data for release without jeopardy to individual or personally identifiable health information. IFMC will continue to provide annual reports for each contract year detailing performance against Department established standards. Reports will be provided no later than October 15, with format and content approved by the Department.

IFMC has developed and submitted annual reports for the past five years which incorporate utilization and quality management of Medicaid services that result in measureable State cost savings.

As the current Medical Services contactor, IFMC increased total State dollars saved after program cost from slightly more than \$9 million in SFY 2007 to in excess of \$17 million in SFY 2008.

This represents a 75 percent increase in savings in one year.

Our current annual reports include documentation of measurable State cost saving. IFMC will continue to calculate cost savings and cost avoidance from the following review activities:

- Acute retrospective review of selected hospital services
- Children’s mental health waiver
- Claims pre-pay review for medical necessity
- Habilitation
- Home and community based services waiver programs
- Intermediate care facilities for the mentally retarded
- Nursing facilities
- Preprocedure
- PA for various Medical Services
- Quality of care review for MediPASS
- Remedial
- PMIC



For this procurement, IFMC will also report on all current cost saving initiatives as well as reporting on:

- Reduction in radiologic procedures
- Reduction in emergency room use
- Preventive healthcare

Our approach will include baseline measurements, documentation of interventions and multiple post measurements. Data will be tracked and trended for response to interventions and to inform program development.

IFMC's programs will result in at least \$10 million State savings in SFY 2011. Throughout operations, we will continue to seek opportunities for added value to the Department through the Medical Services contract. We are confident in our ability to increase State cost savings by no less than seven percent each subsequent contractual year or an increase of seven percent more than the highest overall State savings.

IFMC has submitted an annual report documenting its IME operations each year under the current contract. This report provides data on the health status of Medicaid members grouped into the following cohorts:

- Less than 19 years of age (0 to 18)
- Between 19 and 64 years of age (0 to 19)
- Greater than 64 years of age (64+)
- Disabled aid type

The most prevalent medical problems, listed by major diagnostic category (MDC), and the treatment costs of each category are also included in this report. The data are obtained from the MMIS and DW/DS contractors, as well as the DST CareAnalyzer software. CareAnalyzer provides analytic solution suites that combine elements of patient risk, care opportunities, and provider performance. CareAnalyzer supports ongoing performance improvement by allowing us to readily access summary level quality reports supported by comprehensive member profiles.

Quarterly reports will provide information from paid claims displayed by major diagnostic category for each cohort (above), including the total reimbursement, number served, and reimbursement averages per member per month.

IFMC reviews patterns of illness and utilization to identify measures across three dimensions of quality: effectiveness, safety, and timeliness. The measures will be evidence-based national standards. Outcomes regarding total payments, members served, and cost per member served are compared to previous years. The medical director and the Medical Services management team will review the annual report regarding the health status of Medicaid members and activities implemented during the year to determine effectiveness.



Samples of a portion of the annual health report are provided below.

Medicaid Expenditures by MDC - Children (0 - 18 years of age)

MDC / Description	Total Payment	# Served	Cost per Mbr Served
1 Diseases and disorders of the nervous system	\$1,318,713	305	\$4,324
2 Diseases and disorders of the eye	\$82,559	39	\$2,117
3 Diseases and disorders of the ear, nose, throat and mouth	\$684,130	307	\$2,228
4 Diseases and disorders of the respiratory system	\$4,930,707	1,633	\$3,019
5 Diseases and disorders of the circulatory system	\$1,800,946	78	\$23,089
6 Diseases and disorders of the digestive system	\$2,173,589	752	\$2,890
7 Diseases and disorders of the hepatobiliary system	\$274,590	36	\$7,628
8 Diseases and disorders of the musculoskeletal system and connective tissues	\$1,147,176	212	\$5,411
9 Diseases and disorders of the skin, subcutaneous tissue and breast	\$435,913	176	\$2,477
10 Endocrine, nutritional, and metabolic diseases and disorders	\$946,555	473	\$2,001
11 Diseases and disorders of the kidney and urinary tract	\$697,893	207	\$3,371
12 Diseases and disorders of the male reproductive system	\$16,565	10	\$1,656
13 Diseases and disorders of the female reproductive system	\$116,719	35	\$3,335
14 Pregnancy childbirth and the puerperium	\$2,459,554	1,269	\$1,938
15 Newborns and other neonates with conditions originating in the perinatal period	\$34,324,403	16,309	\$2,105
16 Diseases and disorders of the blood and blood forming organs and immunological disorders	\$353,277	75	\$4,710
17 Myeloproliferative diseases and disorders and poorly differentiated neoplasms	\$306,736	17	\$18,043
18 Infectious and parasitic diseases (systemic or unspecified sites)	\$841,636	310	\$2,715
19 Mental diseases and disorders	\$152,996	65	\$2,354
20 Alcohol/drug use and alcohol/drug induced organic mental disorders	\$24,171	17	\$1,422
21 Injuries, poisonings and toxic effects of drugs	\$507,703	175	\$2,901
22 Burns	\$149,919	24	\$6,247
23 Factors influencing health status and other contacts with health services	\$49,058	19	\$2,582
24 Multiple significant trauma	\$406,700	19	\$21,405
25 Human immunodeficiency virus infections	\$0	0	--
A Pre-MDC	\$926,137	9	\$102,904
B Ungroupable	\$0	13	\$0
C Unrelated operating room procedures	\$434,173	32	\$13,568



**Medicaid Expenditures and Utilization
 by Category of Service - Children**

Category of Service	Members Served (not unduplicated)	Number of Paid Claims	Total Payment	Cost per Member Served
Inpatient	21,882	28,297	\$75,815,329	\$3,465
Outpatient	95,324	221,965	\$42,314,658	\$444
Provider	191,922	1,531,127	\$98,467,276	\$513
Dental	77,579	159,949	\$20,549,528	\$265
Pharmacy	145,305	1,892,422	\$61,127,185	\$421
DME	12,921	28,502	\$3,047,650	\$236
ICF/SNF	8	14	\$47,388	\$5,924
Waivers	356	3,312	\$2,174,104	\$6,107
ICF/MR	3	18	\$147,675	\$49,225
Home Health	6,174	12,117	\$1,795,481	\$291

TRAINING (6.1.4)

IFMC staff are familiar with the Department systems of MMIS and workflow process management. We will participate in all necessary additional training, call center and tracking system training, and training related to the new telephone system. Through our interactions in the Medicaid Value Management project, we have interacted frequently with DW/DS staff to design data queries. We will participate in future DW/DS system training as appropriate.

We trained our staff in 2005 with a train-the-trainer approach for all Department systems and look forward to continuing that successful method. Our designated trainer for each system (ISIS, MMIS, OnBase workflow and Workview, Cisco phones) provides needed guidance and supervision as staff gain competency.

IFMC has designated competent staff members, well versed in the systems, as trainers for ongoing participation in the successful train-the-trainer approach.

Our IME Medical Services managers have developed a detailed orientation checklist for all new employees. Each manager follows the checklist to ensure new employees are trained in systems, security, and operational tasks. An excerpt from the orientation guide follows:



Medical Services – Technical Proposal
 IFMC Response to the Iowa Department of Human Services
 Iowa Medicaid Enterprise Professional Services – RFP MED-10-001

MANAGER OVERVIEW AND TRAINING (ABBREVIATED SAMPLE)				
Task	Resource	Date Completed	Trainer Initial	Employee Initials
<input type="checkbox"/> Position description	Handout			
<input type="checkbox"/> Performance Objectives and Appraisal Goal	Discussion and Handout			
<input type="checkbox"/> Annual Performance Review	Handout			
<input type="checkbox"/> Quarterly Feedback Sessions	Discussion			
<input type="checkbox"/> Use of DHS and IFMC Equipment	Discussion and Handout Online			
<input type="checkbox"/> Annual Attestations Operational Procedure Review	Discussion, Handout and Handout Online			
<input type="checkbox"/> Disclosure of PHI	Discussion			
<input type="checkbox"/> Promoting Safety IME Staff and Medicaid Members	Discussion and Handout Online			
<input type="checkbox"/> Iowa Medicaid Enterprise Facility				
<input type="checkbox"/> DHS Parking Map and Towing Policy	Discussion & Handout			
<input type="checkbox"/> DHS Outlook, Internet Policy and Tumbleweed	Discussion & Handout			
<input type="checkbox"/> Building Access and After Hours Procedure	Discussion			
<input type="checkbox"/> After Hours Log Sheet	Discussion & Location			
<input type="checkbox"/> Badge	Discussion			
<input type="checkbox"/> Aerosols	Discussion			
<input type="checkbox"/> IME Overview	Handouts			
<input type="checkbox"/> Tour Building and Intro to Co-workers	Tour			
SYSTEMS OVERVIEW WITH PROJECT ASSISTANT				
Task	Resource	Date Completed	Trainer Initial	Employee Initials
<input type="checkbox"/> Access Onbase	Desktop Location			
<input type="checkbox"/> Access ISIS, if applicable	Desktop Location			
<input type="checkbox"/> Access MMIS, if applicable	Desktop Location			
<input type="checkbox"/> Access OCRA, if applicable	Desktop Location			
<input type="checkbox"/> Access SSNI, if applicable	Desktop Location			
<input type="checkbox"/> Access IMERS, if applicable	Desktop Location			
<input type="checkbox"/> Access RightFax, if applicable	Desktop Location			
<input type="checkbox"/> Telephone training	Desktop Location			
POSITION SPECIFIC TRAINING – AS REQUIRED WITH CO-WORKER				
MANAGER OVERVIEW AND TRAINING				

During the transition phase for the next contract period, we will review training activities and ensure that our approach, processes and checklist are updated as appropriate for the next operation period.

For all MMIS inquiries and updates and all OnBase workflow tasks, new staff are trained on one function at a time. Employees focus on initial tasks such as checking member eligibility in MMIS or logging documents in an OnBase queue. The employee is required to complete each new task repetitively to establish competency. Initially IQC is completed on new employees' work at a 100 percent level. As the employee demonstrates competency, IQC review is gradually decreased.

Training and education are an integral part of the IFMC culture. Our monthly Limelight meetings are an opportunity for our staff to learn new skills such as URAC requirements and quality improvement processes. New policies and procedures or changes to policies and



procedures are conveyed at the Limelight meetings or at monthly team meetings held by each of our managers. Team meetings are held more frequently if needed.

We emphasize the need for employees to continue to expand their skills. Each employee has their own development plan that includes training designed to improve their skill sets. All managers participate in a manager development program with courses geared to help them successfully coach, mentor, and supervise their staff.

OPERATIONAL PROCEDURES DOCUMENTATION (6.1.5)

We have used the Department approved format to document all operational procedures at a detailed level to ensure program continuity and will continue to provide that level of direction and documentation to our staff. Our operational procedures and process maps are on the IME Universal drive in the prescribed Department format.

We have consistently updated operational procedures in a timely manner. Training on new procedures is provided at the time of the change and discussed during monthly unit meetings, face-to-face team meetings, and in written communications. Versions are noted by the date in the header, per Department format, and the most recent version is posted on the IME Universal drive within 10 business days of the change. We will continue to handle operational procedure documentation in this manner.

As part of the successful paperless system at IME, all operational procedure will be provided in electronic format and posted on the IME Universal drive.

We have complied with all naming and numbering conventions as directed by the Department. We have found the system to be easy to follow and will continue to comply in our documentation of Medical Services procedures. We have not and will not reference our corporate name in any of the documentation.

Also see **Procedure Manuals**, presented earlier in this proposal Tab.

SECURITY AND CONFIDENTIALITY (6.1.6)

We will occupy physical space at IME and will use IME data systems.

For those individuals in home offices, IFMC requires field staff to provide a safe and protected environment for data and computing resources to ensure the integrity of data created, accessed, or modified. IFMC's policies govern the proper and legal use of wireless devices that connect to the Department network and e-mail system.

Workstation security practices include:

- Password/PIN security
- Locking computer when unattended



- Leaving computer on restart at the end of the workday

IFMC provides the Department with a quarterly HIPAA compliance report. This report includes:

- Data interfaces
- HIPAA compliance provisions
- HIPAA training
- Whistle-blower policy
- Incident reporting
- Subcontractor oversight

IFMC is aware of and complies with the guidance provided in FIPS 31 which is now addressed in the National Institute of Standards and Technology (NIST) guidance and FIPS 41 which is contained in the Guidance for Privacy Act found in Office of Management and Budget (OMB) Memorandum A-108.

We understand the importance of protecting member and provider information and have processes in place to ensure confidentiality and security. IFMC follows all state and federal statutes and regulations to maintain the privacy of protected health information. Processes include a confirmation script for callers, use of a step-by-step RightFax process to minimize errors, and use of window envelopes to avoid breaches in confidentiality. Protected health information that is transported by courier to peer reviewers is double-wrapped to ensure security in the event of a vehicular accident.

As a standard component of orientation, all new employees receive training on corporate policies and procedures, as well as state and federal regulations that affect the work we do (i.e., HIPAA, security, safeguards to theft). All staff will understand the importance of privacy, security, and safeguards and will be trained through our performance excellence program.

Our detailed orientation checklist covers security policies and procedures. All IFMC employees are required annually to sign a confidentiality policy indicating that they will take all steps necessary to protect health information. Privacy discussions occur no less often than annually and refresher training is provided in our Limelight meetings.

IFMC staff follow weekend access, visitor, and sign-in procedures to ensure building security. A designated project assistant maintains the inventory of Department-controlled assets and handles all security and system access requests.

Individual passwords are kept secure, confidential information is secured in locked drawers or overhead bins, computers are locked when not in use, individual shred bins are emptied nightly and a sweep of local printers is made at the end of each business day. Sweeps are also made randomly throughout the day to ensure compliance with all security needs.



In addition to corporate security policies, IFMC adheres to the Department’s IME policies. Prior to employment, IFMC requests the potential employee to read, sign, and return the following:

- Confidentiality and non-disclosure agreement.
- IME Employee Identification Access policy.
- Systems security access forms (as needed).
- Vehicle registration form.
- Building access form.

Medical Services staff will report all breaches of confidentiality to their manager in writing using the Possible Confidentiality Breach Report form. This form will be submitted to the unit manager with a plan of action within 24 hours.

Additional related information is provided in **Quality Assurance**, presented earlier in the proposal Tab. We will continue with all procedures described above and implement additional processes as needed or as directed by the Department.

We understand the Department’s right to establish back up security for data. IFMC also assumes responsibility for the security of data related to our programs. Each workflow process has a business disruption plan to ensure business continuity.

For CaseNet TruCare™ backups will be performed five nights a week, four nights of incremental backs during the week and a full system backup each weekend. Files are backed up to tape. The tapes are taken offsite Monday through Friday to a secured tape storage location and are transported in bins locked with keyed padlocks. Each set up backs are stored at the offsite location for three weeks before they are rotated back to IFMC. Only authorized system administrators have access to the tapes while they are outside of the bins and to the tape backup system.

ACCOUNTING (6.1.7)

IFMC recognizes revenue earned in accordance with generally accepted accounting principles, matching timing of revenue recognition within the period of performance. Revenue is recognized only after terms and conditions are finalized and documented through a fully executed contract. Upon award, contract terms, conditions, schedules, and other relevant components will be reviewed to determine the most appropriate method of revenue recognition and billing methodology in accordance with the contract. No costs will be charged directly to any contract until the cost has been determined to be allowable under the terms of the award.

Direct costs include those costs that are incurred specifically for one award. IFMC identifies and charges these costs exclusively to each award or program. Indirect costs are those costs that either benefit more than one award (overhead costs) or that are necessary for the overall operation of IFMC (management and general costs). IFMC Finance and Administration establishes, controls, and maintains a uniform chart of accounts, projects, and organization codes



which prescribes the elements used in budgetary and actual financial reporting. These three structural elements are the framework for the general ledger system, and therefore the basis for IFMC's accounting system. IFMC operates on a fiscal year that runs concurrently with the calendar year, beginning on January 1 and ending on December 31.

IFMC's government accounting system has been approved by the Centers for Medicare and Medicaid Services (CMS) as being adequate for accumulating and billing costs under Government contracts. IFMC's accounting system was evaluated using the requirements contained in the Federal Acquisition Regulations, Cost Accounting Standards, Office of Management and Budget Circular A-122 (Cost Principles for Non-Profit Organizations) and the Health and Human Services Acquisition Regulations. As such, IFMC's billings to the State of Iowa will properly reflect all direct and indirect costs and expenses for labor, materials, equipment, supplies, services, etc., for which payment is requested under this contract.

IFMC's accounting records are maintained in accordance with generally accepted accounting principles and kept separate and independent of other accounting records. Direct costs include those costs that are incurred specifically for one award. IFMC identifies and charges these costs exclusively to each award or program.

IFMC collects, preserves, and maintains paper and electronic records concerning the financial, operational and contractual activities of the company for a period of seven years from last payment/audit/inspection/expiration.

BANKING POLICIES (6.1.8)

In the event IFMC receives any checks or money orders related to the work IFMC performs, IFMC will log and prepare all payments for deposit on the day of receipt and deliver them to Revenue Collections contractor's designated point of contact for daily deposits. IFMC will assist in the maintenance and updating of the existing check. We 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.

PAYMENT ERROR RATE MEASUREMENT (PERM) PROJECT (6.1.9)

IFMC has participated in the PERM project by providing timely medical review on all cases that were identified by the auditors and assigned to Medical Services. We monitored the identified website for review assignments and completed them in a timely manner. We look forward to assisting again as directed by the Department.

PERM is a CMS project to ensure claims are correctly paid by State Medicaid agencies and in accordance with CMS guidelines. PERM auditors randomly select a sampling of 1,000 Iowa Medicaid paid claims to review for potential errors. As PERM auditors complete reviews and identify those with potential errors, an e-mail communication is forwarded to the Department



and Medical Services to inform them of claims being added to the web site for the monthly review process.

The Medical Services review coordinator monitors the web site daily for new claims to be added to the list of monthly reviews. The description of the potential error type and the TCN of the claim are provided on the web site. The review coordinator prints a copy of the claim dispute as they are added to the web site to refer to when the medical records arrive.

At the end of the month, PERM auditors copy the medical records for the disputed claims to a locked CD and ship them by overnight mail to Medical Services to perform the medical record review. The timeframe for the review completion, including physician review if required, is 10 business days from receipt of the medical records. Medical Services findings from each of the medical reviews along with detailed explanation of agreement or disagreement with the PERM auditor's findings are provided to the Department. Disputes with CMS findings from Medical Services are explained in detail to the Department liaison with supporting rationale from the Iowa Administrative Code (IAC) and Provider Manuals. The Department is responsible for notification to PERM auditors of the dispute with findings and the rationale for the dispute. Disputes with the PERM auditors will be further reviewed by PERM and discussion and rationale provided for their consideration.

During the 2008 PERM review, 54 medical records were reviewed over a period of 5 months. Each record requiring research on MMIS for claims information and medical record review which included coding verification, billing and unit validation, appropriate setting of services, medical necessity of procedures and hospital stays. Of the total cases reviewed, five resulted in a recommendation to the Department to dispute the PERM finding.

SUBCONTRACTORS (6.1.10)

IFMC is not proposing any subcontractors for Medical Services.

REGULATORY COMPLIANCE (6.1.11)

All IFMC employees are required to annually attest to understanding and following security and HIPAA requirements. IFMC's confidentiality policy requires the protection of all patient identifiable information. New employees receive security and privacy training. Periodic security reminders are provided in multiple ways, including but not limited to training classes, posters and articles in the corporate newsletter.

The subject of protecting our customers' data is practiced and enforced through a comprehensive set of corporate policies: Confidentiality Policy, E-mail Policy, Destruction of Confidential Information requirements, Building Access Policy, Visitor Policy, Remote Access Policy, Shipping of Confidential Information Policy, De-Identification Policy, and Breach Policy.



IFMC provides a continuing program of confidentiality awareness and training to all employees, temporary staff, and volunteers (collectively “staff”) to understand how and why each individual is responsible for compliance of this policy. New employees learn the policies and procedures of the company, as well as federal and state regulations that affect the work we do (e.g., HIPAA, Security). In addition to training provided upon hire or placement, training is also provided periodically thereafter and whenever policy or procedure changes require additional training. A quiz is completed at the end of the training to ensure understanding.

All suspected or confirmed privacy and security breaches must be reported to the IFMC Security Committee for appropriate management, analysis, and remedies, even when not resulting in damage or loss. Timely, accurate and complete reporting of all breaches is completed in accordance with the Breach Policy. This policy promotes a systematic approach when a privacy and security breach is suspected or confirmed to help management and staff quickly and efficiently respond and recover from security incidents and privacy breaches, minimizing loss or theft of information and/or disruption of critical business activities. We will also report breaches as required by Department processes and procedures and in accordance with our IME contract. All reports will also be forwarded to the Unit Manager. Trends are tracked and analyzed. Interventions and action plans to ensure resolution will be developed and implemented as necessary.

All corporate policies are reviewed and updated annually to ensure continued compliance with state and federal regulation and requirements. As the Medical Services contractor, we will adhere to corporate security policies, as well as Department IME policies including, but not limited to:

- Building security and weekend access
- Confidential material security
- Systems security

The CaseNet TruCare™ system meets all HIPAA requirements for transactions, codes sets, national provider identifier (NPI), privacy, and security.

AUDIT SUPPORT (6.1.12)

Since IME operations began, IFMC has responded to all requests for assistance regarding audits and certifications including the MMIS certification, OIG audit, PERM project, and MIG review. We are partners with the Department and all other vendors in responding to required audits and supporting IME functions.

NO LEGISLATIVE CONFLICTS OF INTEREST (6.1.13)

IFMC has established policies to govern potential conflict of interest. Adherence to this policy is required of all IFMC employees. IFMC is not aware of any potential or actual legislative conflicts of interest where IFMC is directly involved or otherwise supporting legislation impacting the Medicaid program.



Notwithstanding the above, IFMC will notify the Department if it is directly involved with or otherwise supports legislative interest impacting the Medicaid program outside the role of the IME contractor.

IFMC shall have programs in place to identify, evaluate, and mitigate all actual, apparent, and potential conflicts of interest related to legislation that preclude, or would appear to preclude IFMC from rendering impartial assistance or advice on services performed for this contract.

IFMC will at no time 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 IFMC by limiting fair and open competition in the award of this contract upon its expiration or to provide an advantage to IFMC during the term of the contract resulting from this RFP.

No PROVIDER CONFLICTS OF INTEREST (6.1.14)

IFMC is not aware of any potential or actual provider conflicts of interest that would conflict, or appear to conflict, in any manner or degree with IFMC's performance of services under this contract.

IFMC will meet the following specifications to preclude participation in prohibited activities:

- IFMC will subcontract with a firm to conduct any desk reviews or onsite audits of providers if the provider is a client of IFMC and the provider also provides services for the Department. IFMC currently has one contract with
- IFMC 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 IFMC'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.
- IFMC will disclose its membership on any and all boards. IFMC will not use any information gained 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.
- IFMC 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.



TAB 6 – OPERATIONAL REQUIREMENTS (7.2.6)

Medical Services (6.2)

MEDICAL SUPPORT (6.2.1)

IFMC understands quality in healthcare and will apply this in-depth knowledge to each segment of the Medical Services program. As an Iowa-based company, we are committed to improving the quality of healthcare for all Iowa residents. We have enjoyed a collaborative and productive partnering relationship with the Department since 1979. IFMC is the present contractor for Medical Services at IME.

We have incorporated management of appropriate utilization of Medicaid services with identification and promotion of best practices that have resulted in measurable State cost savings.

SFY	State Cost Savings	ROI
2006	\$6 million	\$4:\$1
2007	\$9 million	\$6:\$1
2008	\$17 million	\$7:\$1
2009	\$28 million	\$10:\$1

Contractor Responsibilities (6.2.1.2)

IFMC understands the importance of improving the quality of care for Medicaid members by ensuring their care meets the highest professionally recognized standards. A strong quality and utilization management program protects the integrity of the Medicaid program by ensuring that Medicaid pays only for services and items that are reasonable, medically necessary, and provided in the most appropriate/cost-effective setting.

IFMC understands that the medical support function includes policy development and consulting for specific service areas on behalf of the Department. As the Medical Services contractor, we have made available the requisite medical and professional staff to the Department for professional advice and recommendations to existing coverage policies.

As the current Medical Services contractor, we have represented the Department, upon request, on several occasions, and will continue to provide this support. Some examples include:

- Iowa medical home advisory council
- Remedial services planning task force
- State maternal health task force
- Nursing facility accountability measures committee
- RTS to remedial transition team
- Provision of information related to family therapist qualifications
- Waiver quality assurance (QA) planning committee to meet CMS requirements
- Remedial implementation training sessions statewide

IFMC is committed to maintaining effective and useful contacts with providers regarding medical policy questions, as well as decisions on individual claims. IFMC staff represent the Department at all medical assistance ALJs.

“IFMC has been instrumental in building a strong and comprehensive program. The daily operations and management have been detailed and complex. We have found IFMC to be sound and reliable business partners. They worked diligently through the development and start-up program. We found IFMC to be responsive, locally and corporately, to our evolving needs in relation to the program.”
September 25, 2009 Letter from the Oklahoma Health Care Authority

During the past year, utilization management criteria/procedures and Medicaid policies were reviewed by the Medicaid CAC for approval and/or recommended revisions. IFMC established the CAC at the request of the Department. The CAC members represent the broad range of Medical Services providers. The CAC meets quarterly and is chaired by the Medical Services medical director. Committee activities include:

- Technology and therapeutic review
- Administrative review (policies)
- Support member and provider education
- Act as liaisons between IME and Medicaid providers
- The chair of the CAC convenes ad hoc committees of specialists to respond to specialty issues. This policy allows for peer-to-peer instruction and input (i.e., cardiac committee).

IFMC will continue to assure all individual service claims are reviewed and processed in accordance with current Iowa Medicaid coverage policy. We process approximately 230,000 individual service claims annually. Our experienced team of registered nurses and a certified professional coder process on the average, 97 percent of these claims within 30 days of receipt to IME with a 99 percent accuracy rate. We recognize the data sources that reflect current Iowa



Medicaid policy to be the IAC, Medicaid Provider Manuals, and Informational Letters. Due to the evolving nature of coverage policy, it is imperative that staff have a vast knowledge of Medicaid coverage policy and receive timely notification of any and all policy changes. Our review staff are updated on a daily basis with any coverage policy changes affecting the processing of individual service claims.

Effective and efficient communication among all IME vendors and the Department is crucial to the success of this process. We will continue to work collaboratively with the Department and other IME vendors to ensure all system edits and MMIS indicators reflect current coverage policy by submitting SAMs and CMRs when needed. A SAM is requested for an update needed in any MMIS file and requires sign-off/approval from the Core vendor. A CMR, while similar to a SAM, is for needed hardcoded changes in the MMIS. CMR changes require medical and policy approval prior to production by the CORE vendor. Types of system issues we have collaborated on with the Department and other IME vendors include:

- Place of service and provider type discrepancies (SAM)
- Edits posting incorrectly (CMR)
- Updating service limitations (SAM)
- Adding new editing (CMR)

Each system issue is thoroughly researched and discussed with the Department policy specialists and other appropriate IME vendors to ensure each party has an understanding of how the issue should be resolved. We then work with Core systems staff on the updates or changes that need to be made to resolve the issue.

We have staff with Medicaid experience, ranging from one to eight years (at an average of five years), reviewing claims and entering individual claim decisions in MMIS. This experience promotes efficient use of time and consistent results in claim reviews. As the Medical Services contractor, we are dedicated to updating IME data systems and making Department-requested updates to provider records with new procedure codes, provider types, or prior approval indicators to reflect policy changes. We understand the importance of accurate indicators in the MMIS Procedure, Drug, and Diagnosis (PDD) file and the significant impact this file has on accurate claims payment. We have submitted approximately 350 SAMs since becoming the Medical Services contractor. When changes are requested to a code, we not only review the noted changes, but we take the opportunity to provide a comprehensive review of the code or a range of codes, ensuring the accuracy of current MMIS indicators.

We are dedicated to maintaining effective and useful interfaces with individual providers regarding medical policy questions and decisions on individual claims. Many of our experienced review staff know providers and/or their billing staff by name, with providers having direct telephone numbers for the appropriate review staff who can assist them with their claim and policy questions. This individualized approach results in providers receiving consistent and timely responses on their questions. We often initiate contact with providers during claim reviews when we note routine billing or documentation errors. This proactive approach results



in an increase in the percentage of claims paid on initial submission and a decrease in provider billing errors.

The Medical Services medical director is the lead medical expert for all IME vendors. Medical directors for Member Services and the Medicaid Integrity Program will report to the Medical Services medical director. The medical director provides medical policy explanations and billing issue-related expertise, face-to-face, telephonically, or in written format to all Medicaid providers who request clarification.

We will continue to provide formal policy clarifications or updates to selected provider groups on behalf of the Department in a variety of ways. We will respond to written provider inquiries relating to policy questions. We will also provide assistance with written and edited informational letters to providers regarding changes in policy, coverage of new services, and billing updates. Formal policy clarification will also occur via conference calls; e.g., this approach was used to inform home health providers of the changes being made to the home health EPSDT PA process. Providers were informed of the new format of reviews and the tools that would be used in conducting the reviews. Department policy staff, along with personnel from DIA, Child Health Specialty Clinics, and providers involved in the testing of tools was present for the conference calls to provide support for the change in the PA process. We intend to conduct this same successful statewide conference call training for providers when beginning the PA of magnetic resonance imaging (MRI) and computed tomography (CT) services. We will continue to use a variety of methods to ensure provider feedback and updates (i.e., one-on-one, letters, conference calls, and group training).

We have assisted Provider Services with their annual trainings by reviewing, editing, and updating their training materials and have been available to answer provider questions at the annual training sessions. During the annual trainings that were conducted during the summer of 2009, our remedial staff were available at nearly all remedial service provider trainings to respond to questions and assist providers. Our experienced professional staff have proven to be reliable resources for the Department, providers, and other stakeholders including all IME vendors.

We maintain operational procedures and desk guides reflecting current procedures for reviewing medical codes for claims processing. These detailed documents provide review staff with the specific criteria and guidelines used to review each type of medical claim. Our review staff are updated on a daily basis of any changes in coverage policy and then make updates to the operational procedures and/or desk guides within 10 business days of any changes in review processes. By having current, detailed operational procedures, the Department is assured there is continuous coverage for claims processing.

We will continue to maintain documentation of updates made to medical codes through SAMs, CMRs, and annual Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and International Classification of Diseases – 9th Revision – Clinical Modification (ICD-9-CM) code updates. When we are reviewing codes prior to updates being



made, we document all research, collaboration, and discussions related to integrating the changes in order to preserve the background information of the reasons and rationale for changes made.

IFMC staff have a broad understanding of Medicaid regulations and programs, possessing the skill sets required to conduct detailed and effective investigations regarding new policy or proposed policy changes. Examples of focused investigations include assessments of access to care, utilization of services, coordination of care, continuity of care, health education, and costs. For example, if the Department requests coverage policy for a new procedure or medical treatment, IFMC will obtain coverage information from other State Medicaid agencies through the Medicaid medical director listserve. Our past medical director is an active member of the listserve and will continue active participation in the future as well as introduce our new medical director to the group and the listserve. We also obtain information from commercial insurance companies, medical literature (i.e., Hayes, Willpoint, AHRQ Effective Health Care website), and medical experts at both the state and national level. In addition, we gather cost and utilization information to assist the Department in determining fiscal impact of new services.

***The Department asked IFMC to lead the Economic Loss Training sessions explaining the State’s responsibilities and plans for flooding victim’s needs. “Thanks to you for the time and effort you put into doing these meetings. I realize that it is outside of what you normally have to do every day, and I really appreciate you taking the time to lead these sessions” says Jennifer Vermeer, Medicaid Director.
January 2009***

In order to more efficiently track and document the rationale for changes to Medicaid services, we propose collaborating with Core OnBase staff, other appropriate IME vendors, and the Department to develop a workflow through which the requestor or the vendor receiving the request starts an e-form in OnBase to track the issue. This e-form and any necessary documentation could be sent to any parties who need to review the issue. Each involved party could then enter review comments, preserving an audit trail in OnBase. With this information residing in OnBase, the Department would benefit by having a repository of decisions made with supporting rationale for each decision.

Over the past five years, we have provided professional consultation services to the Department on requested changes to Medicaid services from providers or other stakeholders on a daily basis. When a requested change to Medicaid services is received or identified, our experienced staff including the Medicaid medical director, registered nurses, and a certified professional coder begin researching the issue by obtaining information from other state Medicaid agencies, Medicare fiscal intermediaries, commercial insurance companies, and medical literature. Through this research we ensure Iowa Medicaid covered services are in line with other payers and current medical practice. We also collaborate with Provider Cost Audit and Rate Setting for assistance in determining cost information. When all necessary information has been gathered a recommendation is composed and provided to the Department. Often times, face-to-face



meetings are held with the Department to further discuss the recommendation and answer any outstanding questions, ensuring the Department has all information needed to make a fully educated decision.

For example, IFMC provided consultation services related to monitored anesthesia care (MAC). The Department asked us to prepare a formal response to a provider question regarding noncoverage of MAC by Iowa Medicaid. We conducted an exhaustive literature review, reviewed published studies, and documented how other payors processed claims for monitored anesthesia care. Following the research, a formal response was submitted to the Department indicating the provider type able to administer MAC, as well as quality of care concerns related to non-anesthesiology personnel providing MAC. The Department was then able to forward this information to those questioning the noncoverage of MAC. By providing this detailed review of literature, published studies, and other payors, the Department was able to fully support payment policy for MAC.

We provided consultation services to the Department on a request from a provider regarding the use of QK and QY concurrent anesthesia procedure modifiers used in billing. A provider requested that Iowa Medicaid allow the billing of the QK and QY modifiers. We researched the use of the modifiers with other payors, including Medicare. We also reviewed Medicaid policy to ensure there were no rules prohibiting the use of these modifiers. We collaborated with Provider Cost Audit and Rate Setting to gain information on the reimbursement methodologies that relate to these modifiers. After research was completed, the information was provided to the Department. Once the Department approved the requested change, we worked with the Core unit to develop the needed programming to implement payment for QK and QY modifiers. We also collaborated with Provider Services to develop an informational letter explaining the changes. Changes such as this require collaboration among multiple IME vendors. As the current Medical Services vendor, IFMC has demonstrated success in this collaboration repeatedly.

We also take proactive initiative and recommend changes to Medicaid services as we identify issues. One example relates to home health claim reviews. For many years prior to IME, high level reviews were performed on home health claims. Home health providers had to bill via paper claims and submit documentation with every claim, some of which never suspended for review. We recognized there was not significant value in this review and that Medicaid monies spent on these reviews would produce better value through allocation to a more in-depth medical necessity review. After much research and discussions with the Department and other IME vendors, we proposed that home health providers bill electronically and review be conducted on a statistically valid random sample of claims pulled from these electronic submissions each month. In-depth review is then conducted on these claims. Providers now bill electronically without sending unnecessary documentation. These changes have led to decreased documentation requirements and more efficient use of Medicaid dollars. In addition to efficiencies attained by providers, OnBase scanning by mailroom staff has decreased, and in-depth reviews have resulted in greater ROI for the program.



Following the Department’s award of the Correct Coding Initiative (CCI), the Department requested the assistance of several IME vendors, including Medical Services, in the implementation of the new project. This project has required a great deal of collaboration among the Department, IME vendors, and the CCI vendor. We are very excited about the transparency to providers that implementation of CCI edits will provide. The higher level of editing by the CCI vendor will ensure Medicaid claims approved by the MMIS are appropriate for payment.

As the ongoing Medical Services vendor, IFMC will continue to add value through initiatives consistent with those implemented over the past several years.

IFMC has assisted the Department in responding to appeals related to medical necessity denials for the past five years. Our professional staff have written case summaries and provided testimony in more than 575 appeals in SFY 2009 of which only 1.4 percent of the outcomes were reversed. We will continue to provide the following information to the administrative law judge (ALJ) prior to the scheduled hearing including:

- Overview of review process applicable to the case being appealed
- Case summary of the review
- Copy of denial letter(s)
- Medical record information
- Denial reason and rationale

In addition, our professional medical staff will provide expert testimony in respect to best practices, standards of care, medical necessity, reason and rationale for denial.

IFMC’s review of service requests for policy exceptions received from the Department involves researching the purpose and effectiveness of the item or service. Written requests for additional information are submitted to the provider via fax or e-mail to improve efficiency and facilitate rapid response to the request. Requests may include asking for additional information from the member’s record, scientific research to support the provider’s decision to ask for exception, and/or pricing information to substantiate cost-effectiveness for the member and the Department.

The final step is to obtain outside consultation in the appropriate field or to request that the medical director or clinical assistant review the original request and additional information provided. These experts provide feedback regarding medical necessity and effectiveness in achieving positive outcomes. We also research pricing to identify the least costly manner for obtaining the item or service. The total response is sent as a recommendation to the Department. Exceptions are granted at the complete discretion of the Department of Human Service’s Director after consideration of all relevant factors, including our review recommendations.



IFMC assists the Department in the review of many services and products which are policy exceptions. Examples include:

- Placement in out-of-state facilities
- Drugs and biologicals
- Home health
- DME and supplies
- Dental
- Therapy (i.e., speech, physical)
- Treatments
- Vision
- Surgical
- Level of care determinations

In the past year 588 adult and 622 EPSDT exceptions were reviewed or an average of 49 adult and 52 EPSDT reviews per month.

Recommendations of policy changes due to the responses, frequency of requests, and changes in practice patterns are also forwarded to the policy staff. This process has resulted in changes in policy. An example is the coverage of single and multivitamins which are not on the rebatable drug list. These were moved to regular PAs and are now covered under enteral nutrition.

IFMC has provided professional and technical support to the Department during the past several years for the following:

- State auditor
- OIG audits
- CMS waiver
- EQR onsite visits
- PERM onsite
- MIG review

IFMC will continue to provide professional support (i.e., coding experts, program specialist, CPHQs, medical director) to the Department. Our role of support is varied and includes medical record review, claims coding review, and validation onsite reviews.

***The IFMC Medicaid medical director was a guest presenter at the Rebalancing Healthcare in the Midlands conference. He reported on Quality Improvement Activities ongoing in the Iowa Medicaid agency.
December 2008***



IFMC was designated as the Professional Standards Review Organization for Iowa in 1974 to perform medical peer review for Iowa's Medicare and Medicaid programs. IFMC was designated as the Peer Review Organization in 1984 and currently holds the CMS QIO contract for Iowa. Our QIO work includes beneficiary complaint review and medical record review which is relevant to IME Medical Services responsibilities and whose expertise we can draw on if needed. IFMC has conducted review of Iowa Medicaid services through a contract in accordance with 42 CFR 431.630 for more than 30 years.

IFMC was also the Medicare QIO for the state of Nebraska for approximately 16 years and has been the Medicare QIO for Illinois since 1996.

As the Department is aware, contracting with IFMC allows the Department to claim 75 percent Federal Financial Participation (FFP) for qualifying programs rather than the traditional 50 percent FFP for administrative services.

Using the established OBCR process, IFMC identified necessary changes to OnBase workflows to increase the efficiency of provider inquiry distribution and completion. The Claims Pre-pay team receives the provider inquiry via OnBase workflow and contacts the provider to respond to the inquiries. We will continue to provide professional support to Medicaid providers regarding policy, PA, and billing requirements. We provide oral instructions via telephone and written communication via e-mail to provider questions. All inquiries and responses are documented in OnBase. An increase of 396 percent of provider inquiry reviews has occurred since IME implementation which allowed for a designated provider inquiry process that was not previously available. We have responded to this increased workload efficiently and timely, allocating existing resources, without an amendment for additional monies.

We will maintain contact with providers on a daily basis via e-mail, fax, letters, and telephone calls, assisting them with claim, PA, or policy questions. When responding to providers, we will provide them with information to solve the specific issue at hand, and will also educate providers on how to prevent similar issues. We will use OnBase Workview to track all oral communication with providers. We also support providers through developing or assisting with informational letters, using a proactive approach to educate providers on recent or upcoming changes.

With the wide variety and specialized services that the University of Iowa Hospitals provide, they often have issues that arise that are unique to them (i.e., billing volume, unique services). To assist this provider in resolving these issues and to provide high quality customer service, we have collaborated with Provider Services and now participate in monthly (sometimes bi-monthly) conference calls with the University of Iowa Hospitals. This approach has resulted in a decrease in the volume of billing concerns and allows us to readily identify any system issues that may be impacting this provider. We will continue to collaborate with the University of Iowa (who is the largest provider of specialty services for Medicaid members in the State) to ensure effective solutions to billing issues that may be unique to their institution.



IFMC retains more than 150 medical and social service professionals who are knowledgeable about the Iowa Medicaid programs' policies and procedures regarding coverage and limitations. These requirements are met with both staff positions and a peer consulting panel. IFMC continually recruits peer reviewers of all specialties. The Medicaid medical director assists in locating ad hoc peer reviewers when needed. IFMC has all professional types listed in the RFP, plus additional specialties not included in the RFP. This ensures the availability of clinical expertise for any type of case we may encounter.

IFMC reviews all physician and consultant credentials and licensure prior to approval as a peer reviewer. Recredentialing is completed every two years and encompasses the same credentialing process. Items requested for validation by the IFMC compliance officer include:

- Curriculum vitae
- Copy of current license(s)
- Copy of board certification(s) or board eligibility
- Signed confidentiality statement
- Signed conflict of interest form
- W-9 form
- Copy of liability
- Data bank query

IFMC's medical and professional staff and consultants support the Department in responding to appeals in all utilization management programs. Our medical and professional staff or consultants have participated in more than 575 appeals over the past SFY. We provide expert testimony in respect to best practices, standards of care, as well as reason and rationale for the denial.

A Medicaid member adversely affected by an IFMC denial decision has the right to appeal. IFMC describes the appeal rights as explained in IAC, 441 – Chapter 7, in all denial correspondence. Following notification of an appeal request, appropriate information from the review is submitted to the ALJ. The following information is sent to the ALJ:

- Overview of review process applicable to the case being appealed
- Case summary of the review
- Copy of all denial letters
- Medical record information
- Denial reason and rationale

Complete documentation is vital to the appeal process, it is the foundation upon which determinations are made and sustained. IFMC assembles complete case information for the ALJ and requestor, reducing delays in the appeal process. IFMC management staff, medical director, and/or the clinical assistant to the medical director attend the administrative hearings which are



usually held via teleconference and provide expert testimony regarding the review process and determination.

IFMC currently has a network of consulting providers available to review cases and provide consultation. The consultants also provide feedback on proposed policy changes. Using their own medical expertise and knowledge about the standards of their profession, they assist with policy development, coverage of specific services, member utilization review and determination of medical necessity. Our consultants have also assisted the other IME professional services vendors. Examples include dental and therapy medical necessity and quality reviews completed for the SURS vendor when they are preparing court cases for suspected provider overpayment.

IFMC routinely provides the Department with the names and specialties of all consultants. Adding an in-house dental hygienist has provided the Department with readily accessible dental coverage consultation.

IFMC utilizes criteria outlined in Chapter E of the acute provider manual to conduct certification of new outpatient hospital programs. At the time a Medical hospital provider applies for certification, IFMC reviews the program requirements, program overview, objectives, and policies and procedures regarding staffing, admission criteria, environment, and documentation then makes a recommendation for approval or denial. If a denial is issued, the provider is given the opportunity to resubmit any missing information and additional review is completed. If approval is recommended, the information is forwarded to Provider Services to complete the certification process. IFMC currently reviews the following applications:

- Cardiac rehabilitation programs
- Diabetic education programs
- Eating disorder programs

As the current Medical Services contractor, we review all claims relating to hysterectomies, abortions, and sterilizations. We have specialized reviewers with obstetrical and gynecological experience who focus on these reviews. This ensures consistent and accurate processing of these claims and that the sterilization consent form is completed in accordance with the IAC, or that the hysterectomy acknowledgement of sterilization is included with the claim as appropriate. We understand the importance of accurately adjudicating all claims and we know that paid abortion claims must be appropriately reported for state or federal funding. We ensure all required documentation including the abortion certificate, operative reports, ultrasound reports, pathology reports, lab results, consultation notes, and history and physical accompany the claim to support reimbursement for the services performed. Review coordinators can approve the service if all required documentation is submitted and supports the service. All cases that cannot be approved by the review coordinator are referred to the medical director and/or peer reviewer for final determination, including reason and rationale. Denials can only be determined by the medical director and/or peer reviewer.



We review all orthodontia claims that suspend for review due to discrepancies between the PA and claim to ensure accurate processing. Due to numerous recent changes made by CMS relating to the codes used for billing orthodontia services, we have noted that providers have an increased need for assistance with billing for these services. Typical errors included attempting to bill too many units on one claim line, billing the incorrect codes, or exceeding units approved via the PA due to many adjustments being made. Several procedures have been built into one code (D8070). This code has four different procedures and four different fee schedules associated with the procedures. Each unit requires entry on a separate claim line with a valid description in order to correctly price the service provided. Other special requirements also apply. The review coordinator corrects the error and submits the claim for correction and recoupment.

Our dental hygienist and certified professional coder specialize in dental/orthodontia claims review. These staff are also available to dental providers to answer questions and provide education regarding accurate billing. This support promotes prompt payment of claims.

Our review includes claims which suspend for several reasons, some of which are listed below:

- The PA may appear to be used due to process adjustments. Our review of the claims history in all cases includes determination of whether the PA has been used or not.
- The provider may not have listed the PA request on the claim.
- The provider bills codes other than those approved on the PA.

We will continue to review all claims that suspend for medical necessity review of documentation or pricing. Our detailed operational procedures and desk guides provide a solid basis for consistent and accurate claims review processing. Additionally, our review staff have a thorough understanding of the IAC and Provider Manuals which provide the basis for covered services. We have implemented many process improvements in our IME review of these claims. We will bring these improvements into the next phase of the Medical Services contract as well as continue to seek further improvements and efficiencies.

Great strides have been taken since IME implementation to have well documented, research-based criteria. IME's criteria have been developed from research of Medicare criteria, other State Medicaid criteria, and other payors criteria, along with collaboration with the Department staff and CAC approval, assuring Medicaid criteria reflect current evidence-based medical practice standards.

The pricing of multiple surgery claims is a manual process with the potential for a high rate of human error. Our team of review coordinators includes specialists in the pricing of multiple surgery claims, resulting in consistent accuracy. We developed our process after conducting extensive research on the manual pricing of claims for Medicare. With the Department's approval, we implemented this process for IME utilizing Medicare's multiple surgery, assistant surgeon, and co-surgeon indicators instead of the previous RVS values in the MMIS PDD file narrative screen. By implementing these methodologies, documentation more readily supports



the pricing of Medicaid claims when providers question reimbursement. This in turn promotes provider satisfaction and understanding of Medicaid's payment methodologies. Review coordinators can approve the service if documentation supports the service. All cases that cannot be approved by the review coordinator are referred to the medical director and/or peer reviewer for final determination, including reason and rationale. Denials can only be determined by the medical director and/or peer reviewer.

As the current Medical Services contractor, we conduct monthly home health retrospective medical reviews on a statistically valid random sample of paid home health claims. Presently, this sample excludes private duty nursing and personal care services, as these services require PA. In the next contract period, we will work with DW/DS staff to include private duty nursing and personal care service claims in the random sample for retrospective review and will ensure each home health agency is reviewed at least once annually through this process. Agencies with five or less clients per year will have one review completed. Agencies with more than five clients per year will have a 10 percent random sampling of their clients reviewed.

When the claims to be reviewed have been identified, the requested home health agency documentation is reviewed for medical necessity of the services IME reimbursed to ensure documentation supports the services billed. Following the review we provide written feedback to the provider noting areas of strengths, and any discrepancies found in order to improve the accuracy of claims submitted.

In addition to the above home health reviews, IFMC developed and implemented a quality review of EPSDT home health PAs at the request of the Department, to ensure accuracy of charting and reliability that the services ordered were performed. We will continue this quality review with the new contract. Any concerns regarding the quality review, will be followed up with additional reviews and communication with the Department in a quarterly report.

A Quarterly Report of Abortions will continue to be submitted for Department approval. We understand the importance of accurately reporting state and federally funded abortions and that there is a financial impact to the State, including recoupment by the federal government, if abortions are reported incorrectly to CMS. We have taken steps to ensure all abortions are reported correctly by ensuring required documentation is included with the request/claim.

In addition to performing detailed reviews of suspended abortion claims ensuring all required documentation is included with the claim and compiling these claims for the quarterly abortion report, we have collaborated with the IME Core unit to make improvements to the Abortion COLD report. Previously this automated report was not used by any unit because it was so large. It was not an efficient tool to identify all appropriate abortions to be reported. Through collaboration with the IME Core unit and the Department, the Abortion COLD report was improved by removing procedure codes and/or diagnoses that were not related to abortions while being certain all abortion-related procedure codes and diagnoses were included on the report. We have now been using this COLD report as a second review of paid claims potentially related to abortions that would need to be on the Quarterly Abortion Report.



Most recently, we have been collaborating with the IME Core unit and the Department to work towards an automated Quarterly Abortion Report. When this change is implemented and we review a suspended abortion claim, we will enter an indicator in MMIS identifying the abortion as a state- or federally-funded abortion which will then automatically post to the appropriate line on the CMS report. The manual Quarterly Abortion Report that we currently produce through the above stated process will be used by the Department's budget analyst to verify all abortion claims have been pulled accurately to the CMS report. With the change in this process, the Department has requested they receive the Quarterly Abortion Report in less time than the stated 10 day performance measure. Effective in the first quarter SFY2010, we began providing the Quarterly Abortion Report to the Department within five business days of the end of the quarter. We are committed to continuing to provide the Quarterly Abortion Report to the Department within five days of the end of the quarter during the new contract period.

We facilitate the preparation of the Quarterly Report of Hysterectomies and Sterilizations. Most recently we have collaborated with the IME Core unit and the Department and re-reviewed the code sets that are being pulled to the line on the CMS report for sterilizations and hysterectomies to ensure accurate reporting of these services. These efficient processes for mandated reporting will continue in the next contract period.

We currently perform a quarterly analysis of Medicare policy and code changes but will increase the frequency of this analysis to monthly and then report to Department policy staff changes that may affect Medicaid. This improved process will place IME in a proactive position which ultimately may improve provider satisfaction. We will continue to monitor these changes monthly by reviewing new or updated local coverage determinations (LCDs), national coverage determinations (NCDs), and coverage articles. We also subscribe to e-mail updates from CMS on topics that relate to Medicaid services. When Medicare changes are identified, we research Medicaid policies to determine if the change would apply to Medicaid. If the change does apply to Iowa Medicaid we conduct further review of the Medicare change, the effects it has, and how they have implemented the change. We provide a summary of these changes to the Department for a final decision on determining if the change should be made to Iowa Medicaid as well. If approved, we collaborate with other units at IME as appropriate to identify and work through any needed system changes and determine if an informational letter is needed to educate providers on the update.

As the Medicare QIO for Iowa since 1984, we provide extra value to the Department through regular meetings with the Medicare Carrier to exchange information and data that will assist in each organization's efforts to promote high quality care and appropriate utilization of services. IFMC maintains a formal written agreement with the carrier which describes the administrative relationship between the organizations and specifies the type of information/data that will be shared. IFMC's existing relationship with the Carrier provides unique advantages for the Department.



IFMC meets with representatives from the Carrier on an ongoing basis. Topics discussed vary from meeting to meeting but generally focus on new Medicare rules and regulations that impact our work or on quality and utilization patterns seen during data analysis that may suggest a problem needing further attention by either IFMC or the Carrier.

When appropriate, medical records, operative reports, and other documentation necessary for proper resolution of claims are requested from providers. This is accomplished in one of two ways; either by denying the claim with an appropriate denial message from our list of denial messages, that have been updated and improved to give providers specific information on why the claim denied, or by pending the claim and calling the provider for additional information. The process of calling the provider and requesting documentation without denying the claim is a process we implemented to provide greater customer service to Medicaid providers.

We understand Medicaid providers may not always understand the documentation required to support their claims. Therefore, in an attempt to improve provider satisfaction, we call providers in specific situations and explain what documentation is needed for review and then pend the claim until the documentation is received. This process saves the provider time and money by not having to resubmit the claim, which delays payment, but also avoids IME having to rekey or rescan the claim into MMIS and rework edits before the claim comes to us for the final medical review. The process of calling the provider is used when a provider is routinely having problems submitting the necessary documentation for review or when a provider is missing one key document.

We provide and track communication with providers through the OnBase provider inquiry workflow process. We review claim inquiries and provide a written response, taking the opportunity to educate the provider with information when applicable, in order to assist the provider in obtaining future payment of services on the initial claim submission. We have collaborated with Provider Services and Core to have keywords added to the provider inquiries that identify the type of inquiry. This has made the provider inquiry workflow more efficient and allows specialized reviewers for each type of inquiry which results in accurate and consistent responses. The addition of a keyword for the type of inquiry has also lead to enhanced tracking of provider inquiries. We are able to review the provider inquiry report to identify the volume of each type of inquiry received which can then be used to either provide broader provider education or MMIS enhancements. All communication to a provider can be easily accessed by IME staff through OnBase document retrieval with the member state identification number or the provider or NPI keywords.

Due to the high volume of policy requests, billing procedure questions, appeals that generate from internal and external stakeholders, and in order to efficiently track research completed, we propose collaborating with Core OnBase staff, other IME vendors, and the Department to develop a workflow in OnBase in which a requestor or the person receiving the request could start an e-form in OnBase to track the issue. The e-form and any necessary documentation could be sent to whoever at IME is needed to review the issue. Currently, the majority of this communication, outside of provider inquiries, is tracked through e-mail conversations and only



resides in the e-mails of those who were involved. By adding these communications to OnBase, access could be given to anyone who may need it, timeliness could be easily tracked, and of most benefit to the Department would be a repository of decisions made with the rationale and conversations leading up to the decisions which often relates to policy coverage decisions.

We currently conduct monthly home health retrospective reviews on a statistically valid random sample of paid home health claims. For the claims provided to us by DW/DS, we request home health agency documentation and review for the medical necessity of the services IME reimbursed. For services that are not supported by the documentation provided, or those not medically necessary, providers are notified of the issues and are given an opportunity to provide additional documentation. When providers are notified of the final decision they are also given appeal rights. A recoupment process is completed when appropriate. On a quarterly basis we provide feedback to the Department of the status of the home health retrospective medical reviews. We will add to this quarterly report more specificity of the issues being noted and any global education that could be offered to providers to improve the accuracy of their claims.

The home health retrospective medical review process was developed by Medical Services and proposed to the Department as an improvement of the previous high level home health claim reviews. After the Department approved this new process, a great amount of time was spent collaborating with DW/DS and the Department to ensure the pool of claims being sampled was the targeted claim population and fit with the Department's objectives. During the implementation of this home health retrospective review process, we continually updated the Department to ensure the type of reviews to be performed met the Department's goals.

The new review process samples a smaller, but statistically valid number of claims, and performs a more in-depth medical necessity review, as well as monitors for duplication of other state funded services. The sample is determined by use of an algorithm that identifies claims for review (i.e., number of skilled visits, type of provider, quantities of services). The enhancement of this process has allowed providers to decrease the large volume of documentation being sent for every home health claim while still maintaining the sentinel effect. It has also given providers the opportunity to submit claims electronically and only provide documentation if their claim is pulled in the random sample. Electronic billing for these claims has also decreased the amount of documentation that was scanned into OnBase by the mailroom.

IFMC performs acute retrospective review to identify and eliminate unreasonable, unnecessary, and inappropriate care provided to Medicaid members. The claims selection algorithm is designed to maximize review of the following:

- Monitor quality, necessity and appropriateness of services
- Identify medically unnecessary admissions
- Identify problems with premature discharges from the hospital
- Perform diagnostic related group (DRG) validation
- Question quality of care



- Assess cases that exceed fixed DRG or costs or number of days for an average length of stay
- Identify appropriate length of stay and level of care for swing beds

The program has shown a consistent savings from one SFY to the next. In SFY 2007, there was a 49 percent increase from SFY 2006 year and for SFY 2008 a 46 percent increase from SFY 2007. Savings stated below represent inpatient and outpatient cases. The total cost savings over the last three SFYs is \$1,385,009. Outlier denials of \$314,983 represent 23 percent of the cost savings.

Retrospective Hospital Review Cost Savings

SFY 2006	SFY 2007	SFY 2008
\$207,120	\$421, 136	\$750,753

The processes for conducting acute retrospective review, once done manually, are now completed within the OnBase system. This includes the medical record selection list and request for records. Queues were developed to create a workflow for activities required to complete these functions. Data is tracked that can be used to assess URAC compliance and Department performance standards. A BPI and results summary was conducted on the retrospective process prior to and after the implementation of OnBase. Results showed a decrease in process and staff time.

A retrospective, post discharge statistically valid random sample are selected for case review. This includes inpatient, outpatient, swing beds, critical access hospitals, readmissions, and transfers.

Requests for medical records for the selected sample are sent on a monthly basis. Hospitals supply a copy of the medical record, a copy of the UB-04 bill, and the remittance statement, if needed, within 30 days (60 days for outliers) following the date of the request. If the hospital fails to submit the requested medical record within 30 days, the case is technically denied.

If there are no concerns regarding utilization, quality, or DRG validation, the review will be completed within 30 calendar days.

If the review coordinator has concerns regarding services that are found to be unnecessary or provided in an inappropriate setting, quality of care, or the validity of the ICD-9-CM diagnostic or procedural codes, the case is referred for peer review. If the peer review confirms the concerns, the provider will be given the opportunity to submit additional information. If the provider does not send additional information, the services will be denied.

IFMC reviews selected observation services for stays lasting longer than 36 hours to assess whether the admission and continued stay was medically necessary and that the care received was appropriate. Each case is reviewed to determine the accuracy of billing, quality of services, and appropriateness of the outpatient setting. Additionally, review is conducted to identify



and/or eliminate unreasonable, unnecessary, and inappropriate care provided to the Medicaid member.

Outpatient/non-inpatient review includes a monthly random sample of claims involving the following hospital outpatient programs:

- Cardiac rehabilitation
- Pulmonary rehabilitation
- Diabetic management
- Nutritional counseling
- Pain management
- Substance abuse services for non-managed care clients

We also review a sample of hospital outpatient claims reimbursed under the ambulatory payment classification (APC) payment system. This sample includes all hospital, medical, and significant procedure APCs. During the review, we determine if the services were medically necessary, provided in the most appropriate setting, provided according to appropriate standards of quality care, and coded appropriately, as supported by outpatient coding guidelines.

Requests for medical records for the selected sample are sent on a monthly basis. Providers supply a copy of the medical record, a copy of the UB-04 bill, and the remittance statement, if needed, within 30-days following the date of the request. If the provider fails provide the requested documentation within 30-days, the case will be technically denied.

If there are no concerns regarding utilization, quality, or coding accuracy, the review will be completed within 30 calendar days. If the review coordinator has concerns regarding services that are found to be unnecessary or provided in an inappropriate setting, quality of care, or the validity of the diagnostic or procedural codes, the case is referred for peer review. If the peer reviewer confirms the concerns, the provider will be given the opportunity to submit additional information. If the provider does not send additional information, payment for the services will be denied.

IFMC's CaseNet TruCare™ system will support the retrospective review process. Received requests for a review are entered directly into the system for each case. Depending on the source of the request, this can be either an automatic or manually completed process. For those reviews which need additional medical information, the letter requesting the information will be triggered by the user in the system. A copy of all correspondence generated will be kept in the member's online record for future reference. Information submitted back to IME in response to the additional information request will be imported into CaseNet TruCare™ and attached directly to the review level documentation. Specific business rules, such as number of days between initial information request and resending if a response is not received to the first request, trigger user tasks and auto letter generation in accordance with URAC standards. Throughout the review process, the system moves the case in and out of appropriate work queues allowing for efficiency and consistency. Our staff have the ability to launch directly into medical necessity review



criteria from the clinical review form. When a physician review is required, that review can be completed within the system.

IME Medical Services and IFMC QIO representatives actively participated on the workgroup convened by the Department to develop recommendations to the General Assembly to redesign the nursing facility accountability measure program. Recommendations included changing the title of the program to “Nursing Facility Pay-for-Performance” and establishing measures around four domains which are indicators of quality of care, quality of life, efficiency, and access. Individual nursing facility results for four measures in the Quality of Care domain are calculated from minimum data set (MDS) data using a risk adjusted model adopted by CMS. As the State’s MDS repository, IFMC has access to this risk adjusted CMS MDS data and will enter into a data use agreement with the Department to provide Iowa nursing facility quality measure data for the Nursing Facility Pay-for-Performance Program. The specific nationally reported quality measures which will be incorporated into the pay-for-performance program are high risk pressure ulcers, physical restraints and chronic care pain. In addition, the Department will perform facility-specific calculations of high achievement of these nationally reported quality measures based on data supplied by IFMC. IFMC will provide technical assistance and monitoring of nursing facility P4P programs.

IFMC analytic staff receive Iowa nursing facility quality measure results from CMS on a quarterly basis. There is typically a four to five month lag in the data as reported from nursing facilities through the MDS transmission process. IFMC will analyze quality measure data annually and provide the Department a list of nursing facilities and supporting data who have met the quality measure standards by May 1, of the following year for each payment period. IFMC can provide quality measure ad hoc reports to the Department for overall monitoring of the nursing facility pay-for-performance program or in response to legislative or other inquiries.

MDS is a tool for implementing standardized assessments to facilitate care management for all persons residing in nursing facilities. Concerns have been expressed regarding the reliability and validation of MDS 2.0. CMS has progressed with plans to develop MDS 3.0 for implementation October 1, 2010. MDS 3.0 will increase the NF residents’ voice through interviews and improve the accuracy and validity of MDS information. IFMC provides support to the Department for the MDS and resulting case-mix index in determination of the nursing facility’s reimbursement rate.

Medical Services attends all monthly national conference calls with CMS, representatives from the Department, and other IME vendors regarding the MDS 3.0 upgrade. Our information technology (IT) staff has attended some of the CMS monthly calls, which have discussed programming changes necessary with the 3.0 upgrade and attended planning meetings with the Department and other vendors. Each state will need to create a program to accommodate/store the new CMS National Repository submission flat file, which is to be populated daily for the states download to the MDS system. We will provide IT and MDS support as requested by the Department during implementation of MDS 3.0.



CMS also calls for a new case-mix classification model resource utilization groups (RUG) IV for SFY 2011. These changes will require modification of existing computer systems to accommodate the new grouper. We have worked extensively with the Department and Provider Cost Audit and Rate Setting to plan and prepare for MDS 3.0 implementation for the State of Iowa. Our MDS expert is an MDS-certified resident assessment coordinator with five years of experience and will have a key role in training providers to use MDS 3.0 and offer guidance and education during this transition. We propose to have four to five ICN/live seminars, partnering with providers associations and community colleges for statewide facility trainings.

The establishment and requirement of the CAC are contained in House File 841.

IFMC designed the CAC in 2006 to represent all Medical Services providers and increase the efficiency, quality, and effectiveness of Medicaid healthcare. The committee consists of nine providers with term lengths of two, three, or four years. The Medical Services medical director chairs the CAC and support services (i.e., public notification, meeting agenda, minutes, and annual report) are furnished by Medical Services support staff.

The CAC responsibilities include:

- Recommendations regarding clinically appropriate healthcare, utilization management, and coverage decisions
- Technology and therapeutics review (advanced therapy and new technology)
- Criteria review and recommendations
- Member and provider education support
- Convening ad hoc committees of specialists when necessary to ensure appropriate peer-to-peer input

CAC meetings are subject to the open committee rules in Chapter 21 of the IAC. The meetings are publicly announced in the Des Moines Register and on the IME website seven days prior to the scheduled meeting date.

Medical Services completes an annual report that outlines the year's activities undertaken by the CAC, recommendations to the Department, identifying the responsible party, and the outcomes.

The CAC quarterly meetings' payments are made by pass-through costs as incurred.

IFMC has consistently and will continue to provide a quarterly report of all appeal hearings. Recommendations for policy changes resulting from appeals are given to the Department. Another important aspect to this collaboration is the communication on how to improve our processes to decrease the number of appeals by referencing different sections of the IAC or wording the adverse decision in a clearer manner for the member and provider. The report provides appeal hearing status (pending, complete) and outcome. In addition, specific findings are documented for monitoring and potential policy changes. We will continue to produce these reports and collaborate with the Department.



For the last five years, the Department has received a monthly exception to policy report detailing the information as to the type of requests, timeliness and recommendations. Any policy changes affecting the number of exceptions are reflected in the report. Examples of policy changes which affected the number of exceptions by transition to PA are:

- Vitamins
- Automated medication dispensers
- Cranial orthotic devices
- Changes in the dental coverage
 - first with the inclusion of dental implants
 - in December 2008, the additional authorizations for members older than 21 years of age for some procedures

The practice of close collaboration with the Department will continue into the new contract period.

IFMC will report on retrospective review activities in a format determined by the Department. We currently track and report the number of medical records requested and reviewed, the denial amount, type and percentage of the total number of dollars denied, and quality concerns.

An annual CAC report is developed and submitted to the Department within 90 days of SFY end and we will continue this practice.

This report includes a list of the members and an activity summary. A sample of activities which occurred during SFY 2009 included:

Automated medications dispenser use	Revised, submitted to policy, approved
Bariatric surgery criteria	Revised, submitted to policy, approved
Virtual colonoscopy treatment	Revised, submitted to policy, approved
Pediatric skilled level of care criteria	Approved as is
Varicose vein treatment	Approved as is
Wound VAC criteria	Revised, submitted to policy, approved

As medical support for the CAC, we produce prevalence reports, as well as data reports specific to the treatments/criteria under review by the CAC.



Reports provided to CAC members have included:

- Member-specific utilization (over- and under-utilization).
- Problem focused utilization (peer-to-peer review)
- Number of Medicaid members/providers requesting virtual colonoscopy
- Number of children younger than 19 years of age receiving psychotropic medications

The criteria used when reviewing claims are either published in the IAC, Medicare criteria, or evidence-based criteria developed by IFMC. All criteria used are approved by the CAC and Medicaid medical director, with final approval coming from the Department. We would propose to the Department that action be taken, through collaboration with the appropriate IME vendors and the Department, to make Medicaid criteria more accessible to Medicaid providers (i.e., IME website, provider manuals and annual provider education sessions). We provide Medicaid criteria to providers upon request; however, publishing criteria and making them easily obtainable online or electronically by providers would make claim reviews more transparent to the providers.

We will continue to manually review claims requiring the determination of medical necessity or appropriateness and take appropriate action to adjudicate the claims. Each claim is reviewed using the appropriate administrative rules, coverage guidelines, medical necessity criteria, operational procedures, and desk guides. Medical Services also completes review to determine if the appropriate diagnosis and procedure codes are used, if the number of units billed is appropriate for services billed, or if there is any fragmenting of services. If claims history contains a claim that should not have paid or that contradicts the claim in review, we will submit internal credit/adjustments for correct processing. Physician review is used on any claim where physician judgment is needed in determining medical necessity.

A recent review of Iowa Medicaid claims, performed by an outside entity, found that claim payments for evaluation and management services reviewed by the IFMC pre-pay team had an exceptionally low rate of payment error, approximately one-twentieth of what is usually found in similar payer analyses. November 2008

After claims are reviewed, the appropriate action is taken in MMIS to either pay or deny the claim. When a claim is denied an appropriate denial message is entered on the claim to give the provider the specific reasoning for the denial. All denials are reviewed by the medical director.

Because we have experienced claim reviewers on staff, we can review and adjudicate claims in an accurate and timely manner. At the implementation of IME, there was not a performance measure relating to the timeliness of claims adjudication. We proposed, and the Department approved a performance measure of adjudicating no less than 95 percent of claims within 30



days of receipt at IME. We have consistently met or exceeded this performance measure and will continue to do so.

Due to the rising number of Medicaid members and the increasing number of services the Department requests be suspended for review, we have seen a continuous rise in the number of claims suspending for medical review. We have recently undertaken a comprehensive review of services that suspend for medical review to determine if these reviews are truly effective medical reviews or if medical review attention could be better focused on other types of services. As reviews are found that are either paid a very high percentage of the time or there is not a medical necessity concern, recommendations will be made to the Department on reviews that could cease or reviews that may be of more benefit to the Department.

IFMC staff consistently consult with Provider Cost Audits and Rate Setting regarding the manual pricing of claims when no current Medicaid fee or payment exists. This collaboration has proven to be important in providing consistently accurate payment to Medicaid providers. When a claim is identified that requires assistance from Provider Cost Audits and Rate Setting, an e-mail is sent to Provider Cost Audits and Rate Setting identifying the claim and procedure and/or service needing priced. When Provider Cost Audits and Rate Setting responds with the recommended pricing information, we proceed as recommended by Provider Cost Audits and Rate Setting and note the fee to promote consistent pricing of future claims.

The co-location of vendors has been a great advantage of IME as Medical Services staff have frequent conversations with Provider Cost Audits and Rate Setting when performing the annual CPT and HCPCS code updates. When Medical Services has completed a preliminary review and identified codes that will most likely be covered by Iowa Medicaid, we send Provider Cost Audits and Rate Setting the list of codes so they can begin compiling fees for the new codes. When we have completed the extensive medical review of the new codes, we collaborate with Provider Cost Audits and Rate Setting on any changes made to the preliminary listing of codes they were given and ensure all appropriate codes have a fee. On occasion, when new procedure codes are developed by CMS, fees cannot initially be established. However, we work to identify these codes as they become more established and then request from Provider Cost Audits and Rate Setting fees to recommend to policy to adopt as Medicaid fees.

IFMC has participated in the PERM project by providing timely medical review on all cases that were identified by the auditors and assigned to Medical Services. We monitored the identified website for review assignments and completed them in a timely manner.

We look forward to conducting medical review for the PERM project again as directed by the Department.

Performance Standards (6.2.1.3)

We will continue to notify the provider within five business days of receipt of a claim inquiry with missing or incomplete information and inform the provider of the needed documentation to complete processing of the claim.



We will continue to send final determination letters on claims inquiries to the provider within 10 business days of receipt of complete documentation.

In the past five years, 99.5 percent of the exception to policy reviews were completed timely. In collaboration with Core, the exception to policy workflow in OnBase has been enhanced to allow a streamlined and paperless review process.

In collaboration with Core, we have improved our processes in OnBase to increase efficiency in processing exception to policy requests. Most exceptions require additional information to support either the need for the services or the pricing requested. Additional information requests will be submitted to the provider within two business days of receipt to ensure timeliness in processing. Prompts to the provider/requestor will be completed as necessary. Recommendations to the Department will be completed within eight business days.

***IFMC management staff were recognized by Patti Becker at the IME Director’s Monthly Unit meeting as being instrumental in the Payment Error Rate Measurement (PERM) review. She spoke of their accessibility, collaboration and accuracy.
 March 2009***

CHILDREN’S HEALTH CARE PREVENTION AND WELL-CHILD-CARE PROMOTION (6.2.2)

On a monthly basis, IFMC has and will continue to ensure that reports are available for the Department’s use in initiation and delivery of services. We have developed a variety of reports under the current contract to assist the Department. These reports are produced monthly by DW/DS. The reports include:

Report	Information included/Purpose
Eligibility	Enhanced processing of requests
Encounter data	Enhanced processing of requests
PAs	Authorization for medical necessity
Interdisciplinary team alerts	Improved quality of care/reduced risk for children

Alerts are produced which assist the various interdisciplinary team members in the decision making process regarding care for this vulnerable population (case workers, Child Health Specialty Clinics, and the Department of Public Health). The reports also support the maximization of federal dollars for the program by providing timely alerts and accurate tracking and monitoring supporting the provision of care.



The overall goal of the Children’s Health Care Prevention and Well-Child-Care Promotion program is to improve the health status of the Medicaid members through 21 years of age. Our EPSDT staff embrace this goal and work towards it daily. Our reviewers have noted occasions in which the quality of care is questionable and also when the safety of the child is at risk. We have immediately followed up on safety concerns and have provided agencies and the Department with feedback regarding quality of care. Our staff have also recommended changes to promote the enhanced processing of service requests and overall care provided to children. These proactive approaches to promoting programs goals will be carried forward into the next contract period.

The interdisciplinary team for the EPSDT program is made up of Medical Service’s medical review staff, Child Health Specialty Clinic nurses, case managers, nursing agency staff, and Department policy staff. The close collaboration of all involved allows the focus to be on the child’s needs so they are appropriately met within the State’s guidelines. The member’s family is also included in the care conferences.

Our proactive approach to working with the interdisciplinary team for private duty nursing and personal care services for special need children under the EPSDT program can be demonstrated through past performance. Two examples of processes we implemented:

- Rapid processing of requests for qualifying members who require private duty nursing being discharged from the hospital where the review and approval of requests occur within one business day of receiving the request.
- Care conferences when a decrease in the approved number of hours occurs. The interdisciplinary team reviews the options available to assist the family in maintaining their special needs member in the home. This team approach enables the Department to ensure the member receives the level of care needed with the appropriate funding.

Collaboration between all agencies involved was exemplified by the changes to the review process for private duty EPSDT nursing implemented in 2009. IFMC initiated a review of the EPSDT prior authorization process. The Department was apprised of the outcomes of research conducted of other state programs, inter-rater reliability, testing, and reliability between the current method and the proposed method. The collaboration was then extended to the Department of Inspections and Appeals, providers, SURs, Core, and Child Health Specialty Clinics. This team provided insight on the process and evaluation tools which were developed. They also participated in the conference calls held with providers before and after implementation of the new process. IFMC will continue these collaborations with all IME partners under the proposed program.

Contractor Responsibilities (6.2.2.2)

The Department has charged Medical Services with monitoring EPSDT services and ensuring that information needed by case managers and nurses at the Child Health Specialty Clinics to most effectively perform their functions is updated and posted on a monthly basis. The reports



are posted on the Department's report site by DW/DS and verified by Medical Services. Being web-based, access is potentially available to Department service workers and IMWs.

IFMC has consistently provided this monitoring and notified DW/DS when this information is not available on the report's site. This function was reviewed with the involved agencies over the last few months as the access to the data warehouse changed. We coordinated communication to ensure that reports were visible to the involved parties. These reports allow tracking of care to this vulnerable and at risk population.

Several reports are available to assist in tracking and monitoring member screening and follow-up treatment. Additionally, two of the reports provide linkage of costs to specific conditions. Current reports are as follows:

- **Screenings Due for Foster Care and Medically Needy with Spend Down** is a monthly report of members who are in foster care or are Medically Needy with Spend Down and who should receive an updated EPSDT screening in the next 60 days. This report enables the Department to monitor healthcare services provided to foster care children and medically needy with spend down members and prompt families and foster families to follow up with healthcare needs of the child.
- **Treatment History for Foster Care and Medically Needy with Spend Down** is also a monthly report of members who are in foster care or are medically needy with spend down and who have received services. The focus of this report is treatment as compared to the previously noted report which identified screenings required. This report enables the Department to monitor healthcare services provided to these members and prompts follow up with families and foster families regarding the healthcare needs of the child. This report is also used to monitor and prevent duplication of services should a foster child be placed in a new environment.
- **Screening Center Services Costs** is a monthly report that lists EPSDT services provided by provider (as claimed in the past month) and identifies whether the claim is a fee for service or health maintenance organization (HMO) claim. This report provides the linkage of costs to specific conditions.
- The **EPSDT Service Summary** illustrates the cost of EPSDT claims for particular services. The report lists (by county) the costs of screening, informing, care coordination, and medical transportation for children in the EPSDT program. Members in the EPSDT program are defined as being younger than 21 years of age. Information is gathered from paid claims of three specific claim types (M-regular physician CMS claims, O-outpatient claims, T-capitation claims). The report looks at singularly or in combination the following:
 - Procedure code and/or diagnosis code (medical or capitation claims)
 - APG code
 - Diagnosis codes (outpatient)

This report provides a quarterly view of paid claims



IFMC has collaborated with Core and the Department to ensure that the federal reports are received in a timely manner for review. IFMC provides all report requirements to the appropriate parties, including communicating any needed changes in report requirements. Core then generates the report which includes claims and encounter data on a county and payment basis. The statewide CMS 416 report is also generated by Core. As the current Medical Services vendor, we have ensured that these reports have been timely and accurate for the last five years.

Our proposed Medical Services leadership team has been members of our Medical Services team since the inception of IME. Their expertise and tenure with the program will allow us to effectively meet the EPSDT reporting needs of the Department on an ongoing basis. We also provide our assurance to the Department that our five year track record of 100 percent on time delivery will continue.

On a monthly basis, IFMC has and will continue to ensure that the interfaces listed below are maintained.

- The IDPH has access to a monthly report on paid claims for the non-HMO population.
- The EPSDT Service Summary illustrates the cost of EPSDT claims for particular services. The report lists the costs of screening, informing, care coordination, and medical transportation for children in the EPSDT program. The report gathers information from paid claims of three specific claim types (M, O and T) and looks at either singularly or in combination, the procedure code and/or diagnosis code (medical or capitation claims) or the APG code and/or diagnosis codes (outpatient). This report includes capitated HMO members which are not added to the costs.
- The interdisciplinary team is contacted and gathered when our staff are not able to approve all requested services; the team collaborates to develop an alternative plan.
- The Iowa Department of Education is provided a monthly report that assists them in billing Medicaid services.
- Case manager interface is achieved through our monthly alerts regarding a child's possible need for an additional PA and to alert the case manager of a child turning 20 years of age so that the transition to adult services, if needed, can be facilitated.
- Child Health Specialty Clinics have access to the "Case Load Due for CHSC" report. The goal of this report is to display EPSDT members who have home health PAs which will expire in the coming six months. This report gives the case managers notice that a PA will be expiring and ensures that a lapse in home health coverage does not occur.

Our Medical Services team has sought out ways to improve reporting and report delivery, and will continue to do so in the next contract period. IFMC's Medical Services staff worked with Core and DW/DS to facilitate automated electronic transfer of the eligibility and claim report to IDPH. This report was provided by the previous vendor via delivery of a CD. We also worked with IDPH to implement an automated e-mail notifying us that the report has been received. On two occasions we have noted that the reverse notification did not occur. We were then able to



intervene to ensure that the report had, in fact, been properly received by IDPH, promoting data security and integrity as well as ensuring IDPH access to necessary information.

We have also worked with Core, DW/DS, and the Iowa Department of Education to provide the Department of Education's report in a similar automated and convenient electronic format. Our team will continue to work with IME vendors, the Department and other stakeholders such as IDPH and IDE to facilitate secure, accurate and efficient interfaces as needed.

Our medical director provides consultation to providers regarding EPSDT services. Additionally, our review nurses for EPSDT services are experienced in pediatrics. In collaboration with the Department and Core, we have developed a monitoring and tracking system for EPSDT services. The data collected assists the nurse reviewer in determining if appropriate EPSDT services were provided timely.

This system also enables us to produce monthly reports to assist the Department in evaluating the appropriateness of services. The reports incorporate an interface for the service workers with the MMIS claims system to determine services provided.

We will continue to utilize our medical expertise to assist the Department in determining the appropriateness of EPSDT services.

IFMC assists the Department in the review of many services and products which are policy exceptions. Examples include:

- Placement in out-of-state facilities
- Drugs and biologicals
- Home health services
- DME and supplies
- Dental
- Therapy, Vision
- Surgical
- Level of care determinations

IFMC has consistently reviewed service requests for EPSDT policy exceptions received from providers and the public for the past five years, completing all reviews within the required performance standards. As requests for members younger than 21 years of age are processed, the device, equipment or service in question is researched as to purpose and effectiveness of performance. We request additional information from providers as needed, including additional information from the member's record, scientific research to support the provider's request and/or pricing information to substantiate cost-effectiveness for the member and the Department. Pricing is also researched so the least costly manner of providing the item or service may be documented.



The effectiveness of the requested item or service in meeting the defined need is also researched. The final step in the process is review of the request and all collected information by an outside consultant in the applicable field or medical director or his clinical assistant. Feedback is provided regarding medical necessity and effectiveness/outcomes. The total review response is sent as a recommendation to the Department. Exceptions are granted at the complete discretion of the Director after consideration of all relevant factors, including our review recommendations.

In the past year, 622 EPSDT exceptions were reviewed or an average of 52 EPSDT reviews per month. These were completed with 99.5 percent timeliness, exceeding the contractual performance standards of 95 percent timeliness. In collaboration with Core, the exception to policy workflow in OnBase has been enhanced to allow a streamlined and paperless review process.

As the Medical Services contractor, IFMC will continue this effective review process and collaboration with the Department and other vendors in the next contract period.

Service care planning, i.e. care conferences, are assembled and coordinated by IFMC when needed to address the private duty nursing and personal care services provided to the special needs children under the EPSDT program. As the Medical Services contractor, we coordinate the interdisciplinary team attending the conferences, usually including provider representatives, member's family or primary care givers (such as foster parents), the Child Health Specialty Clinic, IFMC, and sometimes other interested parties. Care conferences are planned when there are specific concerns about the availability of necessary care for the member. Incorporating all view points from the multidisciplinary team allows the collaboration needed to address appropriate care and to explore options available. This process has proved to be a valuable tool for all involved in addressing the care provided to these special needs children and will continue into the next contract period.

As the Medical Services vendor for the past five years, we have consistently processed approximately 400 PA requests per year for private duty nursing and personal care services. We have worked with the Department and Core to streamline the process using OnBase. Until August 2009, this process included reviewing physician orders especially for the continuous medical monitoring order. The predominant need for PA requests under the EPSDT program is in the area of continuous medical monitoring. In addition, we reviewed supporting documentation of four weeks' notes to ensure that services ordered were performed on a consistent basis prior to approving another period of service.

Following much research and collaboration with the Department, the Child Health Specialty Clinics, providers, the Department of Inspections and Appeals, SURS, and Core a new system for review was implemented in August 2009. IFMC developed and implemented this new process to review care plans for medical needs. Provider documentation requirements for PA requests for Private Duty Nursing and Personal Care services provided through the EPSDT Care for Kids program changed with the implementation of this revised process. The new process focuses on evaluating the EPSDT member's medical needs by closely assessing the plan of care,



functional level and availability of support. Agencies are no longer required to submit four complete weeks of visit documentation on a routine basis.

After researching available standardized tools and other state Medicaid agencies' efforts to create tools to assess medical necessity for waivers and home health care, our team of experienced nurses created tools for use in reviewing medical necessity for home health services for children. The tools are the Medical Needs Assessment Scoring Tool (MNAST), the Functional Needs Assessment Scoring Tool (FNAST) and Social Needs Assessment Scoring Tool (SNAST).

The tools were pilot tested through completing side-by-side comparisons of reviews conducted using previous methods and for the reviews of two home health agencies prior to implementation. Agencies receive a copy of the applicable forms with the completed PA. The MNAST is completed by the medical review staff to assist in determining the level of nursing care needed by the member. The FNAST and SNAST are completed to assist in determining the level of home health aide care needed.

Visit documentation is requested from agencies for a full quality of care review based on a random sample of approved authorization requests. We then conduct a full quality review of these cases using established criteria. While nursing visit documentation is not required with every PA request, the agency is expected to maintain documentation standards commensurate with the Iowa Department of Inspections and Appeals and Medicare guidelines. Following completion of the full quality review, agencies receive feedback regarding the quality of their documentation. All agencies are reviewed at least once annually. We will carry this efficient and highly effective quality review process forward into the next contracting period.

IFMC notifies the case managers of special needs children within 60 days of the due date that a PA is due. The Home Health Expiration Report identifies EPSDT members who have home health PAs that will expire in the coming three months. This report is distributed to case managers to provide notice that the PA will be expiring and to ensure a lapse in care does not occur. Reminders are provided as needed. These reports are also accessible to Child Health Specialty Clinics for their clients. All case managers receive the report via monthly e-mailings. Reminders are sent if the PA is still due at 30 days.

When a change in the service request results from our review of the PA, a conference call may be requested by the child's case manager, health care provider, or the family to review the PA decision with the team. This process ensures that the member receives the level of care needed. This process has occurred over the last five years and will continue in the next contract period.



The IFMC EPSDT team completed a pilot of a new PA process for home health services for children. The team developed and tested new assessment tools to determine medical, functional, and social needs and necessary care for homebound children with chronic conditions. Providers who participated in the pilot reported that the IME staff are “super to help” and that the new process would save the home health agencies time and money. Equally positive feedback was received from the Child Health Special Clinic nurse case managers who expressed their appreciation for the new Medical Needs Assessment Tool (MNAAT), Functional Needs Acuity Scoring Tool (FNAAT), Social Needs Acuity Scoring Tool (SNAAT), and noted that these tools will help address the medical needs of the child in an objective and thorough manner. May 2009

Our experienced review team is fully aware of the importance of implementing services to the member in a timely manner. This goal has been met 100 percent of the time during the current contract period and will continue to be met in the future. The review coordinator immediately processes new requests for service often calling the case manager or hospital discharge coordinator. When we receive a PA request we use ISIS to identify the case manager and the request is processed with them. IFMC processes all other new requests within the standards required by the Department.

Prior to the NOD for modifications or denials, a request for additional information which includes the provider’s request for a care conference is sent to the care provider. When a modification or denial occurs a NOD is sent to the interdisciplinary team.

IFMC has consistently followed the process for approval of procedures for private duty nursing of EPSDT special needs children and facilitated coordination of their service care plan for the last five years and will continue to do so in the new contract period. The new MNAAT, FNAAT, and SNAAT tools streamline the process by focusing on the child’s medical needs. This allows the PA procedure to be completed consistently and in a decreased amount of time for approvals. This ensures that the member receives the proper care and there is no service gap. The review is conducted by registered nurses using established EPDST criteria.

We coordinated with DW/DS and the Department to develop the private duty nursing procedures report. Our efforts included identifying the procedure codes for reporting. This report enables Department policy staff to stay abreast of the private duty nursing services which are rendered and the cost of those services. This report is made available to the Department through DW/DS and will continue to be available in the next contract period. We will continue to review the report periodically to ensure appropriate procedure codes are identified and updated as needed.

IFMC will continue to provide e-mail alerts to ensure that members receive the services needed and there is no lapse in care. A notice is e-mailed to the case manager and Child Health Specialty Clinic 60 days prior to the end of a PA to encourage follow-up preventing a lapse in



care. An enhancement initiated in 2009 at the request of the Department was to include communication regarding needs in coordinating care to the Child Health Specialty Clinic nurse in all cases. Previously this communication was included only when a Child Health Specialty Clinic nurse was the case manager or there was no case manager assigned. This added communications has facilitated appropriate continuation of care for the member.

IFMC also notifies, and will continue to notify, the appropriate field manager and case manager of members turning 20 years of age who have active home health PAs. This notice is provided via e-mail 12 months prior to a member turning 21 years of age to alert the case managers assigned to these members that transition planning for adult services may be needed. This effective process minimizes gaps in service and continuity of care is maintained. As the Medical Services contractor, we will continue this proactive notification in the future contract period.

Using our medical resources, in collaboration with the other IME vendors, and through continuing research and updates on the best practices and standards of care for children, IFMC has and will continue to recommend improvements to the EPSDT functionality. Research is conducted using Hayes, Wellpoint, and the AHRQ Effective Health Care website. In addition, we collaborate with the University of Iowa Hospitals and Clinics and the Child Health Specialty Clinics to ensure current EPSDT standards. Based on research and specialty collaboration, recommendations for change will be made to the Department. The reports which have been instituted allow tracking of trends in the care of these at risk members and can be used to assist us in recognizing methods to improve the system of providing EPSDT services.

Performance Standards (6.2.2.3)

We have and will continue to consistently process requests from providers or the public for services under the EPSDT program which are outside of coverage for the regular Medicaid program within 10 business days of receiving complete information. Over the last year, 622 EPSDT exceptions were reviewed with 99.5 percent completed within 10 business days and 100 percent completed within 25 business days. IFMC provides its assurance that we will maintain this standard of performance in the next contract period. In collaboration with Core, the exception to policy workflow in OnBase has been enhanced to allow a streamlined and paperless review process. We revised the exception to policy process to work like the PA workflow to enable expedited distribution to review coordinators completing the review.

IFMC, in collaboration with DW/DS and the Department, developed the home health expiration report. The goal of this report is to display EPSDT members who have home health PAs which will be expiring and to ensure that lapse in home health coverage does not occur. This report is posted on a web accessed data warehouse and retrieved by Medical Services. We e-mail each case manager notification 60 days prior to authorization expiration.

IFMC's experienced staff have reviewed and completed PA requests meeting all timeliness performance standards for the past five years. We have completed requests within 10 business days of receipt of the completed PA and supporting documentation 95 percent of the time and



will continue to do so in the future. Adding completion of 100 percent within 20 business days to our goals for the future will allow us to further focus on customer service. We will track our success in meeting this goal.

IFMC has and will continue to consistently complete 95 percent of requests for private duty nurse and personal care services within one business day when we have received notice that the member is being discharged from the hospital. All requests have been and will continue to be completed within three business days. This process has been facilitated by working with Core to develop a special queue in OnBase identifying when a special request is received. Close communication with the provider community has also enhanced this process. The new process for EPSDT private duty nursing review will enhance the ability to correctly identify the member's medical needs for service.

For the last five years, IFMC has consistently met the current timeliness criteria for EPSDT home health PAs requiring physician review. This process is facilitated by the presence of the medical director and his clinical assistant at IME as active members of the team coordinating the EPSDT program. We will complete the processing of EPSDT home health PAs within 30 business days in the upcoming contract period. Active communication with the providers facilitates the submission of correct information for review.

IFMC has provided alerts to case managers 12 months prior to a member turning 21 years of age. We notify the appropriate field and case manager of members turning 20 years of age who have active home health PAs via e-mail. This notice alerts the case managers assigned to these members that the member is crossing over from the child sector into the adult sector and encourages follow-up to ensure their needs continue to be met.

MEDICAL PRIOR AUTHORIZATION (6.2.3)

Prior authorization (PA) of health services is an important method to manage the use of certain services and equipment provided to Iowa Medicaid members, helping to assure access to appropriate care and control program costs. Working with the Department and other IME vendors, IFMC developed the procedures for review of PA requests which have been in place during the last five years. Department policy development provides the basis for the entire process.

Developing PA policies and procedures involved close collaboration with the Department. An example was the change in automated medication dispensers transitioning from exception to policy to PA review. The Department made the decision to cover this DME item under regular policy as a cost-effective way to provide care to members at risk. IFMC assisted in this process by reviewing the various types of machines available for functionality, cost and use then made recommendations for the medical criteria and pricing to be used in the process. This process of collaboration and policy development has been effective and will be the basis for our future activity in this area.



We have collaborated with the Department and other IME vendors to build the file structure to identify the services requiring PA prior to payment. This has included making recommendations and assisting in the review of proposed revisions. We have also adjudicated all PA requests that have been submitted, using the policies and procedures approved by the Department.

The close working relationship between IFMC, the Department, and other IME vendors has ensured timely adjudication of all requests and accurate claims processing. This collaboration will serve as the foundation for the PA process used in the future.

Contractor Responsibilities (6.2.3.2)

PA is a recognized method for controlling utilization of targeted services by insurance companies and government entities. It helps the provider to comply with clinical standards of care and provides an effective deterrent to inappropriate use of health care services. As the Medical Services vendor for the last five years, we have collaborated with the Department to identify services targeted for PA, developed criteria for making decisions, and assisted in identifying pricing methodologies.

For the last five years, IFMC has consistently met all PA objectives established by the Department. Services which require PA are routinely monitored to identify trends and determine if any changes are needed in the list of targeted items/services. Monthly reports are submitted to the Department with the number and type of services requested and authorizations completed.

***A PA team member at IME noticed some irregular practices by a dental provider and brought it to the attention of the Department. The chain of events that PA staff started led to further investigation and likely return of significant funds to Iowa Medicaid.
April 2009***

Several sources of data are collected to demonstrate the benefits of the PA program. Claims data is used to track the impact of PAs. This is an effective process to determine if the use of a service changes when PAs are initiated or are discontinued. Annual cost savings reports identify monies saved for the State due to denials and modifications on PA requests. The PA total cost savings for SFY 2008 was \$8.9 million.

In addition, we have proposed additional programs for authorization. An example is the high technology radiology authorizations which will be placed on PA in 2010. IFMC identified this as an area where a PA process would be helpful and researched the possible impact for the state of Iowa.

We have adjudicated all PA requests in a timely manner for the last five years. Services requested have been pended for more information, approved, modified, and denied. Modifications may occur when one part of the service meets the criteria of being medically



necessary but others do not, an incorrect code was submitted, or requested services exceed limitations.

Our in-depth knowledge of Medicaid programs and the experience gained from operating the PA program for the last five years offers a firm foundation for the work to be done under the new Medical Services contract. Our close collaboration with the Department and other vendors at IME will enable a seamless transition and support repaid deployment of any changes requested by the Department.

We have extensive experience in processing PA requests for the Iowa Medicaid program. Specifically, we have performed PA for private duty nursing (EPSDT), personal care (EPSDT), dental services, durable medical equipment, hearing aids, eyeglasses, and certain medical and psychological services. Preprocedure reviews have also been conducted for organ transplants and weight loss surgical procedures. In addition, we will be initiating PA review of high technology radiology (i.e., MRI, MRA, CT, PET scans) early in 2010. Our reviews have always met timeliness standards and will continue in the new contract period.

IFMC provides professional medical staff to perform PA of services as directed by the Department, including a full time medical director, registered nurses, and peer reviewers with recognized credentials in the service area being reviewed. Our current physician reviewer panel is comprised of over 150 licensed doctors of medicine or osteopathy in active practice a minimum of 20 hours per week. All physician reviewers and peer reviewers (such as pharmacists, psychologists, dentists, therapists and other medical professionals) are required to complete and sign a credentials form to confirm their current licensure and active practice status, as well as a confidentiality statement. Their credentials are fully vetted by our corporate accreditation committee. The peer reviewers possess the professional credentials to provide expert witness testimony in hearings or appeals, as needed. The peer reviewer selected to conduct the authorization will be the same specialty and practice setting (rural or urban) as the provider being reviewed. The peer reviewer will not have any professional, family, or financial affiliation with the Medicaid member, the attending physician/provider, and/or facility at which the service is to be provided. Peer reviewers are educated to exclude themselves from the review process in such situations. In compliance with URAC guidelines, internal assessments of the performance of our staff and physician reviewers are performed by the Medicaid medical director on a sample of cases. Peer reviewers are evaluated for timeliness, accuracy, completeness, and appropriate reason and rationale of their decision.

IFMC will staff, maintain, and respond to the toll-free hotline that providers call to determine the status of their PA request and handle all routine inquiries and correspondence regarding PAs. IFMC uses OnBase and MMIS for correspondence relating to PAs.

IFMC review coordinators will review all requests for PA using clinical criteria to determine the medical necessity of the requested item/service. Criteria are periodically reviewed and revised to align with changes in technology and science. These updates are made annually. The use of standard criteria helps insure consistent review decisions among the review coordinators.



The review process used for all PA requests will include the following steps:

1. The review coordinator will receive the authorization request in the OnBase queue and initiate a review the information submitted. This information may include the history of present illness, presenting symptoms, laboratory results, radiological studies, and pricing information.
2. If additional information is required, a request for additional information letter will be sent to the provider. Only information needed to complete the review will be requested.
3. After receiving all information needed to make the determination, the review coordinator will use clinical criteria and other resources (i.e., the Department’s Provider Manual) in adjudicating the requests for authorization.
4. For all items/services which are determined to be medically necessary based on the criteria, the review coordinator will approve the item/service and enter the appropriate information in the MMIS to facilitate timely claims processing
5. If the review coordinator questions the medical necessity, the request will be referred to the medical director or his clinical assistant for a determination. The medical director or specialty peer reviewer reviews all denials and modifications and makes the final determination.
6. Following review by the medical director or specialty peer reviewer, the final authorization determination is entered into MMIS. If the authorization is denied or modified, the review coordinator generates a denial letter to the member through MMIS.

The review coordinator will prepare documentation of all aspects of the review and record the information on the PA form including the number of units approved, if the authorization was approved or denied, rational and reasons for any modifications or denials, and the correct coding to be used when the provider submits claims. If the authorization is denied or modified, the reason and rationale for the decision will be entered in the free-form text area on the PA form and in MMIS.

IFMC complies with the Department’s and URAC guidelines by ensuring that only peer reviewers make PA review decisions or modifications which result in the denial of items/services or the approval of services which are less than requested by the provider. Peer reviewers include licensed health care professionals in the same specialty as the attending provider.

When a service requires PA, the Medicaid provider may submit an authorization request to IFMC via paper, facsimile, or electronically. All transmissions and their mode of transmission are fully HIPAA compliant and have been approved by the Department.

PA requests will be received and imaged in the IME mailroom and forwarded via OnBase to IFMC review staff for processing. HIPAA 278 transactions will be received electronically by Core MMIS, captured, reformatted, and then forwarded by the workflow process management



system to the appropriate IFMC staff for processing. IFMC will work within the OnBase system to schedule and prioritize PA requests based on the date received.

PA requests will be accepted from participating Medicaid providers, Department staff, or other entities that have been approved by the Department to submit PA requests. IFMC will only accept PA requests from sources that have the right to use personal health information and are authorized by the Department. IFMC staff, using the Department's provider file, will verify the requestor is a Medicaid provider before entering the request into MMIS. If the dispensing provider is not a Medicaid provider or another entity authorized by the Department, IFMC staff will notify the requestor that the PA has been abandoned.

IFMC will maintain all PA requests and supporting documentation in the Core MMIS and OnBase systems, which are approved by the Department. Hardcopy PA requests and documentation will be maintained in locked files and sorted by Medicaid member name and state identification number. IFMC will forward PA requests and documentation to the Core MMIS contractor for imaging and storage if they have not already done so during the intake process.

Explicit physician-approved medical necessity criteria for the evaluation of PA requests have been developed by IFMC. The criteria are based on clinical practice guidelines and the current Department PA process. The specific process that will be used to complete the PA reviews is described above in sub-section D.

When we are reviewing PA requests and the determination is made that the request contains incorrect information, is missing information, or requires additional documentation, the review coordinator will create a letter in OnBase requesting the information. Only the information needed to make the decision will be requested. The request is pended for up to 45 days. If the information is not obtained within 45 days a technical denial is issued. Following receipt of the additional information, the PA will be completed.

IFMC staff will enter all PA determinations into the MMIS in accordance with Department policies and time lines. IFMC has a long history of working collaboratively with the MMIS vendor to update the system with PA results. These updates occur through file transfer and online updating. The cooperation of the MMIS vendor is critical to the success of the PA processing function. IFMC will continue its policy of collaboration and cooperation with all involved vendors and the Department to ensure timely and accurate claims processing for cases involving a PA request.

NODs are an important component of a successful PA program. As part of promoting the appropriate utilization of health services, the NOD plays an important role in educating both providers and members about program policy, clinical best practices, and quality standards. IFMC, in collaboration with the Department and Core, have developed an educational, instructive notice.



All NODs issued by IFMC will include the reason and the rationale for the adverse decision and reference the appropriate section of the Iowa Administrative Code. Information as to the specific reason for the denial for member’s understanding, and information about the right to appeal are noted on the NOD and addressed specifically on the PA form in the free text area. A copy of the PA form and the NOD will be sent to both the member and provider for all cases involving an adverse decision.

IFMC will send a copy of the PA form along with any adverse action notices to both the member and provider. The identity of the consultant rendering the decision will not be included in any notices issued by IFMC.

The table below identifies the recipients of NODs for PA requests under each circumstance of approval, denial, and modification of a requested service.

Medical PA	Member	Provider
Approved PA		X
Denied PA	X	X
Modified PA	X	X

Using specific emergent diagnoses and/or emergent medical necessity treatments, IFMC conducts the ambulance claims review. We will review all suspended ambulance claims for medical necessity of the service provided. When the ambulance run report is reviewed and medical necessity is not met and the member was not admitted into the hospital following the ambulance transport, the claim is denied with an ambulance medical necessity denial code. When the ambulance medical necessity denial code is entered in MMIS, a system-generated NOD is produced and sent to the member. Appeal rights are included on the NOD.

We realize the importance to providers and members of timely PA processing. A system has been developed in coordination with Core to automatically approve all requests after 60 days following the receipt of a complete request. At the 45th day a reminder report is distributed to the review coordinator to complete the technical denial.

IFMC serves as a business partner to the Department in all aspects of its work. We support the PA process in the most comprehensive fashion, from the receipt of the PA request through the decision in any appeals hearing. IFMC provides expert testimony to complete each PA appeal.

When a decision is reversed on appeal, dialogue is pursued with the Department as to what additional follow-up shall be done. This dialogue focuses on the following:

- Whether the ALJ decision will be challenged, and
- What changes in process are needed to prevent future occurrences.



The collaboration between the Department and IFMC has been beneficial to identifying methods of improving our processes.

IFMC will provide the Department with various management reports both at periodic intervals and in response to ad hoc requests. These reports will assist the Department in managing the PA program and measuring its effectiveness. The monthly PA report will document the timeliness of PA processing and exceptions to policy, the volume of requests received and completed, the rate of denial, the number of overturned decisions and the reasons for the reversal. The report will also include any recommendations for changes that would improve the PA process

We recognize that the medical field is not static. New procedures and medical devices become part of the medical landscape creating the need for new/revised medical necessity criteria. As part of the Medical Services role, IFMC will routinely evaluate the criteria used in the PA program to make sure it is clinically up to date. Annual updates will be made to the criteria set so that it reflects current science and technology. These proposed changes to the criteria will be presented to the Department for approval before they're used in the PA process.

We will document all questions or concerns about the PA process raised by Medicaid providers. We will work directly with the provider(s) to address any concerns they identify. In addition, we will track all concerns, group them by category, and conduct analysis to identify trends or common themes.

In addition, IFMC's internal IQC process includes an annual systematic evaluation of our activities to identify opportunities for improvement. The process also incorporates feedback and recommendations received from health care providers. The results from our IQC process will be combined with the questions/concerns from providers in our overall assessment of the PA process.

When the internal assessment is completed IFMC will provide a written summary to the Department which may include recommendations to change portions of the PA process to address provider concerns, improve efficiency, or increase program impact.

The medical director, clinical assistant, program managers, and review coordinators periodically review the PA tracking logs in the IQC process and respond to provider requests for modifications to identify potential changes to PAs. At the time changes are made, the MMIS files are updated online by Medical Services staff. In addition, narrative related the change is documented on screen five, the free text field.

We are prepared to accept and process ANSI X12 278 and will be doing so with ClearCoverage PAs. The audit trail of changes (including date and staff) is detailed through the MMIS online file updates.



IFMC has developed a proficiency in tracking information in the OnBase and MMIS systems. A unique ten-digit number composed of the last digit of the year, three-digit Julian date, two-digit PA type number and a four-digit document number (YJJPA####) has been developed to identify each PA.

The following are entered into Core MMIS to interface with claims by the review coordinator:

- Iowa Medicaid provider number and NPI, plus unique provider identification number (UPIN), if applicable;
- Member identification number;
- Procedure code – where the provider has submitted a range of procedure codes or specification of multiple, distinct procedure codes, each code is addressed on a separate line as to whether it is approved, modified, or denied by entry into MMIS. This allows accurate processing of the claim;
- Beginning and ending effective dates of the PA;
- Units of service authorized and amount;
- Type of service code corresponding to the type of PA (i.e., 05-DME, 02-Audiology, 03-Vision, etc.);
- The dollar amount requested for each item on the PA is entered, if the information has been submitted by the provider;
- The most specific description possible for the denial including the IAC reference in entered into the free-text field in MMIS. This information is also entered on the PA form in the free text field; and
- The OnBase system assists in tracking the following: Status of PA request including pending, denied, authorized, or modified; the date of the PA request, when the request for additional information was sent; the date of PA determination and when the notice was sent.

In addition to the above information, identification of the authorizing person is automatically entered by MMIS.

IFMC recognizes that these data elements are critical to processing and managing the PA function. Our IQC process reviews for accuracy in data entry.

We will maintain a free-form text area on the PA form to document special considerations which were noted during the review. The reason and rationale for any modifications or denials will also be documented in this area in compliance with URAC standards. In collaboration with the Department and the MMIS vendor, IFMC developed a set of commonly used, pre-defined messages to clarify information for the provider and member. These have been placed in the OnBase workflow to provide consistent messages and easily understood explanations of review decisions for members and providers. We plan to use these previously defined messages in the PA process for the new Medical Services contract.



IFMC, in collaboration with Core, has maintained provider-specific authorizations in MMIS. Recognizing that PAs have been approved for the member to receive services due to their medical need, if the original provider will not be providing the service, procedures have been identified to transfer the approval to the newly identified provider. These procedures include verification that there is no overlap or duplication which would result in inappropriate use of Department resources.

IFMC has consistently and will continue to edit PAs online. To ensure consistency between reviewers and accuracy for claims processing, we have developed PA edits which validate:

1. Provider ID and eligibility
2. Member ID
3. Procedure and diagnoses codes.

Our procedures also include accessing information in MMIS to verify that each PA request is a unique authorization without a duplicate in the system. There is also an edit in OnBase which alerts staff entering PAs into the system of a possible duplication. The alert triggers further research into the case and involves checking the MMIS PA file for any requests with overlapping service dates. This helps prevent duplication of PA requests from separate providers. If a possible duplicate is identified, a request for information letter is sent to the provider to verify accuracy.

IFMC, in collaboration with the Department, Core, and Provider Services, is implementing the process of PA for high-tech radiology beginning March 2010. We recommended adding this review following research into Iowa Medicaid's utilization of high-tech imaging. An exponential increase was noted between SFY 2006 and SFY 2007 for the amount spent and the number of members receiving these procedures. SFY 2008 data showed that the number of high-tech imaging continued to be elevated with 30,482 tests completed at a cost of over \$20 million. IFMC also researched other states' imaging data, as well as a major private payor in the state of Iowa who have implemented this PA process. Our concerns were not only the procedure cost but also patient safety. This process will decrease the number of members who may receive radiation exposure which may not be medically necessary.

The high-tech reviews are for identified outpatient procedures and do not include imaging done in an emergency room or hospital. IFMC has purchased licensed software, McKesson ClearCoverage, as the software for PA of imaging services. IFMC's PA process enables real-time provider access to financial and clinical coverage information via a website.

Providers request the imagery PA via the web portal. Utilizing evidence-based criteria via a question-and-answer style decision support system allows for approval of authorizations within minutes. If the PA request cannot be approved, IFMC's PA staff is alerted that a manual review is required. The review coordinator assembles the information and refers the case to a radiologic peer reviewer for determination. The ClearCoverage workflow captures authorization tracking, status checking, routing, and escalation that ensure all staff are on top of the relevant steps.



Authorizations will be obtained by the ordering provider through a web-based application process with web and call center availability for assistance.

Our implementation of this review process will be monitored for variations which may occur in practice, as well as for cost-effective decision making. The decrease in radiation exposure for the members by ensuring that only procedures that are medically necessary remain an important aspect to the review for the state of Iowa.

Performance Standards (6.2.3.3)

IFMC has consistently met timeliness performance standards over the last five years. In SFY 2008 and SFY 2009, a total of 17,234 PAs were completed and were complete timely 98 percent of the time. We continue to study and improve our processes to ensure continuation of meeting this goal in the next contract period. The PA staff is focusing on reducing the review time. Recent improvements to OnBase, implemented in collaboration with Core, are facilitating reduced review time.

The addition of a dental hygienist has also increased the number of reviews which can be completed by our staff improving the timeliness, providing improved customer service for our providers and members, and reducing peer review time and expense.

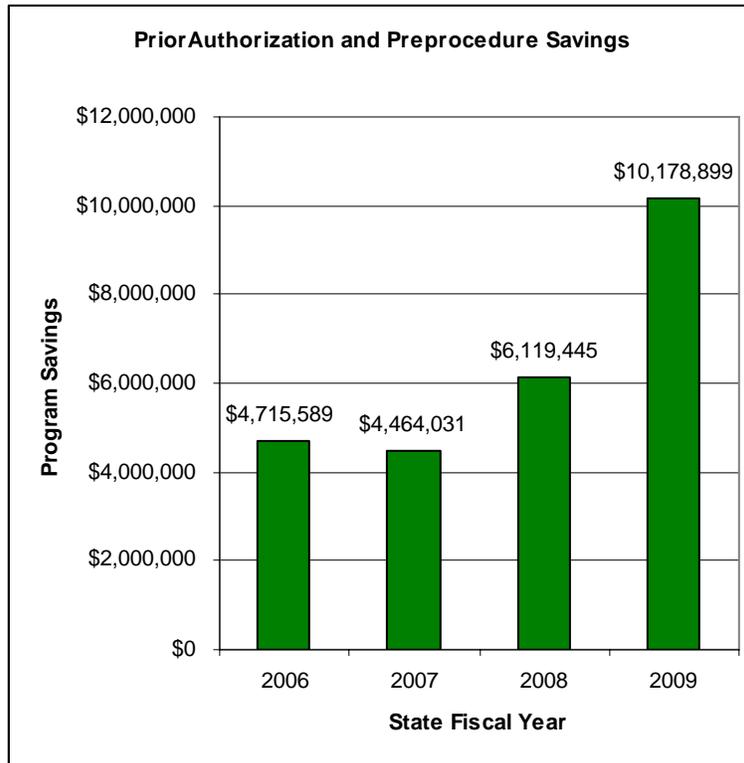
We will meet the performance standard of completing 100 percent within 15 business days.

IFMC will complete 95 percent of PA requests involving physician review within 15 business days of receipt, and 100 percent within 20 business days. During review of processes we determined that if physician reviewers could receive review information sooner we could decrease time and money spent mailing. An electronic submission procedure was implemented with peer reviewers ensuring all information needed for review could be obtained via e-mail, thereby decreasing time needed to complete the review. We will continue to identify and implement changes that will decrease adjudication time and, thereby, facilitate services reaching the member sooner.

Over the last five years, IFMC has consistently met this goal over 99 percent of the time. Collaboration with Core has provided the ability to consistently monitor the system to ensure timely responses to providers. This process also assists in monitoring the length of time a request for information is out to the provider. New methods to reduce the review time have been implemented through collaboration with Core and our peer reviewers. These methods include automated reminders to the team when a PA is still out to the provider for information and is nearing the time limits specified in the contract. IFMC ensures that all PA requests will be completed within 60 business days of receipt.



As the current Medical Services contractor, our PA activities have provided the state with significant increased savings from SFY 2006 to SFY 2009.



PA and preprocedure savings have increased nearly 216% over the past four years.

LONG-TERM CARE (LTC) REVIEWS (6.2.4)

IFMC has been completing reviews for LTC for the past 30 years. We have consistently worked in collaboration with the Department to bring uniformity and accuracy to all reviews. The current review processes are an objective approach to determining medical necessity for each member based on their medical, psychological, and/or mental health condition and functional ability. The criteria for all programs are reviewed and approved by the CAC annually.

IFMC is committed to the ongoing process and future collaboration with the Department to ensure the integrity of the programs. A recent example of our commitment to the integrity of the program is the special project that MFCU, SURS, and Medical Services collaborated on to determine level of care validity for an elderly waiver project. This project is an ongoing group effort to maintain the integrity of the program while working in conjunction with MFCU. At the time of this writing, we continue to work on this project.



Contactor Responsibilities (6.2.4.2)

Currently LTC reviews are completed on admissions to the programs within two days and continued stay reviews are completed within five days once all information has been obtained. Reviews are completed using information provided by the member's physician, provider, and/or case manager.

IFMC has collaborated with physicians and other medical staff to create level of care criteria. The criteria have been approved by the Department and are validated annually by the CAC. The criteria are based on evidenced-based standards and accommodations for the IAC as it relates to the application of the criteria, as required. The annual continued stay review is completed more frequently if a member has had a change in condition or the original level of care was approved for a period of less than one year. Reviews approved for less than one year are determined by medical condition and medical necessity.

Using established criteria ensures that the reviews are completed consistently and objectively with each program and completing the review in a timely fashion ensures that the member does not have a delay in starting services.

Areas of review include:

- Functional ability
- Cognitive status
- Mobility
- Skin condition
- Pulmonary status
- Continence
- Nutrition
- Medications

A holistic approach to a member and their condition is considered when completing the review process. IFMC management staff are available to talk with members and families as questions arise regarding level of care processes and outcomes. Experienced management staff in all LTC programs lends itself to understanding of the member's unique condition and needs.

Recently the home and community-based services (HCBS) team has implemented a pre-appeal hearing conference with the member or their representatives, at the request of the Department. Many members have a voiced lack of understanding with the appeal process and find it helpful to have a one-on-one conversation with an HCBS team member to answer questions and provide education.

Staff responsible for completing the level of care reviews for HCBS medical waivers, nursing facilities, nursing facilities for mentally ill (NF/MI), and Program for All-inclusive Care for the Elderly (PACE) are all registered nurses. The team that completes the HCBS medical waiver



reviews is comprised of eight registered nurses. One of our registered nurses is also a qualified mental retardation professional (QMRP) with mental retardation (MR) population experience and provides an expert resource for the team in determining the MR level of care for the ill and handicapped and brain injury waivers. The current HCBS medical review coordinators are tenured staff who have been dedicated to the medical waiver review process which provides consistent review in a timely manner.

Professional staff conducting level of care for PACE and nursing facility admissions and continuing stays are licensed registered nurses, many of which have a certification in gerontology.

Staff responsible for habilitation level of care review are licensed independent social workers (LISW), BA in psychology, and masters in rehabilitation.

The ICF/MR facility and ID waiver review teams are QMRPs and are either nurses or human service professionals. We find the diversity of backgrounds strengthens the comprehensive nature of the review.

The CMH waiver and remedial review coordinators are licensed professionals of the healing arts (i.e., LISWs, licensed mental health counselors, marriage and family counselors). They are master level clinicians with expertise in the area of children’s mental health.

The remedial team at IME, received recognition from a Remedial Service Provider. The customer was highly appreciative of the Team’s efforts in providing quality customer service when their agency records were lost to a fire. Team members compiled necessary documentation within the IME database, which allowed the provider to proceed with necessary mental health treatment. April 2009

The team that conducts PMIC review is registered nurses with experience in mental health or licensed practitioners in the healing arts (LPHA).

Each team includes a quality improvement coordinator to measure inter-rater reliability within the team. This process allows for consistent reviews and provides educational opportunities for team members, as well as program integrity. The inter-rater reliability outcomes are reported to the Department on a monthly basis.

IFMC ensures adequate qualified staff to complete reviews in an accurate and timely manner through cross-training and back-up partners. Staff qualifications will be submitted to the Department for approval.



HCBS Waivers

We complete level of care reviews for the institutional and HCBS waiver programs in accordance with all state and federal requirements. To meet federal requirements, reviews for the waiver programs are conducted using the same criteria established for acute or institutional care.

All medical waiver initial and continued stay level of care reviews are initiated through a fax certification form from providers and/or case managers. The certification form is faxed to OnBase at which time IFMC support staff keyword the OnBase document and assign to a review coordinator. Utilizing criteria, review coordinators determine approval for level of care at which time they document the approval in both ISIS and the CaseNet TruCare™ system. The approval in ISIS notifies the case manager and the IMW that approval has been determined. If the review coordinator cannot approve level of care based on the criteria, the case is referred to the clinical assistant to the medical director via OnBase workflow. If the clinical assistant is able to approve the case it is routed back to the review coordinator for entry of the approval into ISIS. If the clinical assistant is unable to approve level of care, the reason and rationale for that decision are routed to the medical director or peer reviewer via OnBase. If a denial decision is made by the medical director or peer reviewer, the care manager and IMW are notified through ISIS and are responsible for mailing NODs.

Working in collaboration with the Department and Iowa State University (ISU), IFMC participated in an extensive review to ensure all level of care processes were aligned with CMS requirements. The initial work included completing the elderly waiver application which was cross referenced with all CMS requirements. The application information and review processes were modified to ensure compliance. This work became the template to achieve compliance for all of the other waiver programs.

Partnership with the Department and other vendors is ongoing as we create a provider incident reporting process and the review of the incident report. New work in the form of a HCBS death review is forthcoming as we determine the process for completing this review.

ID Waiver

ID waiver level of care review is initiated when a certificate of need and assessment information related to diagnosis, symptoms, behaviors, previous services, and treatment plan is faxed to OnBase. The review is assigned to a review coordinator based on an assigned geographic service area. Utilizing criteria the review coordinator determines approval and enters the decision into ISIS. If the review coordinator cannot approve based on criteria, the case is e-mailed to a peer review psychologist for determination. The psychologist faxes the response to the review coordinator through OnBase including reason and rationale if a denial is determined. A denial can only be determined by the peer reviewer.



If approved, the review coordinator enters the approval into ISIS. If denied, ISIS alerts the care manager to send the NOD. Continued stay reviews are completed annually and are initiated by the case manager through ISIS.

PACE, NF, NF/MI

Admission reviews for these programs are initiated at the time a level of care certification form is received from the member's provider. The review coordinator determines approval based on criteria and the IMW is notified via ISIS. If the review coordinator cannot approve based on criteria, the clinical assistant to the medical director reviews the case. If the clinical assistant approves the admission, the case is sent back to the review coordinator to process. If unable to approve, the review is conducted by the medical director or peer review. If the case is not approved by the medical director or peer reviewer, NODs are mailed by Medical Services to the member. In addition, the denial determination entered into ISIS notifies the IMW of the denial. Continued stay reviews are completed by a qualified medical professional and faxed to us. The Department's Assessment and Services Evaluation criteria are utilized by Medical Services review coordinators to determine if the member meets level of care. To ensure compliance with state and federal law, Medical Services under the direction of the Department, uses approved NF level of care criteria for institutional and HCBS services.

ICF/MR

ICF/MR level of care review is initiated at the time the level of care certification form is faxed to OnBase. The review is assigned to a review coordinator based on an assigned geographic service area. Utilizing the criteria the review coordinator determines approval and enters review information into the CaseNet TruCare™ system and calls the facility with the approval. If the review coordinator cannot approve based on criteria, the case is e-mailed to a peer review psychologist for determination. The psychologist e-mails the response to the review coordinator including reason and rationale if a denial is determined. A denial can only be determined by the psychologist peer reviewer. If approved, the review coordinator enters information into CaseNet TruCare™ and notifies the facility of the approval. If denied, IFMC completes the NOD and sends to member, guardian, and facility. Continued stay reviews are done during the ICF/MR annual onsite review.

PMIC

PMIC admission level of care review is initiated at the time we receive an e-mail or telephone call from the admitting facility. The review coordinator, based on criteria, may approve the level of care and e-mail the determination to the facility. The data is entered into the CaseNet TruCare™ system. If the review coordinator is unable to approve based on criteria, the case is e-mailed to a peer review psychiatrist. The peer reviewer's determination is documented and returned via e-mail to the review coordinator. If the peer reviewer approved level of care, the review coordinator e-mails the facility with the determination. If the peer reviewer denied level of care, the review coordinator sends the NOD via mail to the facility and the member's



guardian. A denial can only be determined by the peer reviewer. All information is entered into CaseNet TruCare™. Regular continuing stay reviews are completed no less often than every 90 days.

***A PMIC review coordinator received recognition from a Department Income Maintenance Supervisor due to her assistance with problem-solving payment issues that arose for PMIC facilities as a result of system changes. The supervisor stated the review coordinator was “a HUGE assist in this matter...KUDOS to her for saving us.”
June 2009***

Habilitation

The care manager enters an ISIS milestone and submits the level of care certification form to OnBase which alerts Medical Services that a level of care review is required. The certification form is then retrieved from OnBase by the review coordinator. The review coordinator completes a checklist based on criteria to determine approval. The completed checklist is stored in the RHC drive and the ISIS milestone is updated. If the review coordinator cannot approve, the case is referred to a peer review psychologist via e-mail or fax. A denial can only be determined by the peer reviewer. The peer reviewer’s decision with medical reason and rationale is received via e-mail or fax and submitted to OnBase for storage. The review coordinator enters the milestone in ISIS and the provider receives notification.

Remedial reviews are received through OnBase at which time they are logged and keyworded for assignment to review coordinators. The OnBase document includes an order and the plan of care for the remedial provider. If the review coordinator approves remedial services, the approval is documented in OnBase. In addition, an effective date, a diagnosis, service codes, and numbers of units are entered into ISIS. If the review coordinator is unable to approve per criteria, the case is referred to a peer review psychologist or psychiatrist via fax. The peer reviewer, using medical judgment, determines the appropriateness of services. Denials can only be determined by a peer reviewer. The peer reviewer’s decision is faxed to the review coordinator with documented reason and rationale. All decisions, approved or denied, are mailed to the member and faxed to the provider and documented in OnBase and ISIS.

IFMC is responsible for completing the Level I Preadmission Screening and Resident Review (PASRR) to determine if a nursing facility applicant has a diagnosis of mental illness or mental retardation. Those applicants with a qualifying diagnosis will require a Level II screen to identify the members’ needs due to a mental disability. The goal for the PASRR is to increase the quality of life for people who are admitted to a nursing facility with a mental illness or mental retardation.



IFMC generates a letter to the nursing facility to inform them of the Level I screening outcome. NFs are required to maintain this letter in the resident's medical records. If a Level I screen results in a finding of mental illness, mental retardation, development disabilities, or related conditions, a Level II screening must be completed. The nursing facility is responsible for arranging for the Level II evaluation and providing services identified in the Level II evaluation.

The Level I screening is completed telephonically by IFMC registered nurses. Staff may be reached by telephone during regular business hours of 8:00 a.m. to 4:30 p.m., Monday through Friday, with the exception of state holidays. Secure voicemail is available for the nursing facility to leave clinical review information. Voicemail is monitored by the review staff periodically throughout the day. Staff will respond to provider and member questions about the review process within one business day. For Medicaid members, PASRR screening is required before Medicaid payment can be approved for the NF level of care.

For screening process, "mental illness" is defined as a current primary or secondary diagnosis of a major mental disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders. Mental illness includes schizophrenia, paranoia, mood disorders, major affective and schizoaffective disorders, and atypical psychosis, and the disorder has resulted in impairment that limits functional abilities. It does not include a primary diagnosis of dementia including Alzheimer's disease. Additionally the following situations are exempt from screening: convalescent care, terminal illness, severity of illness, brain injured, or respite care. The clinical data will be documented in the CaseNet TruCare™ system.

We instituted a process change through collaboration with Core that disseminates Level I letters within one week of the telephonic review. IFMC recreates letters and resends at the nursing facility request when the facility has misplaced the original. We are currently collaborating with the Department and the State Mental Health Authority in making plans and recommendations to enhance the PASSR processes in Iowa.

Quarterly PASRR Reports to the Department include the total number of PASRR reviews performed and letters created. Details of the number of non-exempt nursing facility residents with mental illness/mental retardation/development disabilities requiring level II evaluations are provided.

When the IFMC review coordinator determines that additional info is required to complete the medical necessity review for waivers, nursing facilities, PACE, out-of-state facilities, PMIC, ICF/MR, and mental health institutes (MHI), the provider is contacted by telephone or e-mail to gather the additional information. No less than two attempts, three business days apart, are made to contact the provider to obtain the required information prior to proceeding to peer review. In addition, information may be obtained from the Iowa Medicaid Electronic Records System (IMERS) for diagnosis clarification, medication information, and recent procedures that the member may have had.



If additional information is needed to complete the habilitation or CMH waiver, an electronic note is entered into ISIS. The ISIS milestone process will prompt the case manager that additional information is required to complete the review.

Having all information available during the review process increases the accuracy of the review, maintains program integrity, and allows for prompt initiation of services for the member.

All LTC review coordinators will document demographic and clinical information obtained in each review in the CaseNet TruCare™ system. Clinical documentation will include diagnoses, service history, medication list, functional limitations that meet level of care criteria, approval or peer review outcomes, appeal data, any other information to support the level of care decision, and next review. The clinical documentation in CaseNet TruCare™ is a record of all services received by the member and is a database from which reports can be generated.

All review documents received will be scanned and stored in OnBase workflow for easy retrieval or to support appeal requests.

IFMC will continue to communicate the outcome of the review through ISIS. All documentation in the CaseNet TruCare™, ISIS, and OnBase will be available for review by the Department.

NF

Quality of care review and MDS validation will be completed onsite annually for a sampling of nursing facility members. Quality indicators include

- PASRR I completed
- PASRR II completed as needed
- Dementia/Alzheimer's diagnosis
- Safety risks (i.e., falls, difficulty swallowing, skin breakdown)
- Discharge planning

All indicators present should include care plan interventions. A follow-up report with all findings and recommendations will be provided to the facility and the Department within 30 days of the onsite visit.

An IFMC manager conducts IQC of nursing facility review decisions monthly to ensure consistency and reliability of the process using a random sample of admission and continued stay assessments from each review coordinator. Feedback to the staff will be provided identifying concerns. Additional staff training will be provided as necessary. Any errors noted during the IQC review process will be corrected within three business days of detection.

PACE

A PACE organization's quality assessment and performance improvement program will be evaluated annually during an onsite visit using objective quality measures and direct observations. Items evaluated during the onsite will include, but are not limited to:

- Influenza and pneumococcal immunization rates
- Grievances and appeals
- Enrollments and disenrollments
- Readmissions
- Unusual incidents or sentinel events
- Participant deaths

Participant satisfaction is also measured through surveys and interviews. The PACE organization must meet or exceed minimum levels of performance on standardized quality measures established by CMS and the State administering agency. Following the onsite visit the PACE organization will develop and provide to us corrective action plans for any areas identified with potential concerns. The corrective action plans will incorporate ways to improve performance in the delivery of care to their participants. An interdisciplinary team will be involved in the development and implementation of quality assessment and performance improvement activities. The PACE program and the Department will receive a report of the final outcome of the onsite quality review within 30 days of the review.

An IFMC manager conducts IQC of PACE review decisions monthly to ensure consistency and reliability of the process using a random sample of admission and continued stay assessments from each review coordinator. Feedback to the staff will be provided identifying concerns. Additional staff training will be provided as necessary. Any errors noted during the IQC review process will be corrected within three business days of detection.

ICF/MR

IFMC utilizes the ICF/MR review criteria to identify quality of care issues related to treatment planning and effectiveness of active treatment. Those issues are addressed by the IFMC reviewer at the time of the review. A systematic review of quality of care, service and placement is completed through the 42 CFR 456 Utilization review as described in 6.2.1.2.h.

Habilitation, Medical waivers, TCM

Currently we complete quality reviews for all waiver programs and plan to expand to include habilitation and TCM.

Quality reviews will be conducted in accordance with state and federal requirements for Iowa 1915 (C) HCBS waiver programs. Medical staff review the member's interdisciplinary team records and address the following desired outcomes:



- Member's health, safety, and welfare needs are monitored,
- Member's services identified need for approved level of care. and
- Member's service plan is developed and implemented toward a positive outcome.

The quality review process was revised in 2009 due to a collaborative effort with IFMC, the Department, and Iowa State University. A team of IFMC medical staff with expertise in waiver programs developed a standardized quality assessment tool. The tool was approved by the Department and is consistent with CMS requirements. A desk review is conducted on a statistically valid sample of members in the waiver program, as determined by the Department. Sampling methodology utilizes a representative sample at the 95 percent confidence level.

The manager will receive a list of members from DW/DS to review each month. The TCM, case manager (CM) and/or service worker (SW) and specific provider(s) will be sent a letter requesting information using names and addresses from ISIS. A second request letter is sent to those TCMs, CMs, SWs, or provider(s) who have not submitted information within 15 business days.

Medical records and/or documentation received from providers will be electronically scanned and forwarded to the review coordinator upon arrival. Compact discs of information are batched together for import into OnBase and then forwarded to the review coordinator.

Quality assurance review is conducted by reviewing supporting documentation supplied from providers. The review coordinator reviews the member's record to complete the identified measures located in the quality tool. The review coordinator will complete a single quality tool on a member.

The review coordinator will review the records to answer each quality component on the waiver quality tool. The review coordinator will evaluate and look for the following items:

- Member's individualized safety risks are identified
- Intervention(s) to address safety risks are in service plan
- Documentation indicates the adult member takes nine or more over the counter and prescription medications; or documentation indicates the child member takes five or more over the counter and prescription medications; and the physician is aware
- Member had diagnosis or rationale documented for each medication taken
- Documentation of a major incident reflects submission to the Department
- Documentation supports level of care determination
- Services received reflect level of care determination
- Level of care completed in the last twelve months
- Service plan addresses the member's needs
- Service plan implemented as written
- Evidence of team communication regarding services coordinated by the TCM or CM/SW



- Member is meeting goals as written

The review coordinator records information as specified on the waiver form in an Access database.

IFMC is collaborating currently with the CORE team to further enhance and transition the quality review process in OnBase. This enhancement will provide for more efficient process.

Staff must give a score and rationale for each component. The outcome of the QA review will be displayed in a quality tool and mailed to the TCM, CM/SW, and provider(s) within 30 calendar days. If a provider does not supply documentation for a review, the provider will receive a noncompliance letter. Providers who do not respond to requests for documentation are tracked and submitted to the Department.

By the fifth business day of the month the manager or designee will manually select random reviews and assign to the quality improvement coordinator to complete IQC. Sampling methodology utilizes a representative sample at a 95 percent confidence level based on the number of complete admission and continuing stay reviews. The quality reviews will measure compliance, accuracy and inter-rater reliability.

Remedial

The quality review process for remedial services will be a new process implemented in 2010 due to a collaborative effort with IFMC and the Department. Medical staff will review the member's provider records, and address the following desired outcomes:

- Member's mental health needs are addressed
- Member services identified need for approved level of care
- Member's plan implemented toward a positive outcome

A team of IFMC medical staff with expertise in remedial services will develop a standardized quality assessment tool. The tool will be approved by the Department and will be consistent with state and federal requirements. A desk review will be conducted on a statistically valid sample of members as determined by the Department. IFMC supports sampling methodology that utilizes a representative sample at the 95 percent confidence level.

IFMC remedial teams received appreciation from the Provider Services vendor for their participation in annual provider training across the state. Remedial team members provided feedback on training content, attended training sessions, and provided clarifications at the sessions. The Provider Services account manager noted, "Medical Services (IFMC) . . . stepped up to have a presence at the remedial service modules to answer specific provider questions making it even more valuable for all providers. That is the type of coordination that helps make IME seamless to providers."



IFMC will collaborate with the Department to develop a process of identification of members. The manager will forward list of members to review to program specialist to upload into a database. The provider(s) will be sent a letter requesting information using names and addresses from ISIS. A second request letter will be sent to those provider(s) who have not submitted information within 15 business days.

IFMC staff will complete remedial services quality review by reviewing the documentation supplied from providers. The review coordinator will complete a quality tool on each identified member, and send the completed tool to the provider(s) who submitted records allowing for full transparency of the process and results.

Measures supported by the Department will be reviewed and may include the following:

- Member's individualized safety risks are identified
- Intervention(s) to address safety risks are in service plan
- Documentation of a major incident reflects submission to the Department
- Documentation supports level of care determination
- Services received reflect level of care determination
- Level of care review completed in the last six months
- Service plan addresses the member's needs
- Service plan implemented as written
- Member is meeting goals as written

The review coordinator will record information as specified on the quality assurance form in the identified database, either OnBase or a specialized quality review database. Staff must enter a score with a rationale on the quality assurance form. Upon completion of the quality review, a final letter, and tool, will be sent to the provider(s) who submitted records.

IFMC is supportive of increased and coordinated quality of care review within remedial services for the members. With the Department and Juvenile Court support, a copy of the quality assurance letter, may also be sent to the assigned Department social worker or Juvenile Court officer when the member is involved in the Child Welfare or Juvenile Justice systems. As case managers for members on their assigned caseloads, Department social workers and Juvenile Court officers are in a unique position to assist the member and provider with coordination and monitoring for quality of care. Communication regarding quality of services with the assigned Department social worker or Juvenile Court officer will enhance their ability to participate in and support the quality of care for the member.

The outcome of the quality review will be included in a follow-up letter with quality tools attached and mailed to the provider(s) and, when applicable, the Department social worker or Juvenile Court officer within 30 calendar days.

IFMC will complete remedial services quality assurance review reporting to provide summary data to the Department. The report will list the quality component, the score and scoring



rationale and any quality feedback comments made by the review coordinator. IFMC will negotiate the content, format, and frequency of reports with the Department, as they are determined to be necessary and appropriate.

Medical staff will complete remedial services IQC on the quality assurance review. This will measure inter-rater reliability with follow-up education and remediation as necessary. The quality improvement coordinator will make a random selection of each coordinator's quality reviews each month to measure compliance, accuracy and inter-rater reliability. The quality improvement coordinator will complete IQC review evaluating the following:

- Documentation reflects that the review was completed within 10 days of receiving all information from providers
- Member's safety risks are identified
- Documentation of a major incident reflects submission to the Department
- Documentation supports the level of care determination
- Score and rationales are pertinent to information submitted
- Manager review needed

Sampling methodology utilizes a representative sample at a 95 percent confidence level based on the number of complete admission and continuing stay reviews.

ICF/MR, NF/MI, MHI

Since October 2008, IFMC has conducted onsite reviews of all State Resource Centers, community based ICF/MR facilities, NF/MIs, and MHIs. The reference for inspection of care for ICF/MR programs is 42 CFR 456 Utilization Control, Subpart F-Utilization Control: Intermediate Care Facilities and Subpart I – Inspections of Care in Intermediate Care Facilities and Institutions for Mental Diseases. IFMC utilized the CFR 456 to develop an inspection tool that evaluates the medical record including the certification of need, comprehensive assessment including psychological testing, appropriateness and content of treatment for level of care, benefit of active treatment as documented in progress reports, physician and nursing notes. We also document the results of the observations we perform of the member and an observation of member in their environment. The tool is scored to provide facilities the ability to compare progress over time and to help them identify opportunities for improvement. In addition to the score, IFMC also documents recognition for notable practices and suggestions for improvement.

When scoring reveals serious concerns with treatment plan and/or treatment progress, a corrective action may be required. The facility has 30 days to respond with a plan to correct deficits. The Department is informed when facilities fail to cooperate with the corrective action plan. The report provided to the facility is also made available to the Department. Results of the reviews conducted monthly are aggregated and provided to the Department for review of the relative strengths or concerns. As a new program IFMC has provided consultation on the requirement the 42 CFR 456, consistency in program documentation and suggestions improvements.



PMIC and Hospitals

Since implementation of the onsite review process for PMIC facilities in October 2008, our review team has been to each facility in the state of Iowa serving children at the PMIC level of care. Facilities were given no more than 48 hours advance notice prior to the onsite review. The review tool developed for this process is an outline of all requirements of federal regulations in 42 CFR 456. By completing this tool our staff can determine if the facility is meeting those requirements and that services are meeting the treatment needs of the member. Based on the findings, recommendations for improvements and/or corrective action can be made to the facility. If it is determined that a member is not appropriately placed, Medical Services will complete a level of care review, including peer review and issue a denial if necessary.

The reviews completed over the last year showed that facilities are lacking in complete multi-discipline assessment and discharge planning for members. By completing the onsite inspection of care that includes reviewing facility records, Medical Services was able to identify these areas as needing improvement and offered education and recommendation to the facilities.

Hospital Medical Services staff completed a baseline desk review of all Iowa acute and critical access hospitals during calendar year 2009. All acute care hospitals were evaluated on their compliance with CFR 42, Part 456, Subpart C, which prescribes requirements for hospitals to control utilization of inpatient hospital services. In addition, all critical access hospitals were evaluated on their compliance with CFR Part 485, Subpart F, sections 485.635-.641, ensuring that each critical access hospital had documented policies and procedures in place to meet the requirements of the regulations.

We developed tools from the appropriate regulations for both acute and critical access hospitals. In addition, an Access database was created to house the results from the tools, as well as utilized as a tracking mechanism for documentation that was received. All documentation was scanned by the IME mailroom and is available through OnBase. As documentation was received from the facility, Medical Services staff reviewed the documentation and scored as appropriate on the tool. A copy of the appropriate tool was then sent back to each hospital in the state which outlined the findings and made suggestions for subsequent review. Because this was a baseline review, no corrective action plans were identified for the facility.

Subsequent reviews will be completed for all Iowa hospitals on a triennial schedule beginning in 2011 for all critical access hospitals, and in 2012 for all acute hospitals. During this review, any deficiencies in the documentation will be reported to the facility. If necessary, corrective action plans will be put into place for any facility found to be lacking in the reviewed categories after review with Department policy staff.

We created a complete operational procedure for this review process and will continue to update this procedure as necessary.



NODs for remedial services are generated and proofed by review coordinators within ISIS for approved and denied services. Use of ISIS ensures members meet Medicaid eligibility and providers have valid remedial service codes and current rates in ISIS. NODs are printed on State of Iowa letterhead with the Department approved right to appeal printed on the back. Manual NODs are generated by review coordinators for approved remedial services which allow members not currently in MMIS/ISIS to obtain prompt mental health services subject to Medicaid eligibility. IFMC provides manual notice consistent with Department approved protocol.

Review assistants complete a second review of all NODs to proof for accuracy and confidentiality. NODs are sent through USPS mail to the member upon completion at the address generated from ISIS. Remedial providers are faxed a copy of the NOD and right to appeal via RightFax to their identified fax line. Review assistants respond to requests for duplicate copies of NODs within one business day.

IFMC teams submit reports for ICF/MR, NF/MI, PMIC, and MHI within 30 days of the onsite visit to the facility and the Department. IFMC sends a copy of the individual member's tool and a cover letter summarizes the results of the review and need for corrective action if necessary.

IFMC prepares a monthly and quarterly report for the Department which includes facility and over-all percentages according to the 42 CFR 456 criteria. The reports include data collected during the review, including admissions, continued stay, denials, appeals, corrective actions and timeliness. The Department and IFMC meet quarterly with the Department of Inspection and Appeals to discuss concerns identified during the review and to avoid duplication or miscommunication between the Department and the Department of Inspections and Appeals.

The outcome of the quality review for HCBS waiver programs currently are sent to the providers who participated in the review process. The habilitation and TCM programs will be included in the new contract. The outcome of the review is included in a follow-up letter with copies of actual quality tools attached and mailed to the CM/SW, CM/SW supervisors, and provider(s) within 30 calendar days by Medical Services. The scored quality tool is shared with providers in an effort to provide transparency of the review outcome and to facilitate education regarding quality of services. Providers are given comments to assist them in remediating areas that need improvement.

A copy is sent to the CM/SW supervisor to increase awareness of the outcomes of the review and assist staff in making improvements with service coordination. The Department will receive a copy of this report monthly, as well.

If a provider does not supply the requested documentation for a review, a letter will be sent noting that no information was provided. Non participation information is also shared with the Department.



Medical Services will complete all documentation of the results of MDS validation and mail the facility the follow-up letter and copies of the worksheets within 30 business days of the exit conference with the facility.

We will update IME data systems (CaseNet TruCare™, ISIS, OnBase) with the results of the review by initiating the level of care or completing ISIS milestones on each member as the review is completed. Effective dates are entered along with the level of care for which the member is eligible. If the review is sent to peer review, that information will also be entered into ISIS with the outcome of the peer review. If the review results in a denial, the rationale for the denial will be listed in the note section so that case managers are aware of the reason and rationale for the denial.

Including the reason and rationale for a denial was requested by the Department to assist the CM/SW. This process has helped the CM/SW to be actively engaged with their assigned member and involved in the level of care process. In addition, this process serves as an opportunity for one-on-one education to the CM/SW to facilitate knowledge on the level of care process. This also allows the case manager an opportunity to provide additional information that may be needed to evaluate for the level of care. Review coordinators have found that engaging case managers early in the process results in more timely and accurate assessment information. We will continue to build relationships with the CM/SW to enhance the review process and ensure members receive the right services timely.

IFMC management staff have assisted with CM/SW training and collaborated with the Department on revision of the 16K manual to provide informational resources for the CM/SW about the workflow of the level of care milestone process.

IFMC staff may be reached by telephone, fax, or e-mail during regular business hours of 8:00 a.m. to 4:30 p.m., following the state holiday schedule. Voicemail boxes are secure and will be reviewed throughout the day. Staff will respond to provider and member questions about the review process and/or status of admission or continued stay reviews within one business day as required by URAC standards. We presently exceed the contract expectation of two business days and will continue to do so.

MDS is a core set of screening, clinical and functional status elements, including common definitions and coding categories which form the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in Medicaid or Medicare. IFMC reviews the RUG-III classification scheme that identifies a member in one of the major categories on the basis of clinical characteristics and functional abilities:

- Rehabilitation
- Extensive services
- Special care
- Clinically complex
- Residents receiving complex clinical care or with conditions requiring changes



- Impaired cognition
- Behavior problems
- Reduced physical functioning

Annually, IFMC reviews a 25 percent sample of Medicaid-eligible members in all facilities to verify the correct RUG-III classification of the member. We perform the MDS validation onsite and require the member's medical record, care plan, MDS assessments, Resident Assessment Protocol Summaries (RAPS), and any supporting documentation for the MDS review.

The validation process identifies MDS items coded in error, as well as omitted MDS items. Staff provide recommendations to improve documentation when inconsistencies are identified between the medical record documentation and the MDS validation.

Feedback is designed to help reduce future errors and increase the accuracy of MDS coding. Feedback is provided during the exit interview between Medical Services and nursing facility staff.

Following feedback the nursing facilities are required to make changes as appropriate to ensure MDS, case mix index, and related reimbursements are appropriate.

IFMC documents the results of MDS validation and trends inconsistencies to report to the Department. We mail the facility a follow up letter and copies of the individual member worksheets within 30 days.

Any nursing facility with an error rate greater than 25 percent of the expected threshold will have their sampling increased by an additional 25 percent and the Department will be notified of the increase. Any patterns of erroneous coding will be reported to the Department.

These review protocols will be continued in the new contract.

IFMC MDS validation review coordinators have more than 40 years of combined experience reviewing MDS assessment data in comparison to medical records and care planning documentation. All review coordinators are registered nurses and are certified in gerontology.

Determination of need for services for the habilitation program will be made by a review coordinator who is experienced in working with members served in this program. The review coordinator will apply the habilitation criteria outlined in the IAC. Within two business days of receiving complete information for initial reviews and within five business days for continued stay reviews, the review coordinator will conduct the level of care review and issue a decision regarding approval or denial of habilitation services. All approved decisions will be sent to the member's case manager through ISIS to allow the case manager to print and send the NOD to the member. Habilitation services may be approved for up to one year. If the review coordinator is not able to approve the service, the case will be referred to a psychologist or psychiatrist peer reviewer for a determination. If the peer reviewer determines the service is appropriate, an approval will be entered into ISIS. If the case is denied by the peer reviewer, the review



coordinator will generate a NOD that will include a reason and rationale for the adverse decision. The NOD will be sent to the member, the member's legal representative (if applicable), and the case manager. The NOD will also include information for the attending physician to call and have a one-on-one conversation with the peer reviewer who denied the request.

Once it has been determined that the member is appropriate for habilitation services, the case manager is required to enter a service plan and submit it through ISIS to IFMC for review. Upon receipt of the request for service plan approval, the review coordinator will review the service plan entered by the case manager, the assessment, social history, and the other program requests and services the member is currently receiving to ensure that there is not a duplication of service. If appropriate, the review coordinator will approve the service plan in ISIS. This will generate a milestone notification to the case manager of the service plan approval. If the review coordinator determines that the service plan is not appropriate, a request for additional information will be sent to the case manager in ISIS. Following receipt of additional information the review coordinator may approve the service plan and submit it to ISIS. If the review coordinator is not able to approve services, the case is referred to a psychologist or psychiatrist peer reviewer for a determination. Only a peer reviewer may issue a denial. If the case is denied by the peer reviewer, the review coordinator will generate a NOD including reason and rationale for adverse decision and send to member and case manager.

In accordance with 42 CFR, Part 460, a PACE organization's quality assessment and performance improvement program must include, but is not limited to, the use of objective measures to demonstrate improved performance with regard to the following:

- Utilization of PACE services, such as decreased inpatient hospitalizations and emergency room visits
- Caregiver and participant satisfaction
- Outcome measures that are derived from data collected during assessments
- Effectiveness and safety of staff-provided and contracted services, including goals and measurable outcomes
- Non-clinical areas, such as grievances and appeals, transportation services, meals, life safety, and environmental issues

In the past year, IFMC attended the technical advisory onsite visit in cooperation with the CMS staff. Our assistance was given in performing the clinical and administrative review of the PACE organization. We will continue to participate with the CMS onsite review of the PACE organization annually for the first three years of implementation and biannually thereafter.

IFMC, in collaboration with the Department, will conduct an unannounced onsite visit annually to interview staff and participants regarding the quality of care and their satisfaction with services. The CMS quality review tools will be used.

A PACE organization must do the following:

- Use a set of outcome measures to identify areas of good or problematic performance
- Take actions targeted at maintaining or improving care based on outcome measures
- Incorporate actions resulting in performance improvement into standards of practice for the delivery of care and periodically track performance to ensure that any performance improvements are sustained over time
- Set priorities for performance improvement, considering prevalence and severity of identified problems, and give priority to improvement activities that affect clinical outcomes
- Immediately correct any identified problem that directly or potentially threatens the health and safety of a PACE member

A PACE organization must ensure that all interdisciplinary team members, PACE staff, and contract providers are involved in the development and implementation of quality assessment and performance improvement activities and are aware of the results of these activities.

A summary report of onsite compliance visits will be formatted using the CMS guidelines and will be provided to the Department within 30 days of the visit.

We will monitor the development, implementation and follow-up of any corrective action plans required following the onsite compliance visits.

We work closely with DW/DS who pulls a report quarterly of all final paid claims for remedial providers for the previous quarter. After the report is generated by DW/DS, our statistician selects a statistically valid random sample that includes at least one TCN from each remedial provider that was paid during the quarter. After each provider is selected at least once, the remaining sample is a random selection of all providers. This sampling process ensures that each remedial provider is reviewed at least quarterly and is provided ample feedback. We will continue to work with the Department to strategize ways to expand the effectiveness of the sampling methodology.

To be compliant with IAC Chapter 78 Section 12, remedial service providers are required to submit all progress notes to Medical Services every six weeks. The progress notes are stored in OnBase. This requirement makes the notes available to our review coordinators for the sampling process. Our review coordinators review the identified notes for compliance with Medicaid documentation standards and remedial service requirements. We also review the notes to ensure that they are in compliance with the LPHA order and provider implementation plan and that the service is medically necessary and in accordance with best practice of mental health services.

Once the initial review is complete, the provider is sent a preliminary finding letter that outlines the issues identified from the review of the notes. The provider is allowed to request a reevaluation of the findings and to submit supplemental information to Medical Services. The review coordinator then reviews the additionally submitted information and makes a



determination on whether or not recoupment is necessary. If the concerns are resolved based on supplemental information submitted, the provider is sent a letter indicating that all concerns are resolved. If recoupment is necessary a credit/adjustment letter is sent to the provider outlining the necessary recoupment amount and the reason for the recoupment. All actions are taken in accordance with IAC Chapter 79 section four.

When an overpayment is determined, the amount is calculated based on multiplying the number of units requiring recoupment by the unit rate for the service that the provider was paid. Our staff completes a credit/adjustment form in OnBase that takes the recoupment amount from future claims submitted by the remedial service provider. Each provider is allowed the option of appealing the decision that an overpayment has occurred. We have a great deal of experience with the Department's appeal process. This experience will benefit the Department in recouping overpayment for remedial services not documented appropriately. We will continue to represent the Department in appeals regarding overpayments for remedial services.

We currently participate in all hearings regarding recoupment for remedial service progress notes. At the time the Department asked Medical Services to perform this review, it was new ground for us. Our staff worked closely with the SURS unit and the Department's Program Integrity staff to ensure understanding of how to go about the recoupment process. We continue to work closely with these units to strengthen our review and appeal process in the area of recoupment. All processes were developed in accordance with IAC Chapter 78 section 12 and Chapter 79, sections three and four.

The review process for remedial progress notes is structured to be completed on a quarterly basis and to be complete at the end of each quarter. All final letters sent to providers indicating concerns resolved or necessary recoupment are sent by the last day of the quarter. Currently we wait 30 days to initiate the recoupment in OnBase in order to ensure that a provider has not filed an appeal. The entire review process is completed within 20 business days prior to the end of the quarter.

IFMC will access remedial services performance and clinical data documented in OnBase system to report the following to Department policy staff monthly:

- Number of initial authorizations completed
- Number of initial authorizations approved
- Number of initial authorizations denied
- Untimely initial authorization count
- Initial authorization percentile timely
- Number of continuing stay authorizations completed
- Number of continuing stay authorizations approved
- Number of continuing stay authorizations denied
- Untimely continuing stay authorization count
- Continuing stay authorization percentile timely



- Total number of authorizations completed
- Denial reasons
- Number of missing component requests
- Number of appeals and appeal outcomes

IFMC completes accumulative quarterly reports and prepares an annual report comparing assessment activity from one SFY to the next and annual cost avoidance and cost savings data.

IFMC will access ISIS management reports and clinical data documented in OnBase to report the following to Department policy staff monthly, quarterly, and annually for LTC services. The activity report will include:

- Number of initial assessments and reassessments
- Number of assessments and reassessments approved
- Number of assessments and reassessments denied
- Denial reasons
- Number of assessments and reassessments completed timely
- Number of assessments pended and pended reasons
- Number of appeals and appeal outcomes by program
- Statistical comparison of SFY to SFY assessment activity

IFMC will prepare monthly and quarterly reports, as well as an annual report comparing assessment activity from one SFY to the next.

IFMC will monitor performance standards data monthly. Following are the performance standards for long term care assessment activities:

- Assessment reviews and reassessment shall be completed for 95 percent of the members within five business days
- Enter assessment reviews and reassessment review requests requiring a peer review (as determined by the Department guidelines) into ISIS within three business days of completion
- Update the manual within three business days of Department approval of a change or Department request for a change
- Identify and correct any errors on the pre-screening assessment within three business days of the error detection
- Complete reports as required in Section 3.2.2.9.6 of RFP MED-04-034 pursuant to Department standard guidelines

IFMC will complete all documentation of results of onsite MDS validation. Inconsistencies will be trended and reported to the Department. The quarterly narrative report to the Department includes MDS review activity.



IFMC completes the onsite facility review report within 30 business days of the onsite visit. The report includes the total score for all members reviewed. The report and individual scores are forwarded to the Department for approval, and then to the Iowa Department of Inspections and Appeals.

Within 30 days of the onsite review an aggregate letter with a total score of all members reviewed and a copy of each inspection of care tool is mailed to the facility. This letter includes notable practices, recommendations, and/or required corrective action.

If corrective action is required, the facility will have no more than 30 days from the date of the aggregated letter to address and correct the concerns by responding in writing detailing steps they are taking to address the problems. A follow up onsite visit is then completed. As with other onsite visits, no more than 48 hours notice is given to the facility.

We will monitor the development, implementation, and follow-up of any corrective action plans required following the PACE onsite compliance visits. A summary report of the onsite compliance visit will be formatted using the CMS guidelines and will be provided to the Department within 30 days of the visit.

Performance Standards (6.2.4.3)

In the past five years, IFMC level of care determinations for admission have been routinely completed within two business days 95 percent of the time and within five business days 100 percent of the time. We will continue to meet this performance standard.

In the past five years, IFMC has maintained 99 percent timeliness with completion of continued stay level of care determinations and are committed to continue the same level of performance.

To be in compliance with 42 CFR 456 we will ensure that each facility is reviewed annually and that subsequent reviews are completed within 10 to 12 months after the previous review. This is tracked annually and all reviews are planned to allow for schedule adjustments when necessary and to ensure compliance.

Within two business days of receiving complete information for an initial review decision, the review coordinator will complete the level of care review and issue a decision regarding approval or denial of habilitation services. All approved decisions will be sent to the member's case manager through ISIS to allow the case manager to print and send the NOD to the member.

Within five business days of receiving complete information for a CSR, the review coordinator will complete the level of care review and issue a decision regarding approval or denial of habilitation services. All approved decisions will be sent to the member's case manager through ISIS to allow the case manager to print and send the NOD to the member.



Upon receipt of the request for service plan approval, the review coordinator will review the service plan entered by the case manager, the assessment, social history used to determine habilitation services were medically necessary and appropriate, and the other program requests and services the member is currently receiving to ensure that there is not a duplication of service. If the service plan is appropriate the review coordinator will approve the service plan in ISIS. This will generate a milestone that will send notification to the case manager of the service plan approval. If the review coordinator determines that the service plan is not medically necessary and appropriate a request for additional information will be sent to the case manager in ISIS. Once the information needed to approve the service plan is received, the review coordinator will send notification of approval to the case manager through ISIS within two business days.

Completion of remedial services plan reviews for members with mental health needs will be within required timeframes. IFMC has a history of timely authorization of services as evidenced by 99 percent timely completion. This exceeds current contractual timeframe requirements of 95 percent timely.

Referrals for initial and continuing reviews for remedial services are faxed by remedial providers to IFMC. The review assistant will receive the review in the remedial OnBase logging queue and confirm member information using the MMIS system. The review assistant will determine review type by searching OnBase by member's SID and last name. The review assistant will re-index the review document in OnBase as Remedial Corr for initial reviews and as Remedial CSR for continuing reviews. Keywords are entered and assignment to a review coordinator is completed within OnBase.

Submitted documentation will be reviewed to ensure that the request includes an LPHA order and implementation plan. A request for additional documentation is completed, if needed.

The review coordinator completes the review using the remedial services criteria. The review coordinator will use the appropriate task depending on the outcome of the review. Options include request for additional information (missing component request), peer review, denial, or approval.

When the review is complete, the review coordinator updates the review in OnBase. If the services are approved the review coordinator completes ISIS entry and generates an approved NOD. The review assistant sends the NOD to the member by mail and will RightFax a copy to the remedial service provider.

A request for additional information results in a missing component request created within OnBase using an e-form. Only information that is necessary to approve the service will be requested. The review assistant will fax the missing component letter to the provider using RightFax. The OnBase timer on review completion pends until requested documentation is received from the provider.

If the review coordinator is unable to determine that review criteria were met, the review coordinator will pend the implementation plan in OnBase until the peer review decision is



obtained. Only peer reviewers make denial decisions. Peer reviewers include licensed health care professions in the same category as the attending provider. Peer reviewers for remedial services are licensed PhDs, psychologists, and psychiatrists.

The review coordinator provides the documentation to the peer reviewer. Documentation includes the LPHA order, implementation plan and, if appropriate, remedial progress notes. If the peer review results in approval, the review coordinator will complete approved NOD procedure.

If the peer review results in denial determination, the review coordinator completes a NOD indicating the denial of services. The NOD explains the right to request an appeal within 30 days and delineates the process of appeal. The reason and rationale are not included on the NOD due to limitations within ISIS. However, reason and rationale are provided upon request to the member, parents/guardians, and provider. IFMC staff respond to questions from members and/or parents/guardians regarding the review process and determination, consistent with HIPAA requirements.

Notice of the availability of the peer-to-peer conversation is included on the IME website. The Manager will arrange for the peer-to-peer conversation within one business day of the request unless there are extenuating circumstances outside of Medical Services' control. IFMC initiated the provision of the peer-to-peer conversation in 2009. This process is consistent with URAC standards and exceeds contractual expectations.

If the member/guardian requests an appeal within 30 calendar days of the date of the decision or before the date a decision goes into effect, the Department policy staff will notify Medical Services. An appeal packet is prepared and mailed to the ALJ and appellant.

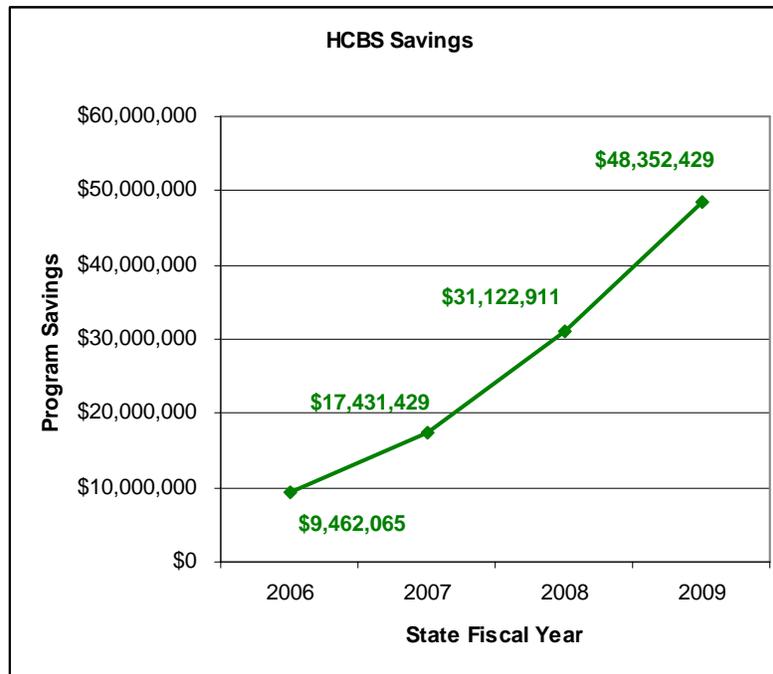
Members receiving remedial services are reviewed for criteria eligibility within six months of the date of their approval or as determined appropriate. Continued approval must meet medical necessity criteria, per IAC 441-77.12(249A).

Urgent requests for PA of services will be reviewed and a decision rendered and communicated in no less than 72 hours from receipt of the request. A request is urgent if the situation poses an immediate threat to the health and safety of the Medicaid member or if the attending physician, TCM, member, or family member indicates that the need is urgent. This time frame includes holidays and weekends. When an urgent request is received, the review coordinator will confer with their manager and log the request on a spreadsheet. This urgent review standard was initiated by IFMC in 2009 to meet URAC standards and exceeds contract expectations.

Regardless of the review decision, all NODs will be completed and sent to the member and provider within specified timeframes. Initial reviews will be completed within two business days and continuing reviews within five business days.

Selected LTC Savings

In addition to meeting all standards for operational performance (i.e., turnaround times, etc.), IFMC actively seeks and implements program improvement to enhance our ability to provide the state a solid return on investment through our LTC services. HCBS savings over the past four years are highlighted in the following chart.



IFMC is committed to continuous program enhancement and providing significant results for our clients.

QUALITY OF CARE (6.2.5)

IFMC has conducted the quality of care (QOC) function for the Department since IME implementation. Our prior work has focused on MediPASS quality reviews, special authorizations, and provider utilization feedback reports. We have also conducted annual External Quality Review (EQR) onsite assessments of managed care entities participating in the Iowa Medicaid Program.

Quality of care reviews for the MediPASS program include:

- Ensuring adequacy of provider panels
- Compliance with 24-hour coverage
- Compliance with access standards
- Special authorizations



We will build on this experience to meet all quality of care contractor responsibilities specified by the Department in the scope of work for Medical Services.

Contractor Responsibilities (6.2.5.2)

As the current IME Medical Services contractor, we focus on the managed care organizations participating in the Iowa Medicaid program as the basis for the QOC function. The managed care programs include MediPASS (a primary care case management system) and the Iowa Plan (the mental health plan administered by Magellan Health). Currently there are no other managed care plans participating in Medicaid. IFMC will use the monitoring programs currently in place as a foundation for QOC activity performed under the new contract. In addition, we will work with the Department to design a comprehensive “report card” that looks at quality of care across all Medicaid managed care programs. These activities will address the primary QOC objectives:

1. Measure provider compliance with contractual requirements specified in their services agreements with DHS
2. Assess the current health status of Medicaid members
3. Design a process for ongoing measurement of the overall health status of Medicaid members.

Additional detail about the operational programs used to meet these objectives is provided below.

The Department will provide the Medical Services contractor with a quarterly report of the HMOs participating in the Iowa Medicaid program including a list of their enrolled providers. IFMC 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 included in the health plan’s provider network. The findings are reported to the Department.

IFMC, as the Iowa EQRO, conducts the onsite visit to the Iowa Plan annually to ensure federal requirements are met utilizing the CMS standards. At the time the Department contracts with an MCO/HMO, IFMC will conduct an onsite EQR for that entity.

IFMC will assist the Department in preparation of any managed health care waivers.

IFMC will assess provider panel adequacy utilizing GeoAccess software comparing the location of enrolled members to providers per mileage access standards at the time of an EQR.

IFMC will participate in federal reviews at the request of the Department.

IFMC will conduct appointment surveys and after hour activities to ensure adequate coverage for MediPASS. All findings are reported to the Department quarterly. At the time the Department contracts with an MCO/HMO, IFMC will conduct these activities for that entity.



IFMC will conduct review of MCO/HMO call center policies and procedures, as well as QA/UR functions at the time a contract with an MCO/HMO is entered into with the Department.

IFMC ensures that the MCO/HMO retains medical expertise for reviews and appeals.

IFMC will review the training and education activities of the MCO/HMO ensuring that their staff understand the QA/UR systems and grievance procedures.

IFMC will conduct a quality review of MCO/HMO IT systems to ensure integrity of all encounter data.

At the request of the Department, IFMC will attend meetings with the MCO/HMO and provide meeting minutes.

Each year, IFMC will conduct onsite assessments at each managed care organization participating in the Iowa Medicaid Program. During these EQR assessments, IFMC will evaluate performance by the organization in the following areas:

- Utilization review
- Quality improvement
- Grievance resolution
- Data collection
- Technical analysis

Following the completion of each onsite assessment, IFMC will prepare a report documenting our findings. The report will describe performance by the plan in each performance area and identify any areas needing improvement or non-compliance with provisions of the Service Agreement with the Department. The report will also specifically address any issues related to member access to services, inappropriate limits on provider referrals or service delivery, and member-reported quality of care issues. A copy of the report will be provided to the Department and to the health plan.

Information included in the report will be collected by IFMC staff using a standard administrative tool which addresses performance by the health plan in each of the areas listed above. IFMC has extensive experience in the development and use of assessment tools to evaluate health plan performance. IFMC's standard tool incorporates all state and federal requirements for the external quality review of managed care organizations. Beginning in 2003, CMS mandated EQR review activity protocols for all Medicaid EQR activities. IFMC has used a tool based on the CMS protocols for all Medicaid EQR reviews since that date.

This standardized tool allows IFMC to evaluate performance of the health plan over time. A standardized tool and consistent scoring method also results in the ability to compare performance among health plans. This Department-approved tool includes a scoring system that allows IFMC to display longitudinal, as well as plan-to-plan comparison scores in reporting categories defined by the Department.



IFMC will evaluate the adequacy of provider panels for the contracted MCOs through the EQR process. Plan specific provider networks will be evaluated during each annual onsite assessment. IFMC will also use GeoAccess software to compare the location of network providers to the location of Medicaid members enrolled in the Plan. The results from our assessment of the Plan's provider network will be included in the report submitted to the Department following each onsite evaluation.

IFMC conducts telephone surveys among MediPASS patient managers after normal business hours to ensure compliance for 24-hour coverage for assigned Medicaid members. After-hour telephone calls are made to 20 patient manager offices per month to assess the information available to members including the availability of the provider, coverage in the absence of the provider, the adequacy of recorded information provided to members regarding how and where to obtain emergency or after hours care, and for other providers to access the MediPASS patient manager (PM) for referral inquiries.

Following the surveys, notices of compliance or noncompliance will be sent to PMs. Responses are required from providers who receive noncompliance letters. Provider responses must describe the actions they have taken to resolve the identified problems. Follow-up calls are made to ensure the issue has been resolved and that the PM's 24-hour access meets the established Department standards. This process is also completed for any PM suspected of noncompliance based on provider complaints or referrals. The findings from the monitoring process are summarized and included in the quarterly managed health care report provided to the Department.

Under our current contract as the EQRO, IFMC performs technical analyses, data collection, and reporting on the performance of the Iowa Plan. Our current procedures will be used as the basis for activity under the new Medical Services contract.

IFMC currently monitors the Iowa Plan to ensure Federal requirements for managed health care contracting are met. IFMC is knowledgeable about state and federal requirements for MCO contracting. The federal requirements implemented three mandatory protocols for annual review of Medicaid MCOs. Knowledge and understanding of the mandated protocols assists in ensuring contracting requirements are met.

IFMC will assist the Department in the preparation of any managed health care waivers necessary to operate the program at the request of the Department.

IFMC currently determines network adequacy for the Iowa Insurance Division MCO expansion requests. IFMC also reviews Medicaid MCO panel adequacy as required by the CMS protocols during the annual onsite evaluations of managed care plans participating in the Medicaid program.

IFMC will participate in federal reviews at the request of the Department. IFMC participated in the first federal review of the PACE program during the past year. We assisted in medical record documentation review, onsite visits with members, as well as review of policies and procedures.



IFMC will provide ad hoc reports, create presentations, and gather other information at the request of the Department.

IFMC currently reviews appointment surveys to assess scheduling and appointment access of MCO networks during the EQR annual review and will continue to conduct this survey.

IFMC will conduct an evaluation of the Iowa Plan call center hotline functions to determine if contractual performance requirements are being met. This evaluation will be performed during the EQR annual review. IFMC will request copies of internal call center reports for review. The reports will be evaluated to identify any activities not meeting contractual performance standards. We will report our findings to the Department and provide recommendations for additional training to the Iowa Plan if necessary.

The IME medical director and panel of peer reviewers will provide assistance to the Department for review of health service and/or treatments denied by the Iowa Plan. The Department will provide a copy of the appeal request to the Medical Services operations manager. IFMC staff will record the demographic information in an appeal log and determine if all relevant information is present. If additional information is required, IFMC staff will contact the Iowa Plan enrollee and the Iowa Plan within one day of the Departments' notification to request information. Following receipt of the information, the medical director or appropriate peer reviewer will conduct medical necessity review. The peer reviewers' determination and rationale will be documented for use in the appeal process. The peer reviewer will be available for inclusion in the appeal hearing at the request of the Department.

The current EQRO contract requires IFMC to assess the Plan's provider satisfaction and knowledge of quality improvement activities, utilization review processes, grievance processes, and disease prevention and health promotion guidelines. IFMC reviews the survey outcomes and action plans for improvement.

IFMC's experience as the Medicaid EQRO has included review of the Iowa Plan's encounter data for the past eight years. IFMC will use this experience and expertise to ensure adequate system entry and data integrity of all encounter data. IFMC will evaluate documented data collection and management processes to ensure:

- Data are confidential and protected
- Data are submitted, completely, timely and accurately
- Data processes are adequately documented
- Data edits identify missing or inaccurate data
- Data system backups adequately protect the integrity of the database
- Procedures are in place to correct inaccurate data in the database

IFMC will design, in conjunction with the Department, a "report card" that can be used to provide a qualitative assessment of the MCOs in the Iowa Medicaid program. IFMC uses similar



assessment processes in its role as the EQRO. The data collected may include information about quality improvement activities, performance measures, access and availability, utilization management, and encounter data integrity. Collaborating with the Department, IFMC’s test version of the “report card” will be ready by the beginning of the second year of operation or sooner.

As the current EQR contractor for IME, IFMC has historical data from annual onsite evaluations for all Medicaid HMOs/PIHPs. We will continue to conduct the annual onsite evaluations and work with the Department’s contracted report writer for reporting the findings in an understandable format to CMS in a timely fashion.

IFMC will receive referrals regarding continuity of care concerns via telephone from managed care enrollees, Workview notices from other IME units, and faxes from treating providers. These referrals will trigger the initiation of the special authorization process. When a referral is received, reviewers will consider the request and issue an authorization number to the treating provider only when the criteria are met. If a special authorization request indicates there is a potential quality of care concern, the request will be forwarded to the Medicaid medical director for further review. All special authorization requests will be logged and monitored for patterns or trends by a provider or member. A letter will be sent to both the assigned patient manager and the treating provider explaining the special authorization. A report of all special authorizations will be included in the Quarterly Managed Health Care report provided to the Department.

A Medicaid hospital provider thanked IFMC staff for providing excellent customer service. The provider stated they had been having extreme difficulties getting a question resolved. IFMC staff took ownership of the issue and was able to promptly resolve the problem. July 2009

We have collaborated with the Member Services unit to make this process more efficient. This led to the use of OnBase Workview as a means for Medical Services to receive special authorization requests from Member Services. We will continue our close collaboration with Member Services to ensure effective oversight of the program.

IFMC has been the EQR for Iowa Medicaid since the early 1990s. Annual onsite EQR visits have been conducted to all participating Medicaid MCOs utilizing the mandated CMS protocols. Following these visits, IFMC has collaborated with the Department’s contracted report writer for the past five years, relaying information to this contractor in a timely fashion. We will continue to conduct the annual onsite EQR visit at the Iowa Plan and any plans that may become Medicaid MCOs.

In-depth collaboration with DW/DS was completed during IME implementation in order to obtain data for MediPASS utilization. Quarterly, the Patient Utilization Report is sent to active MediPASS providers which displays their average member’s individual utilization of each



service category (i.e., physician office, outpatient, outpatient ER, inpatient, etc.), averages for all PMs across the state, and the averages for all other PMs within specific specialty provider types (i.e., family practice, OB/GYN, IM, etc.). The purpose of this utilization report is to provide PMs with the utilization of services by their MediPASS members and is not intended to be an indicator of their performance as a PM.

We also provide to MediPASS PMs a MediPASS Utilization Exception Report. This report provides MediPASS PMs specific MediPASS member utilization for members who have fallen two standard deviations outside the statewide utilization averages for one or more of the MediPASS managed services. This report includes the actual units of service utilized during the reporting period and compares them with the statewide average for all MediPASS members for the same reporting period. This report also provides the units of service used of those services that the PM does not manage, such as chiropractic and pharmacy encounters. This information assists in providing the PM with an overall picture of the services utilized by the member. These reports accompany a cover letter that explains the reports and offers a contact with Medical Service staff for any questions arising from the reports. These reports will continue to be distributed to providers during the next contract period.

On a quarterly basis, DW/DS provides us with a report identifying a sample of 1.25 percent of paid claims where a referring provider was indicated on the claim. Letters are sent to the indicated PM requesting they respond to authenticate each referral. If a PM is unable to authenticate the referral, letters are sent to the treating provider requesting supporting documentation of the receipt of the referral from the PM.

Educational letters are sent to any treating provider who is found to have treated a MediPASS member without adequate referral from the PM. This correspondence includes language stating that if further noncompliance with the MediPASS referral process is identified, subsequent payments will be recouped by the SURs Unit. A log is kept of all educational letters sent for noncompliance, as well as all subsequent SURs referrals. A report detailing the results of responses from both PMs and treating providers is included in the quarterly managed health care report for the Department's review. Any quality of care concerns identified are forwarded to the Medicaid medical director for review and communicated to the appropriate Department staff. IFMC will continue to conduct the paid claims audits on a quarterly basis.

IFMC has developed a process in collaboration with DW/DS to export required encounter claims for quality and validity review for the EQR process. We have utilized HEDIS data obtained from the Department's contractor, the University of Iowa, to evaluate MediPASS member's utilization. All information gathered is used to conduct a data encounter validation review.

Following the data encounter validation and performance measure review, IFMC will notify the Department of the need for further review/investigation.



Performance Standards (6.2.5.3)

We collaborate with Member Services, Provider Services, and SURS to produce the quarterly managed health care report as each of these units provide information that is displayed in the report. Near the end of the quarter, we send an e-mail reminder to Member Services, Provider Services, and SURS noting the deadline for the quarterly managed health care report is approaching and giving them a due date for their information. If there is a delay in any component, e-mail reminders are sent and unit managers are notified for assistance.

When the information is received, we collate all components into the collective quarterly report. This supports the creation of a single quarterly report for submission to the Department, rather than multiple reports from various IME contractors. The final report is provided to the Department within 10 business days following the end of each calendar quarter.

IFMC will work with the Department's contracted EQRO report writer to ensure the final EQR report is submitted to the Department within 45 business days following the annual onsite visit to a managed care organization.

HEALTH INFORMATION TECHNOLOGY (6.2.6)

The Department has begun development of a State Medicaid Health Information Technology (HIT) Plan that will strategically align with the Iowa e-Health Project and other statewide HIT initiatives, such as the proposed Iowa HIT Regional Extension Center. The State Medicaid HIT plan will support the following objectives:

Alignment The State Medicaid HIT plan will align with the State Health Information Exchange (HIE) efforts underway in the Iowa Department of Public Health (IDPH). IDPH is the official state agency for the four-year HIE Cooperative Agreement Program established by the ARRA legislation. IDPH plans to create an Office for Health IT to oversee the ongoing efforts of the Iowa e-Health Project.

As part of the broader health reform effort, the goal of the Iowa e-Health Project is to improve patient centered health care and population health through the use and exchange of health information. Funding from the cooperative agreement will be used to prepare and execute a comprehensive State Plan. This State Plan will be compliant with all expectations of the Office of the National Coordinator (ONC) for Health IT for a strategic and operational plan

The State Medicaid HIT planning effort will formally coordinate with the IDPH Office for Health IT through scheduled leadership meetings and joint committees and workgroups to ensure regular communication, coordinated strategies, and optimal progress between the two efforts.

Provider Adoption The Department supports federal and state efforts that promote the adoption of health IT by Medicaid providers. This includes the technical assistance programs and provider incentives designed to help providers adopt and meaningfully use electronic health records (EHRs).



The HITECH Act authorizes incentive payments for eligible Medicare and Medicaid providers who can demonstrate meaningful use of certified EHR technology. Medicaid incentives most likely will begin in 2011. The Department will manage the Medicaid incentive payments available to eligible providers in Iowa. Dedicated Department staff will monitor and manage this task and ensure that the requirements of the federal HIT incentive programs available through Medicaid are fully communicated to Iowa providers and correctly administered in Iowa.

The Department will also support the HIT Regional Extension Center (REC) for Iowa once that contract is awarded. The Department supported IFMC's preliminary and full application to ONC to serve as the HIT Regional Center for Iowa. Assuming IFMC is awarded the REC contract for Iowa, we will collaborate and align our efforts with the Department and IDPH to achieve maximum progress in the adoption and meaningful use of electronic health records by Iowa providers.

Data Availability Health care stakeholders in Iowa are working to advance HIT and HIE in the State by promoting data-driven health care decision making designed to elevate the quality, safety, and efficiency of health care. The Department sees value in coordinating Medicaid activity with statewide health information exchange efforts in order to leverage the availability of clinical data to promote efficiencies and improved clinical outcomes.

Implementation of IMERS several years ago was a first step in making electronic claims data available to Iowa providers and administrative parties through a web-based portal. The HIT plan recognizes that much work remains to both provide and access real-time clinical data for Medicaid patients statewide to optimize administrative efficiencies. The Iowa HIT plan will look to other states and the Iowa e-health Project as these efforts are advanced.

Quality Data Reporting The ability to capture clinical data electronically through HIT significantly enhances the process and validity of quality data reporting. This leads to improved clinical outcomes for individual patients as well as the overall population.

The Department HIT goals of quality reporting are shared by the Iowa e-health Project and the REC program, and are part of the initial meaningful use requirements announced by ONC. The Department recognizes the clinical value of having health IT components in place that support quality reporting and enable the effective management of population health for the Medicaid program in Iowa. IFMC is well positioned to assist the Department in achieving its objectives for related to state Medicaid HIT.

IFMC will build on our experience in this area and help the Department to develop quality reporting capabilities, ensure the accuracy and validity of the data, and coordinate activities with other data reporting programs currently active in the state.



IFMC received a letter from Senator Tom Harkin expressing his thanks for our partnering with Mercy Medical Center in creating the Medical Home Program. This played a key role in Mercy Clinic Inc. receiving the 2008 Acclaim Award from the American Medical Group Management Association. In the Congressional Record Statement that was read on the floor of the United States Senate, IFMC was recognized for providing the CareMeasures Disease Registry, which is the quality reporting tool used by Mercy in their program. December 2008

Contractor Responsibilities (6.2.6.2)

Under direction of the Department, we will participate in the development of the Iowa Medicaid HIT plan. We will align our activities with other HIT and HIE efforts in the State in order to effectively and efficiently combine the expertise and resources available to support the Department's HIT plan. We will devote dedicated resources to this effort and build upon the Department's existing HIT infrastructure and staff expertise to ensure success in achieving the goals of the HIT plan.

IFMC will represent the Department in discussions with Iowa stakeholders regarding the development of a State HIT plan. During the past two years, we have represented the Department on the Medical Home Task Force, the HIT/HIE task force, and several other statewide initiatives and have collaborated with other state agencies, provider groups, commercial payers, and medical associations on various projects involving HIT and HIE. IFMC experts will continue to participate in State HIT planning activities as requested by the Department.

IFMC understands and adheres to all rules and policies related to the confidentiality and security of Medicaid member protected health information. We have extensive experience in this area resulting from our work in the national Health Information Security and Privacy Collaborative (HISPC). Under this program, IFMC was designated by the governor to represent the state of Iowa. Program goals were to identify ways to increase the exchange of clinical information among health care providers while protecting the privacy and security of the information. Privacy protections are built into all data policies and procedures at IFMC and will be used to insure the privacy of Medicaid members in all recommendations made to the Department.

IFMC developed and deployed a provider incentive program for the Oklahoma Medicaid Agency as part of our contract to operate a Health Management Program for Medicaid members in that state. Our staff have participated in numerous CMS initiatives regarding the development of clinical performance measures used in provider incentive programs. In addition, we contract with CMS to operate the Physician Quality Reporting Initiative (PQRI) program, the physician incentive program used by Medicare. IFMC also supports the hospital incentive program used by Medicare. This expertise and experience will be used to assist the Department in developing provider incentive strategies for use in the Iowa Medicaid program.



As a partner with the Department, IFMC has been a positive, vocal supporter of the Department's initiatives over the years. As the Department moves forward with health care reform, including the development of HIT/HIE plans, we will serve as the Plan Champion within the Department. In this role, we will ensure all Department personnel are fully informed about the plan and understand how it aligns with other Department priorities. We will also serve as the Plan "experts" to help insure that operational features and future enhancements to the Plan are developed to be consistent with overall objectives of the Plan and the Department.

IFMC has significant experience in the development and execution of provider assessments of HIT use. We conducted the first statewide assessment of physician adoption of electronic health records in 2006. Data from the assessment were used by several stakeholder organizations to develop future HIT deployment strategies. More recently, we have worked with IDPH on the design of an assessment tool to collect current information about the rate of HIT adoption by Iowa providers. We will use our expertise to assist the Department in the planning and execution of statewide provider assessments that may be needed as part of the Medicaid HIT plan.



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TAB 7 – PROJECT PLAN (7.2.7)

Our experienced and proven management team combined with trained and dedicated staff offers a project management strategy that capitalizes on our experience with the Department and our expertise with utilization and quality management services. Our program management approach is focused on meeting core deliverables and achieving and exceeding performance measures.

Key objectives of our project management approach include:

- Align tasks to achieve goals
- Provide triggers for risk and decision- making
- Enable transparency into project processes and staffing barriers
- Automatically adjust and prioritize work
- Provide graphic reports

We understand that planning is essential to contract success. As the current Medical Services contractor we have included transition and operation plans. We will cooperate with the Member Services vendor to ensure a smooth transition of the disease management, EPCM, and Lock-in programs. Our current work will continue without gaps and with the addition of HIT.

IFMC's project plans for transition and operations are included in this proposal. All project plans have detailed steps with timelines and are specific to Medical Services functions.

Our overall project plan, including each phase, will address:

- Required proficiencies
- Deliverables
- Milestones
- Timelines
- Barriers/risks

A variety of tools are used to support our project management efforts. These include Microsoft Project Server (enterprise project management), Deltek CostPoint (cost accounting) and Ceridian Business (electronic time accounting) systems. These tools support our management team in managing and ensuring availability of resources at the appropriate time and increase our effectiveness in handling large numbers of different tasks that are proceeding simultaneously.

Any good project management process includes a mechanism for periodic reviews. We prepare progress reports that summarize the financial and technical status of task(s) on a monthly basis. The feedback from review of these reports can result in technical redirection, schedule modification, or staffing changes to mitigate identified risks.

Our commitment is to meet or exceed all performance standards on time, accurately and completely, and within budget.



Transition Phase

During the transition phase, the IFMC management team will meet with the Department unit manager and other specified policy specialists no less often than weekly to ensure effective execution of the project plan. A standing agenda will be created to ensure appropriate and timely updates are made regarding all crucial issues and interfaces. Regular coordinating will also be held with the Member Services contractor and the Integrity Program contractor to ensure disease management, EPCM, Lock-in, and MVM are turned over smoothly.

We will provide the Department electronic access at any time to our transition progress report which will be updated weekly. This report will include real-time data and information to support transition activities. IFMC will remain flexible to changing needs and priorities of the Department.

Interfaces such as MMIS, IMERS, ISIS, and SSNI will already be in place for IFMC.

Our project plan for the Transition Phase is on the following page.



Medical Services – Technical Proposal
*IFMC Response to the Iowa Department of Human Services
Iowa Medicaid Enterprise Professional Services – RFP MED-10-001*

Transition Phase Project Plan



Operations Phase

During the operations phase, IFMC will meet all performance standards and complete all required reports. We believe the current coordination that occurs in the unit meeting is effective and we will continue to participate in all necessary activities to ensure that IME delivers quality service to its members.

We will incorporate the program management approach discussed above to guide our performance during the operations phase. When dictated by changes in contract requirements or other circumstances that may affect performance or resources, project plans for operations will be modified as needed to ensure continued success.

We currently report all performance measures monthly, quarterly, and/or annually via report cards as directed by the Department. Rather than waiting to analyze performance data at the time it is assembled for the standard report cards, we monitor real time data and information by collecting and reviewing interim measures to assess our progress. This strategy allows for early identification of problem areas and swift remedial action in order to have a positive impact on our performance.

When addressing variances or indications of potential problems, we will assemble appropriate team members and conduct a preliminary assessment of the issue(s). This includes activities such as assessing performance trends (e.g., one time variation or negative trending results) to decide if action is needed. When a need for corrective action is identified, the appropriate team will conduct an in-depth assessment of the issue(s) and design a corrective action strategy. The following steps are typical of the process:

- Decide who will receive feedback regarding the variance or opportunity for improvement
- Assess the underlying cause of the variance and measure the current state process
- Determine potential strategies for improvement or identify needed process changes (this may involve guidance from the Department, IME vendors, and the health care community)
- Develop detailed strategies specific to the measure (e.g., should individual members be targeted to improve performance or is there an overall problem with the effectiveness of the interventions we are promoting?)
- Implement the process changes, including spread (once established)
- Use small tests of change to implement larger, manageable change
- Continue to monitor changes and ongoing status

IFMC has several strategies to ensure quality management. Our detailed employee orientation requires demonstrated proficiency prior to staff being able to work independently. We have a monthly IQC process to ensure accurate decisions are made and that our processes have inter-rater reliability. We also have our own quality improvement process, which provides our staff with a framework for identifying concerns, developing measures, and implementing BPI.



Operations Phase Project Plan



Turnover Phase

Six months prior to the end of any contract, the Department will request current vendors to develop a Turnover Plan. The plan will provide detailed methods that will be used to ensure a smooth transition to the successor contractor.



The Plan will include all information requested by the Department and at a minimum the following elements:

- Roles and responsibilities of the IFMC turnover team
- A milestone chart detailing the resources, time lines and stages of transition from the effective date of contract performance the successor contractor assumes sole responsibility for the work
- Plans to communicate and cooperate with the successor contractor
- Proposed approach to transition technical support for the successor contractor
- Transfer of all relevant information to ensure successful transition of operational activities including:
 - Data in a file extract of all utilization reviews and quality reviews
 - Clinical information necessary for ongoing management of services
 - Operation support documents
 - Outstanding issues and tasks
 - Contact and communication material

During the turnover phase IFMC will work to ensure services to members are not disrupted and the change to the successor is transparent. We will continue to meet performance expectations during the turnover phase.

Overall Project Plan

Our overall project plan, including each phase, will address:

- Required proficiencies
- Deliverables
- Milestones
- Timelines
- Barriers/risks

Our project plan, also included in this proposal, will encompass each phase and will address elements specific to transition and operations.



Overall Project Plan



Medical Services – Technical Proposal
IFMC Response to the Iowa Department of Human Services
Iowa Medicaid Enterprise Professional Services – RFP MED-10-001



Risk Management

Successful implementation of the Medical Services program is dependent, in part, on the identification and management of risks that could have an adverse effect on member enrollment and outreach activities. Our existing relationship with the Department, our long history of working with Iowa Medicaid members and health care providers, and our strong partnerships with other IME vendors will aid in minimizing risk. However, no project is without some risk. Corporately and at the project level, we assess risk and potential risks and establish strategies and mitigation plans. The overall objective of these efforts is to minimize the business impact and the impact on individual contract success.

Our project management methodologies include risk analysis and mitigation in their basic foundation. This provides early warning of potential risk and allows us to mitigate the risk before it escalates. Ongoing reports, meetings, and communications include looking at risks, identifying them, and mitigating them. Milestones serve as a way of tracking the project and early identification of potential slippage or problems that need to be addressed before resulting in major negative impacts. Communication is key to identifying and dealing with any potential challenge to the program.



In addition to the Business Disruption Plan through IME, we have standing procedures in place through our corporate Business Continuity Plan (BCP) that address operational risks. A strong BCP allows us to continue to function through many challenges and/or to return to full functioning within an acceptable timeframe. The table below provides a listing of critical risk areas, potential causes, probability of occurrences, areas impacted, and mitigation strategy.

Risk	Cause	Probability of Occurrence	Area(s) Impacted	Mitigation
Staff unable to get to office	Severe Weather	Low to medium	Call Center	Plans in place for key staff to work from home
Resources	Pandemic/ epidemic	Low	All	Business Continuity Plan in place
Security breach	Information sent to wrong member or provider	Low	Member, Provider, Department, IFMC	Procedures in place to prevent, audits performed, incident process in place
Performance measure missed	Contract changes	Low to medium	Project overall or a small portion of the program	Project management plan, work plan, reporting, ongoing communication and meetings
Communication	Meetings cancelled or minutes not distributed or stakeholders not provided information	Low to medium	Department, members, providers, other IME Vendors	Project management plan include focus on communication and ongoing assessment to improve communication

By incorporating our project management methodologies, our BCP, our experienced, skilled management team, and our relationships with the Department, other IME vendors, members and providers, we have created a winning combination for a successful project with minimal risk. Risks more specific to the Medical Services component are presented in the Executive Summary (Tab 4) of this proposal).



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TAB 8 - PROJECT ORGANIZATION (7.2.8)

IFMC has extensive experience in project management, especially in the development and deployment of large-scale health management programs on a statewide level. We will rely on this experience, our program knowledge, and the lessons learned as the current vendor for Medical Services to provide the Department with a seamless transition to the new contract.

We understand that program success does not depend on IFMC alone. Close collaboration between the Department, IFMC, and other IME vendors will be necessary at all times. Our existing working relationships with all key organizations will also contribute to successful program operations. Our experience in establishing collaborative relationships and our knowledge of IME interfaces will assist us in effectively working with new IME vendors.

IFMC supports service delivery to our clients through several business units. To accommodate the breadth and scope of our product and service lines, IFMC has adopted an organization structure that supports specialization to promote innovation and improve quality. Each business unit is specialized and available as a resource to the others. Business units can build on focused areas of expertise and extend that expertise to the larger organization.

Each of our clients is unique with a different set of priorities and challenges. This diversity requires matching our experience and abilities to every client and customer to create a customized program and solution. Our successful customization program has resulted in client retention levels of more than 90 percent for the past 10 years.

We are committed to following the U.S. Commerce Department's National Institute of Standards and Technology (NIST) Baldrige National Quality Program to implement performance excellence throughout our organization. The Baldrige Criteria for Performance Excellence provides a systems perspective for understanding performance management. The criteria reflect validated, leading-edge management practices against which an organization can measure itself and represent a common language for communication among organizations for sharing best practices. When applied to our internal operations, the Baldrige criteria provide a valuable tool to critically examine our programs and identify opportunities for improvement. This approach will help insure a high level of operational performance for all Medical Service activities.

Our proposed staffing model for Medical Services is described in Tab 5 of this proposal. Our staffing model includes a full time account manager and a full time transition manager. The transition manager will become a full time operations manager at the beginning of the operations phase of the contract. A second operations manager will be in place prior to the start of contract activities on July 1, 2010. A full time chief medical director will provide medical direction for all IME vendors and the Department. We have designated six program managers. All key personnel are currently employed or have committed to IFMC.



The objectives of our proposed staffing plan for Medical Services include:

- Leadership to ensure collaboration with the health care providers and IME vendors
- Medical knowledge to ensure on-going development of utilization and quality management programs that enhance care for members
- Organizational skills to ensure deliverables are met
- Software support
- Personnel management to ensure qualified professionals are hired and trained to successfully perform required activities
- Quality improvement to ensure effective and efficient processes and to identify opportunities for program improvement

Organization Charts (7.2.8.1)

TRANSITION PHASE

IFMC’s proposed transition phase structure will ensure a coordinated program transition. With our five years of experience at IME and staff retention expected, the transition tasks will be less difficult.

Our transition team will be led by _____, transition manager. The team will include _____. In addition, clinical support and direction will be provided by our medical director to ensure our utilization and quality management programs are structured on evidenced-based guidelines and appropriate to meet the needs of Medicaid members.

Our transition staff will work as a team, meeting no less than weekly to ensure timelines and performance targets are on schedule. The transition manager will meet regularly with the Department about work progress and priorities.

We have a proven track record of meeting performances standards, timelines, and deliverables and will continue to commit the necessary resources to ensure a successful transition. The following chart summarizes the level of effort and responsibilities for Key transition staff:

Key Personnel	Level of Effort	Number of Staff	Responsibilities
Transition Manager	100%	1	Create and implement all project plans for transition, operations, turnover, and staffing of each phase; coordination of communications with Department staff and other IME vendors; coordination of interface needs; oversee hiring and training of staff; manage resources; maintain communications with IFMC corporate staff and community partners; oversight of contractual obligations; and QA coordination.



Representative Job Descriptions

Position: Director, Program (Transition Manager)

Position Summary:

Essential Functions:

Requirements:

Additional Comments:



Position: Medical Director

Position Summary:

Essential Functions:

Requirements:

Additional Comments:





Physical and Mental Demands:

Position: Manager, Quality and Accountability (Program Manager)

Position Summary:

Essential Functions:



Requirements:

Physical and Mental Demands:

Position: Specialist, Program

Position Summary:

Essential Functions:



Requirements:

Additional Comments:

Physical and Mental Demands:



Position: Programmer

Position Summary:

Essential Functions:

Requirements:

Additional Comments:

Physical and Mental Demands:



Physical and Mental Demands:

Position: Assistant, Project

Position Summary:

Essential Functions:

Requirements:



Additional Comments:

Physical and Mental Demands:

Our staff will maintain current operations of the Medical Services contract during the transition. Transition tasks in the last month prior to operations will include revising protocols and training.

OPERATIONS PHASE

We have experienced personnel who have supported the utilization and quality management programs during our tenure as the Medical Services vendor. These staff will continue to support these programs under the new Medical Services contract. This will help ensure minimal disruption in member support and continuity in program operations.

Our extensive experience with program operations is strengthened by a rigorous internal quality management program, based on stringent URAC standards. Our management team will use this program to monitor our compliance with all contract performance standards and requirements. This will allow early recognition and resolution of potential issues. Following contract award, we will customize this plan specifically for Medical Services and submit the plan to the Department for approval. The approved plan will be used during the operations phase of the contract to help ensure successful performance.



The following table identifies the staffing levels, roles and responsibilities for key personnel during the operations phase of the contract:

Key Personnel	Level of Effort	Number of Staff	Responsibilities
Account Manager	100%	1	Coordinate communications with Department staff, IME vendors, community partners, and IFMC corporate VP; oversee all operational responsibilities; manage resources; ensure contractual obligations are met; and quality assurance coordination.
Medical Director	100%	1	Provide medical guidance for IFMC staff, other IME vendors, and the Department; maintain network of medical consultants; serve as a medical expert for state policy staff; maintain knowledge of current medical standards.
Operations Managers	100%	2	Coordinate operations of Medical Service programs, oversee hiring and training of staff, and monitor budget and resources. The managers will be cross-trained and provide backup for one another.

Representative Job Descriptions

Position: Director, Senior (Account Manager)

Position Summary:

Essential Functions:



Requirements:

Additional Comments:

Physical and Mental Demands:

Position: Medical Director (Please refer to Transitions Phase)



Position: Director, Program (Operations Manager)

Position Summary:

Essential Functions:

Requirements:

Additional Comments:



Physical and Mental Demands:

Position: Program Manager (Please refer to Transition Phase)

Position:

Position Summary:

Essential Functions:

Requirements:



Additional Comments:

Physical and Mental Demands:

Position: Program Specialist (Please refer to Transition Phase)

Position: Programmer (Please refer to Transition Phase)

Position: (Please refer to Transition Phase)

Position: Coordinator, Quality Improvement

Position Summary:

Essential Functions:



Requirements:

Additional Comments:

Physical and Mental Demands:



Position: Coordinator, Review

Position Summary:

Essential Functions:

Requirements:

Additional Comments:



Physical and Mental Demands:

Position: Assistant, Review

Position Summary:

Essential Functions:

Requirements:



Additional Comments:

Physical and Mental Demands:

Position: Project Assistant (Please refer to Transition Phase)

TURNOVER PHASE

All key personnel will remain through the turnover phase. We will ensure sufficient staff will be maintained during the turnover phase to ensure continuity of operations and quality service to Medicaid members.

Six months prior to the commencement of a transition from IFMC to a successor contractor, we will submit a detailed transition plan to the Department that provides adequate detail to ensure uninterrupted Medical Services. Activities will be administered effectively and efficiently during the transition and completed within a reasonable timeframe.

The transition plan will provide detailed methods that will be used to ensure a smooth transition from IFMC to the successor contractor. The transition plan will include the following:

- A milestone chart detailing the resources, time lines and stages of transition until the successor assumes responsibility for Medical Services
- An organizational chart that displays internal and external organizational relationships



- Plans to communicate and cooperate with the Department and the successor
- Proposed approach to transition technical support to the successor

Transition activities will include the transfer of all relevant information to ensure a seamless transition of operational activities. At a minimum, this includes:

- All client and service data in a usable format
- Operation support documents
- Outstanding issues and tasks
- Contact and communication material

Thirty days following turnover of operations, we will provide the Department a turnover results report detailing all activities and results of the executed turnover plan. Should our plan or execution of the plan not meet expectations, we will work collaboratively with the Department to resolve all issues in a timely and efficient manner.

ORGANIZATIONAL CHARTS

The following organizational charts outline our key staff that will support the Medical Services contract. The charts also show the lines of authority and inter-relationship of the various operating units that will be involved in Medical Service activities.

The first organization chart provides a high-level overview of our executive team and its connection to the Medical Services contract:



Medical Services – Technical Proposal
*IFMC Response to the Iowa Department of Human Services
Iowa Medicaid Enterprise Professional Services – RFP MED-10-001*



The following chart provides a listing of the personnel involved in the Medical Services contract for the Transition Phase:



The following chart provides a listing of the personnel involved in the Medical Services contract at an operational level:

As noted in the organizational charts, key positions for the Medical Services contract are filled by individuals with prior experience supporting the IME. This will ensure a successful operational deployment without the need for a new management team or operational staff to learn about the program or build relationships with the Department or other IME vendors.

Staffing (7.2.8.2)

IFMC has an established track record of securing staff who have the requisite skills to meet all contractual requirements. This has helped us meet or exceed all performance standards for Medical Services during the past five years of IME operations.



The account manager and two operation managers for Medical Services have experience in IME operations during the past five years. We understand the complexities of a multi-vendor enterprise and the need for quality service for Medicaid members.

We have a history of success with recruiting associated staff. For example, during our 2005 implementation of the IME Medical Services contract,

Our recruiting process makes it very easy for potential candidates to apply, be screened and eventually hired. We use an on-line applicant tracking system which provides a one-stop-shop for all applicants, managers and recruiters. Depending on the position, we will use standard forms of recruiting including newspaper advertisements and posting to job boards such as Career Builder, Monster and Dice.com.

As needs arise, we will seek staff knowledgeable about IME programs and skilled in communication activities, claims, and program administration to fill the specialist positions. This will be accomplished by leveraging current staff or recruiting professionals with Department experience, such as income maintenance workers.

Key Personnel (7.2.8.3)

RN, CPHQ, will serve as the account manager for Medical Services. reports directly to , vice president, Quality Management Business Unit at IFMC. will be responsible for ensuring all contractual obligations are met. is a certified professional in healthcare quality and has over 20 years of experience working with Medicaid review and quality management programs. is currently employed by IFMC as our account manager for IME and has had management and fiscal responsibility for IFMC’s Iowa Medicaid contracts since 1998.

, LISW, will serve as the transition manager and operations manager. has more than seven years of Medicaid management experience. She has managed the programs and supervised IFMC staff responsible for member health education and lock-in, rehabilitative treatment, psychiatric medical institutions for children, claims pre-pay, PA, quality of care, EPSDT, and other medical support services. She is currently employed by IFMC as an operations manager for IME Medical Services.

As noted in Tab 5 of this proposal,

. This role will be filled by

have been members of our Medical Services team since the inception of IME. This group’s average experience is nearly four years experience with IME Medical Services and more than eight years average Medicaid experience.

, MD, FAAP, CHBE has committed to join IFMC by the beginning of the contract start date. He will be oriented and trained by , DO, current IME Medical Services medical director. will provide medical leadership for Medical Services and the IME.

is board certified in pediatrics. will have the opportunity to work with
, the current IME medical director for at least 60 days prior to operations.

Resumes and references for all key personnel are provided in Tab 5. All key personnel are current IFMC employees or committed to IFMC.

Subcontractors (7.2.8.4)

IFMC will not have subcontracts for Medical Services.

Quality Control

The values that drive IFMC as a leader in health care management also drive our commitment to continuous process/quality improvement. We continuously measure our own performance, identify opportunities for improvement based on analysis of performance data and implement changes designed for improvement. This approach to ongoing performance monitoring and improvement will be rigorously applied to all activities included in the Medical Services contract.

During the program transition phase, we will submit a project work plan that details our quality monitoring and corrective action processes. During the operations phase, we will operate under this plan. The information below details our quality assurance and improvement programs.

IFMC Quality Assurance Program

Our quality management policies and procedures provide a systematic approach to addressing quality assessment and process improvement at all levels of our organization to support the IME Medical Services contract. Our procedures outline processes for:

- Annual development of quality management program goals and objectives
- Development of quality indicators for administrative and contract requirements
- Compliance to URAC standards, state and federal regulations
- Data measurement plans for ongoing evaluation and tracking of performance
- Implementation of quality improvement projects or corrective action plans
- Reporting mechanisms and timelines
- Communication plans

We propose to use standardized clinical and administrative performance measures when available. We will collaborate with the Department on the final selection of the performance measures.



Categories of suggested measures may include the following:

- Clinical outcomes including improved health status based on disease-specific evidence-based guidelines
- Financial indicators such as cost avoidance, changes in service utilization including emergency department services and total claims cost
- Internal quality control such as timely review completion, timely delivery of reports,

We will establish and monitor baseline measurements over time for each performance measure. IFMC's internal quality control (IQC) plan includes information on the source of data, time period of baseline measurement, re-measurement period, frequency of measurement, the analysis plan and reporting frequency. When appropriate and to assist in monitoring, we may develop proxy measures to track performance over time. Analysis of performance data will be completed weekly, monthly or quarterly, depending on the measure. We will look for trends to identify developing patterns that may adversely impact our ability to meet performance standards. We will address any problem trends immediately through process changes designed to reverse the trend and avoid a problem before it impacts our ability to meet the Department's expectations.

Should any area of our performance fall below our performance benchmarks or state-specified levels, we will clearly identify the problem and develop a corrective action plan. Through our IQC program, we will use quality improvement tools to evaluate barriers to meeting performance expectations and document corrective actions. We have adopted the rapid cycle PDSA method in our approach to internal process improvement. Led by our operation managers, we will complete PDSA forms to identify barriers in existing workflow processes, possible solutions and the results of interventions to mitigate the barriers. If the proposed solution(s) does not improve performance, we will rapidly implement another solution and then evaluate and document the results. We will keep the Department informed of concerns and steps taken to resolve any problems.



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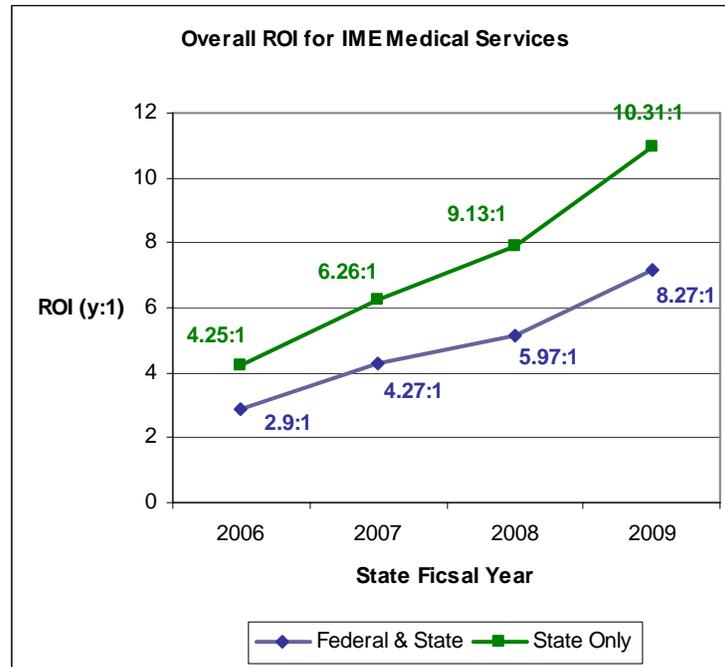
TAB 9 - CORPORATE QUALIFICATIONS (7.2.9)

Corporate Organization (7.2.9.1.a)

IFMC is nationally recognized as a leading provider of health care quality improvement, care coordination and medical information management. Founded in 1971 as a 501(c)(6) non-profit organization, we have served as a trusted state and federal government contractor for 37 years, providing the Iowa Department of Human Services, the Centers for Medicare and Medicaid Services (CMS), and other clients and customers with products and services to promote health care quality and access for their members. We are headquartered in West Des Moines, Iowa, with offices in Illinois, Maryland and Oklahoma. With more than \$95 million in annual revenues, our company provides services impacting more than 40 million people nationwide, providing client-driven, flexible solutions. Our three major lines of business include: Care Management Programs, Health Care Quality Programs and Information Management Services.

Since 1979, the Iowa Department of Human Services (DHS) has contracted with IFMC for utilization management, quality improvement, and special project services involving recipients of medical assistance. The Department's confidence in IFMC's sustained ability to produce desired outcomes has been supported by being award increased program responsibility over the past 30 years. Examples include Rehabilitative Treatment Service authorization in 1998, Disease Management for Diabetes and Adult Rehabilitation Options in 2003 and a significant expansion of the Recipient Health Education Program also in 2003.

Since 2005, IFMC has held the Medical and Pharmacy/Medical IME contracts. Our IME programs are highly effective and have consistently resulted in significant cost savings, both federally and for the State of Iowa, as documented in the following graph:



IFMC offers a proven track record of demonstrated results for the Department.

In 2008, IFMC was awarded an Oklahoma Medicaid contract to provide care management and quality improvement programs. IFMC specializes in enrollment and disenrollment, health risk assessment, nurse care management, client outreach and education, practice facilitation for quality improvement and provider education services for the Oklahoma SoonerCare Health Management program.

“IFMC has been instrumental in building this strong and comprehensive program. The daily operations have been detailed and complex. We have found IFMC to be sound and reliable business partners. They worked diligently through the development and start up of the program. As we worked collaboratively through both expected and unexpected challenges in the first year, we found them to be responsive, both locally and corporately, to our evolving needs in relation to the program. OHCA confidently recommends IFMC to other states as a potential health management contractor.”

***Dr. Michael Herndon, Medical Director, Oklahoma Health Care Authority,
Reference letter dated September***

Our extensive knowledge and experience with state Medicaid programs and our direct operational experience with the IME model will ensure the successful operations of the Medical Services Program. As is our standard with all clients, IFMC will work cooperatively and expediently with the Department and contractors to ensure efficient ongoing program operations.



IFMC employs more than 800 staff members including physicians, nurses, health information technology specialists, quality improvement experts, pharmacists, social workers, programmers, biostatisticians and epidemiologists. We have a long history of successfully launching new programs at both the national and statewide level involving both transitions from a prior contactor and launching new programs. In all cases, we have succeeded in meeting client expectations and initiating new programs on time and within budget.

Our corporate organization chart follows:

Staff Assigned to Project Oversight (7.2.9.1.b)

Our company supports the delivery of our Information Management, Care Management and Quality Management services to our clients through several business units. Within each business unit, directors report to a vice president. Directors are mentored with long-term succession in mind. While possessing a broad knowledge of IFMC programs and services, our individual directors offer expertise in specific programs/systems and/or with specific clients.

_____ has served as our Chief Executive Officer since 2004. _____ is responsible for the overall leadership and financial direction of the organization. With 30 years experience in health-care related fields, _____ has worked with a variety of clinical and operational quality initiatives. He has also been involved in organizational quality improvement and accreditation processes that contributed to winning industry, state, and national recognition. _____ received his master's degree in business administration from the University of Illinois in _____



Champaign-Urbana, Illinois, and his bachelor's degree from Olivet Nazarene University in Kankakee, Illinois. He earned a diploma in respiratory therapy from the University of Chicago in Chicago, Illinois.

, RHIT, CPHQ, Group Vice President for Quality Management, will have responsibility for signing the contract and monitoring and ensuring the performance of duties and obligations under the contract. has more than 30 years experience in managing health information and quality improvement programs with more than 28 years with IFMC. She was previously a member of the Iowa Medicaid management team for over six years and also served as the director of the national QIO Support Contractor (QIOSC) contract with CMS. During her tenure with IFMC, she has had oversight for all aspects of project management for numerous federal, state and commercial contracts. and her teams, which include the IME Medical Services staff, are committed to providing the clinical and technical expertise necessary to ensure a successful implementation of the Medical Services program and meet or exceed all contract deliverables.

is Group Vice President for Information Management at IFMC. He provides oversight of health information management services, applications and health care informatics. With more than 14 years of experience in technology, leadership and technical direction has been instrumental in managing client relations for a variety of IFMC projects and programs. His team is responsible for providing technical expertise for the implementation of the CaseNet TruCare™ system which will be used to collect member identification data and document care plans. holds a biomedical engineering degree from Bombay University and master's degrees in biomedical engineering from the University of Iowa and information technology management from Creighton University. has been with IFMC for five years.

is Vice President of Finance and Administration. In a role she has held for 3 years, she is responsible for managing accounting, finance, contracting, compliance, purchasing, and facilities for IFMC. She will assure IME Member Services contract terms are met, generally accepted accounting principles are followed and required financial documents are submitted on time. She has 10 years of senior leadership experience and over 20 years of accounting and finance experience. Prior to her role at IFMC, she most recently served as chief financial officer for the State of Iowa, Administrative Services in Des Moines. Her involvement with state agencies has given her experience with contracting and purchasing requirements and compliance with the Federal Circular, OMB and FCC laws and regulations and working with other state agencies. She holds a bachelor's degree in business administration and a CPA certification.

is Vice President of Organization Development. He provides leadership in organization development and structure, employee involvement, and organization culture and development. will provide oversight for the recruitment, education and retention of IFMC Member Services staff. He has nearly 20 years of professional experience in human resources including serving as assistant vice president of human resources for a global property/casualty insurance company and manager of HR, benefits design, and employee



relations for a durable goods manufacturing company. He has successfully planned, led and managed strategic and tactical HR activities and increased organizational performance through management development sessions. holds a bachelor’s degree in business administration from the University of Iowa and is currently completing a master’s degree. He is certified as a Professional in Human Resources (PHR).

Management Staff Assigned to IME

, RN, CPHQ, will serve as the Account Manager for IME Medical Services. serves as the Senior Director of Medicaid Quality Improvement and reports directly to . will be responsible for ensuring all contractual obligations are met. or her designee will provide immediate access to IFMC staff for DHS personnel concerning contract-related issues. has over 20 years of experience working with Medicaid review and quality management programs and special project activities. She has had management and fiscal responsibility for the Iowa Medicaid review program since 1998. offers her expertise in working with Medicaid managed care and fee-for-service populations and her experience with the Iowa Medicaid program’s policies and procedures. She has extensive experience monitoring and ensuring all contract deliverables and performance standards are met. As a certified professional in healthcare quality, she is committed to continuous quality improvement and demonstrates the ability to operationalize these principles into workflow processes.

, LISW, will serve as the transition manager and one of two operation managers. reports directly to . has worked in healthcare for more than 30 years providing direction necessary for the delivery of quality healthcare services. She brings with her an understanding of process improvement, organized delivery systems and implementing continuous quality improvement programs. As an operations manager, will direct day-to-day operations and provide technical guidance for the IME Medical Services contract. She will motivate and evaluate professional and support staff and provide resources and supports as needed to meet the goals of the IME.

As noted previously, the

. This role will be filled by

since the inception of IME. This group’s average experience is nearly four years experience with IME Medical Services and more than eight years average Medicaid experience.

, MD, FAAP, CHBE, will serve as Medical Director. He earned his medical degree from the University of Iowa, College of Medicine in 1998. Originally from the Minneapolis/St. Paul area, he earned his bachelors degree in Biology, Chemistry and Music from the University of Minnesota in 1994.

since 2004. He has extensive background in chart audits, peer





review and quality assurance, working both in internal systems locally in Iowa and for the Arkansas Foundation for Medical Care in Arkansas. His clinical interests include preventive care, education, technology in medicine and alternative treatments. He is a Certified Happiest Baby Educator (CHBE) and has undergone special training in pediatric clinical hypnosis and child physical and sexual abuse.

Technical Staff Assigned to IME

, Programmer, will provide support and maintenance to all Medical Services system interfaces. will coordinate communication between IME Medical Services, DW/DS, Core, as well as IFMC Information Management personnel. has five years experience with IME systems and has established a collaborative and cooperative relationship with IME IT vendors.

Legal Structure of IFMC (7.2.9.1.c)

IFMC was established in 1971 as a 501(c)(6) Iowa not for profit corporation, registered to do business in the State of Iowa.

IFMC is governed by a 14-member Board of Directors which oversees all corporate activity and as such has no owners. The Board of Directors is largely comprised of elected members from IFMC’s physician membership (8) as well as other appointed members (6). IFMC’s CEO, , reports directly to the IFMC Board. IFMC’s structure includes six (6) business units: Care Management, Quality Management, Information Management, Finance and Administration, Business Development, and Organization Development. Within each business unit, directors report to a vice president or group vice president. Each vice president or group vice president reports directly to the CEO. Oversight of the Medical Services program is located in the Quality Management Group under the direction of , Vice President.

As a nonprofit corporation IFMC has no owners. The following table provides the names and credentials of the executive staff. Please refer to the organization chart above for the reporting structure.

Name	Title	Credentials
	Chief Executive Officer	<ul style="list-style-type: none"> ➤ Master’s in Business Administration ➤ 30 years health care related experience
	Group Vice President Quality Management/ Interim Group Vice President Care Management	<ul style="list-style-type: none"> ➤ Registered Health Information Technologist (RHIT) ➤ Certified Professional in Healthcare Quality (CPHQ) ➤ 30 years experience managing health information and quality improvement programs



Name	Title	Credentials
	Group Vice President Information Management	<ul style="list-style-type: none"> ➤ Master’s in Biomedical Engineering ➤ Master’s in Information Technology Management ➤ 14 years information technology experience
	Vice President Finance and Administration	<ul style="list-style-type: none"> ➤ Bachelor’s in Business Administration ➤ Certified Public Accountant ➤ 19 years executive leadership experience
	Vice President Organization Development	<ul style="list-style-type: none"> ➤ Bachelor’s in Business Administration ➤ 20 years experience in human resources
	Vice President Business Development	<ul style="list-style-type: none"> ➤ Bachelor’s in Health Sciences ➤ 30 years health care management experience

Evidence of Iowa Business License (7.2.9.1.d)

IFMC is a corporation formed under Iowa Code Chapter 504A. A copy of IFMC’s Certificate of Good Standing issued by the Iowa Secretary of State (IA Business License) is presented at the end of this Tab (page 228).

Established Community Partnership Relationships (7.2.9.1.e)

IFMC is a long term Iowa-based company with long-standing relationships with the Iowa Medical Society, the Iowa Osteopathic Medical Association, Iowa Academy of Family Physicians, the Iowa Hospital Association, the Iowa Healthcare Collaborative (IHC), the Iowa Pharmacy Association, and Iowa’s long term care associations (Iowa Health Care Association, Iowa Association of Homes and Services for the Aging, and ABCM Corporation), Des Moines University, University of Iowa, Iowa/Nebraska Primary Care Association, FQHCs, and RHCs.

IFMC has formed many partnerships and collaborative relationships with other state government departments and private organizations, including the Iowa Department of Inspections and Appeals (DIA) and the Iowa Department of Public Health (IDPH). From 1989 through June 2009, we were responsible for providing statewide nursing facility education regarding the Resident Assessment Instrument. The Department and DIA (through its survey process) suggested clinical topics, which we incorporated into educational programs.

IFMC staff serve on the Electronic Health Information Advisory Committee at IDPH, which is focused on providing input and feedback to the state as they develop and deploy a health information exchange (HIE) in Iowa. In addition to the statewide advisory committee, we also serve on several workgroups formed by IDPH to provide specific technical guidance for HIE development. IFMC committee appointments include:

- Governance & Finance
- Privacy & Security
- Provider Adoption
- Continuity of Care

IFMC is represented on the IHC Board of Directors, the Community Advisory Council and other advisory committees and active working groups. We have collaborated with IHC on several projects including promoting the concepts of patient centered medical home in primary care and reducing health care associated infections and pressure ulcers. IFMC serves as a collaborative team member with the University of Iowa through the Agency for Healthcare Research and Quality Accelerating Changes and Transformation in Organizations and Networks (ACTION). IFMC's presence on a short list of eligible contractors allows us to collaborate with the University and respond to AHRQ-released task orders to put research into action.

We have developed, produced, and/or distributed educational materials and quality improvement tools to Iowa healthcare providers. Examples of these materials include:

- Disease process fact sheets
- Healthcare promotional aids
- Data collection tools
- Established healthcare guidelines
- Flowsheets
- Continuous quality improvement information and tools

We have presented statewide educational forums to healthcare providers on numerous topics including:

- Preventive care (e.g., pneumococcal and influenza immunizations, mammograms)
- Disease processes (e.g., diabetes, coronary artery disease)
- Health care topics for long term care (e.g., restraint reduction, pressure ulcer prevention, pain management, infections, decline in physical functioning)
- Continuous quality improvement; rapid cycle techniques
- Collaborative learning sessions on surgical infection prevention
- HIT/HIE forums

In 1996, we formed the Iowa Immunization Coalition, which included representatives from the AARP, Area Agencies on Aging, Iowa Hospital Association, Iowa Alliance for Home Care,



Iowa Department of Public Health, Iowa Medical Society, Iowa Pharmacy Association, and nursing facility associations. Members of the Coalition meet on a regular basis and partnered to implement quality improvement activities to increase Iowa's adult pneumococcal and influenza immunization rates.

Through our Quality Improvement Organization contract with CMS and the nursing home and home health quality initiatives, we have established partnerships with numerous long term care and home health care providers, trade associations, payers, regulators and consumer advocacy groups. IFMC is a founding member and coordinates bimonthly meetings of the Iowa Person Directed Care Coalition; a multistakeholder group that promotes best practices in long term care facilities. By expanding our knowledge and resources through partnerships, we can achieve greater and more immediate improvements in the quality of medical care.

We will use our established relationships plus our experience in establishing these types of partnerships to assist the Department in development of interfaces and relationships essential to the success of the comprehensive IME program.

Other Similar Projects (7.2.9.1.f)

The Department awarded IFMC the IME Medical Services and Pharmacy/Medical Services contracts at the beginning of IME. We collaborated with Department staff and IME vendors to implement and operationalize a successful IME business environment. We are committed to the mission of the IME to:

- Ensure all Iowans have access to the same quality of healthcare they would have through a private insurer
- Operate in the most cost effective manner possible
- Ensure a fair return for Iowa's network of healthcare providers

We have conducted utilization, quality, and care management for Iowa Medicaid for over 30 years. Our utilization program safeguards the integrity of the Medicaid program by ensuring payment is made only for medically necessary services.



A summary of the Medical Services and Pharmacy Services contract follows.

Program/Project Title	IME Medical Services and Pharmacy Medical Services
Effective Dates	2004 through present
Summary of Program Services	<ul style="list-style-type: none"> ➤ Medical Prior Authorization ➤ Claims Pre-pay ➤ Retrospective Review ➤ Exception to Policy ➤ PMIC ➤ Habilitation ➤ Remedial Treatment Plan, Service and Progress Note Review ➤ Waivers (Intellectual Disability, Elderly, Ill and Handicap, Physical Disability, AIDS, Brain Injury and Children’s Mental Health) ➤ Nursing Facility ➤ ICF/MR ➤ 465 Onsite ➤ Home Health Retrospective Review ➤ Quality of Care ➤ MHEP/LI ➤ Disease Management ➤ Enhanced Primary Care Management ➤ EPSDT ➤ PACE
Contact	



Iowa Medicaid Utilization and Quality Review

Our Medicaid management team has more than 30 years of combined experience with developing and implementing Medicaid utilization and quality improvement programs. Our knowledgeable and tenured staff have well-established working relationships with numerous members of the Department’s staff. We consistently met or exceeded all performance standards established by the Department within the current contract. From 1979 until implementation of IME, the Department has contracted with IFMC to conduct utilization management and quality review services in the following settings:

Since 2004 this work has been included in our IME Medical Services:

Program/Project Title	IME Medicaid Utilization and Quality Review
Effective Dates	1979 through 2004
Summary of Program Services	<ul style="list-style-type: none">➤ Nursing Facilities (including Pre-admission Screening and Resident Review)➤ Intermediate Care Facilities for the Mentally Retarded➤ Mental Health Institutes➤ Psychiatric Medical Institutions for Children➤ Hospitals (Acute & Outpatient)
Contact	



Iowa Medicaid – Member Health Education and Lock-in

The Department awarded IFMC the contract for Member Health Education and Lock-in programs in 1991. A summary of the Member Health Education and Lock-in program follows.

Program/Project Title	Member Health Education and Lock-in programs
Effective Dates	1991 through present
Summary of Program Services	<ul style="list-style-type: none">➤ Expanded program enrollment to a minimum of 5,000 members in 2003➤ Expanded existing age parameters to enhance identification of the misuse of pharmacy services➤ Eliminated existing managed health care plan restrictions to enhance identification of the misuse of pharmacy services➤ Expanded the Lock-in program for members duplicating controlled medications➤ Applied statistical methods to extend identification of member misuse and/or overuse of benefits➤ Maintained member’s enrollment in Medicaid Managed Healthcare or MediPASS while participating in Lock-in pharmacy, when needed
Contact	



Managed Care External Quality Review

The _____ has contracted with IFMC since 1985 to perform managed care external quality review activities for Managed Care Organizations (MCOs).

Program/Project Title	Managed Care External Quality Review
Effective Dates	1985 through present
Summary of Program Services	<ul style="list-style-type: none">➤ Reviewing the quality sections of certificate of authority applications for new MCOs applying for licensure➤ Reviewing MCO expansion requests to ensure access and availability of services are present in specific counties where the MCO is requesting to expand its program(s)➤ Conducting onsite evaluations at MCOs and limited service organizations with commercial members every two (2) years or more frequently as requested➤ Conducting special projects for the _____ as requested
Contact	



Medicare Quality Improvement Organization

IFMC is the Medicare Quality Improvement Organization (QIO) for the states of Iowa and Illinois. We were selected as Iowa’s PRO/QIO by the Centers for Medicare & Medicaid Services (previously Health Care Financing Administration) in 1984, and the PRO/QIO for Illinois in 1996.

In the mid 1990s, we implemented Medicare’s Health Care Quality Improvement Program (HCQIP) in Iowa and Illinois as part of the PRO/QIO contract. A primary goal of HCQIP is to establish partnerships among members of the health care provider community, beneficiaries, and other health-related organizations, to work collaboratively to improve the quality of care provided to Medicare beneficiaries. We also have many years of case review experience involving care provided to Medicare beneficiaries in hospital inpatient and outpatient settings and ambulatory surgical centers.

Program/Project Title	Medicare Quality Improvement Organization
Effective Dates	1974 through present
Summary of Program Services	<ul style="list-style-type: none"> ➤ Medicare’s Health Care Quality Improvement Program ➤ Beneficiary grievances ➤ Hospital inpatient case review ➤ Outpatient case review ➤ Data warehousing ➤ Public reporting
Contact	



SoonerCare Health Management Program

We were selected by the Oklahoma Health Care Authority (the state Medicaid agency) to deploy and operate the SoonerCare Health Management Program (HMP). We launched HMP in September 2007 to provide care management for high-cost and high-risk Medicaid clients in two tiers, based on the level of risk and client needs; and to facilitate quality improvement activities in physician practices.

Program/Project Title	SoonerCare Health Management Program
Effective Dates	2007 through present
Summary of Program Services	<ul style="list-style-type: none"> ➤ Enrollment and disenrollment ➤ Health risk assessment ➤ Nurse care management ➤ Client outreach and education ➤ Practice facilitation for quality improvement ➤ Provider education ➤ Data support
Contact	



Other Current Contracts or Projects (7.2.9.1.g)

MDS and OASIS Automation

IFMC maintains the state of _____ in accordance with CMS’ records specifications.

Program/Project Title	MDS and OASIS Automation and Transmission
Effective Dates	2009 to 2010
Summary of Program Services	<ul style="list-style-type: none"> ➤ Day-to-day operations of the system ➤ Receive and validate MDS and OASIS data. ➤ Verifying electronic transmission of MDS and OASIS data to the states repository ➤ Provide operational and technical support on MDS & OASIS to _____, nursing facilities, home health agencies, associations, and software vendors ➤ Develop and conduct statewide educational seminars regarding the transmission of MDS and OASIS data
Contact	



Corporate Experience (7.2.9.2)

RELEVANT GOVERNMENTAL EXPERIENCE (7.2.9.2.A)

Title of the Project:	Medical Services for the Iowa Medicaid Enterprise
Name of Client Organization:	Iowa Department of Human Services
Client Reference, Title, and Current Telephone Number:	
Start and End Dates of Original contract:	July 1, 2004 – June 30, 2010
Total Contract Value:	
Average staff hours in FTEs during operations:	
Workload Statistics:	Perform professional and medical support functions for utilization management (PA, LTC, Waiver, PMIC, ETP, Pre-procedure, Retro-review), quality management (remedial, habilitation, LTC, PMIC) and care management (disease management, lock-in)
IFMC is prime contractor	

We perform professional and medical support functions addressing utilization management, care management, quality improvement and cost reduction for fee-for-service Medicaid patients. We have provided utilization and care management and quality review services since 1979.

Our Medicaid management team has more than 30 years of combined experience with developing and implementing Medicaid utilization and quality improvement programs. Our knowledgeable and tenured staff have well-established working relationships with numerous members of the Department’s staff. We consistently met or exceeded all performance standards established by the Department within the current contract.

DHS awarded IFMC the contract for Recipient Health Education and Lock-in in 2003 and transferred the work to IME in 2006. We expanded the number of Medicaid members in RHEP and Lock-in to a minimum of 5,000 members with a goal to achieve savings to the Medicaid program in excess of one million dollars (State share) during each fiscal year.

We use licensed practitioners to ensure care provided or proposed for a Medicaid member is based on medical necessity and professionally recognized standards of care.



Title of the Project:	External Quality Review
Name of Client Organization:	
Client Reference, Title, and Current Telephone Number:	
Start and End Dates of Original contract:	April 1, 1985 – March 31, 2011
Total Contract Value:	
Average staff hours in FTEs during operations:	
Workload Statistics:	All managed care onsite evaluations scheduled and report and recommendations completed on time, according
IFMC is prime contractor	

We provide the following services for the

1. Review and provide written evaluation of the quality sections of certificate of authority applications for new managed care organizations (MCOs) applying for licensure. Our review is based on _____ and includes an evaluation of the MCO's:
 - a. Provider/practitioner network related to access and availability of services
 - b. Proposed quality management program
 - c. Provider/practitioner credentialing and monitoring program
 - d. Medical records systems and confidentiality
2. Review and provide written evaluation of MCO expansion requests to ensure access and availability of services are present in specific counties where the MCO is requesting to expand its program(s).
3. Conduct onsite evaluations at MCOs and limited service organizations with commercial members every two years, or more frequently as requested, to ensure members receive appropriate quality health care services. The written evaluation and recommendations are based on managed care industry standards and nationally recognized health care recommendations for disease prevention and health promotion.



Title of the Project:	SoonerCare Health Management Program
Name of Client Organization:	Oklahoma Health Care Authority (OHCA)
Client Reference, Title, and Current Telephone Number:	
Start and End Dates of Original contract:	September 27, 2007 – June 30, 2012
Total Contract Value:	
Average staff hours in FTEs during operations:	
Workload Statistics:	5,000 patients enrolled in Care Management program per month. Quality improvement projects implemented in 50 primary care physician practices per year. Education and outreach available to over 650,000 Medicaid members throughout the state.
IFMC is prime contractor	

We provide care management services for high cost, high risk Medicaid clients enrolled in the SoonerCare Health Management Program (HMP). We provide the following services for the HMP:

- Enrollment and disenrollment
- Health risk assessment
- Nurse care management
- Client outreach and education
- Practice facilitation for quality improvement
- Provider education
- Data support



Title of the Project:	MDS and OASIS Automation and Transmission
Name of Client Organization:	
Client Reference, Title, and Current Telephone Number:	
Start and End Dates of Original contract:	October 1, 2009 through September 30, 2010
Total Contract Value:	
Average staff hours in FTEs during operations:	
Workload Statistics:	Providing technical assistance for more than preparing and distributing quarterly newsletters (NH and HHA), preparing and presenting more
IFMC is prime contractor	

We provide technical support for the transmission of MDS/OASIS assessments to the state repository with help desk assistance and automation seminars statewide. We automated education coordination responds to technical calls from nursing facilities, home health agencies and software vendors. Educational seminars are conducted statewide

Education efforts are extended through newsletters and updates posted on the MDS/OASIS submissions page. We perform database checks to maintain data integrity and work with facilities and agencies to correct data transmission errors. This contract supports the MDS validation reviews completed in nursing facilities by IFMC review coordinators.



RELEVANT COMMERCIAL EXPERIENCE (7.2.9.2.B)

Title of the Project:	Utilization Review, Catastrophic Case Management and Disease Management
Name of Client Organization:	
Client Reference, Title, and Current Telephone Number:	
Start and End Dates of Original contract:	January 1, 2002 to Current
Total Contract Value:	
Average staff hours in FTEs during operations:	
Workload Statistics:	Provide Medical Management and Case Management services to
IFMC is prime contractor	

Through our wholly owned subsidiary, ENCOMPASS Health Management Services we provide utilization review and catastrophic case management for . The case management program goals are to encourage appropriate, cost-effective use of health care services; educate the consumer to make informed medical decisions and improve quality of life and quality of care. A Disease Management program was added in 1998 for diabetes, cardiac, asthma and COPD. The program was expanded in 2006 to include chronic disease as the fifth condition. For this contract, chronic was defined as three or more co morbid conditions or claims exceeding a threshold. The goals of the program are to promote healthy lifestyle modifications; educate on the importance of informed medical decision-making; and empower the member toward self management.



OTHER GOVERNMENTAL HEALTHCARE PROGRAM EXPERIENCE (7.2.9.2.c)

Title of the Project:	
Name of Client Organization:	Centers for Medicare & Medicaid Services
Client Reference, Title, and Current Telephone Number:	
Start and End Dates of Original contract:	September 27, 2007 – September 26, 2010
Total Contract Value:	
Average staff hours in FTEs during operations:	
Workload Statistics:	Utilize the approved protocol and tools to determine if the national Accreditation Organizations () effectively apply and enforce the providers across the country to ensure their performance meets these requirements.
IFMC is prime contractor	

We audit a sample of _____ across the country to ensure their performance



Title of the Project:	Quality Improvement Organization (QIO) – State of Iowa
Name of Client Organization:	Centers for Medicare & Medicaid Services
Client Reference, Title, and Current Telephone Number:	
Start and End Dates of Original contract:	August 1, 2008 to July 31, 2011
Total Contract Value:	
Average staff hours in FTEs during operations:	
Workload Statistics:	This project aims to improve the quality of care and protect Medicare beneficiaries through three themes: Beneficiary Protection, Patient Safety and Prevention. Quality improvement initiatives focus on improving surgical care, care for heart failure patients, reducing pressure ulcers, physical restraints and hospital infections and promote drug safety. The prevention project focuses on assisting providers with electronic health records to improve screening rates for breast and colorectal cancer and to improve immunization rates for influenza and pneumococcal pneumonia.
IFMC is prime contractor	

As Iowa’s Quality Improvement Organization, we are working toward a health care system that is more effective and efficient. We work with providers to evaluate and improve health care quality to prevent illness, decrease harm and reduce waste for the more than 500,000 Iowa Medicare beneficiaries.

In recent surveys we received an overall score of 91% for satisfaction, knowledge and value from Iowa health care organizations and providers.



Title of the Project:	Standard Data Processing System (SDPS)
Name of Client Organization:	Centers for Medicare & Medicaid Services (CMS)
Client Reference, Title, and Current Telephone Number:	
Start and End Dates of Original contract:	August 1, 2008 – January 31, 2010
Total Contract Value:	
Average staff hours in FTEs during operations:	
Workload Statistics:	The project requires the management and oversight of an enterprise application supporting more than 53 organizations through the completion of 506 major tasks, including a helpdesk infrastructure to
IFMC is prime contractor	

We provide all systems support for the 53 QIOs nationwide. This includes receipt and storage of all Medicare administrative claims data, tracking systems used by QIOs and CMS for utilization review decisions and quality improvement activities.



Title of the Project:	Physician Quality Reporting Initiative (PQRI)
Name of Client Organization:	Centers for Medicare & Medicaid Services (CMS)
Client Reference, Title, and Current Telephone Number:	
Start and End Dates of Original contract:	May 18, 2007 – July 31, 2009
Total Contract Value:	
Average staff hours in FTEs during operations:	
Workload Statistics:	Through this project IFMC
IFMC is prime contractor	

We provide program, project, software engineering, integration, help desk and operations services to deliver PQRI/OPPS application, data warehousing, reporting and payment solutions.



Title of the Project:	Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) and Hospital Quality Alliance (HQA) Reporting Activities
Name of Client Organization:	Centers for Medicare & Medicaid Services (CMS)
Client Reference, Title, and Current Telephone Number:	
Start and End Dates of Original contract:	August 1, 2009 to July 31, 2011
Total Contract Value:	
Average staff hours in FTEs during operations:	
Workload Statistics:	This project involves completion of 15 tasks to include a kick-off meeting for all staff; ; reporting at weekly, monthly, quarterly, annual and adhoc intervals; national education sessions; and updating the national hospital quality measures specifications manual.
IFMC is prime contractor	

We provide national support for the Hospital Quality reporting efforts, including the Specifications Manual for National Hospital Inpatient Quality Measures; the Hospital Quality Alliance and Public Reporting through Hospital Compare; and the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU). Program support is provided to CMS, The Joint Commission, measure development and measure maintenance contractors, QIOs and vendors.

The RHQDAPU program provides full annual reimbursement updates to hospitals that submit data for specific quality measures for health conditions common among Medicare recipients. In addition to the reporting requirements, hospitals must pass the validation requirement of a minimum of 80 percent reliability based upon the chart-audit validation process.



Corporate References (7.2.9.3)

Letters of reference for three previous clients are presented on the following pages. These reference letters are presented on referenced companies' letterhead and address the clients' knowledge of IFMC in providing services similar to those described in the Medical Services RFP and in this proposal.

Oklahoma Health Care Authority

Carolyn Reconnu, Manager, SoonerCare Health Management Program
405-522-7630

Iowa Insurance Division

Thomas O'Meara, Deputy Bureau Chief
515-281-4222

City of Chicago

Nancy L. Currier, Benefits Manager
312-744-6725



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Medical Services – Technical Proposal
IFMC Response to the Iowa Department of Human Services
Iowa Medicaid Enterprise Professional Services – RFP MED-10-001

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER



BRAD HENRY
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

September 25, 2009

Peg Mason, Vice President
Quality & Care Management
Iowa Foundation for Medical Care
1776 West Lakes Parkway
West Des Moines, IA 50266

This letter is to speak of our work with Iowa Foundation for Medical Care (IFMC) in the administration of the SoonerCare Health Management Program, the chronic disease management program for the Medicaid program in the State of Oklahoma. As IFMC is interested in pursuing similar contracts with other states, we would like to express our recommendation of IFMC. While the information below is known to you, it is offered to provide a summary of our program scope to prospective clients of IFMC.

IFMC won the bid for services and the program was launched 2/1/08. Our program consists of a two-armed approach based on the Chronic Care Model developed by Dr Edward Wagner. Our ultimate goal is to improve the health of Oklahomans by fostering an activated and informed patient as well as a prepared and proactive provider.

Nurse Care Management is provided for our top 5000 high risk members. The 1000 highest risk receive face to face care management by 14 nurses located regionally throughout Oklahoma. The remaining 4000 receive nurse care management through telephonic services provided by 24 additional nurses out of the call center in Iowa. Nurse Case Management focuses on supporting the members' educational and self-management support goals. Thorough assessments including health literacy, pharmacy management, behavioral health needs and community resource needs are completed for every member. IFMC employs a Community Resource Specialist who locates resources for members with various needs.

We also have a robust Practice Facilitation component. The overall objective of this component is to achieve system care redesign to improve the quality of care for persons with chronic illness. This service is provided by 8 practice facilitators who are registered nurses with strong clinical and quality improvement backgrounds. They are located regionally and have provided facilitation services to 76 practices since program inception in February 2008.

Our goals for practice facilitation are:

- to assist with building empowered proactive teams
- to assist with implementation of evidence-based guidelines
- to facilitate staff involvement and investment with quality improvement activities including measurement of performance (NQF Ambulatory Care Starter measures)





Medical Services – Technical Proposal
*IFMC Response to the Iowa Department of Human Services
Iowa Medicaid Enterprise Professional Services – RFP MED-10-001*

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER



BRAD HENRY
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

- to create office process design plans that promote and support disease prevention
- to implement a web-based health information and management tool (Disease mgt registry called “Care Measures”)
- to create processes that are stable and predictable

In relation to practice facilitation services, IFMC has also partnered with OHCA in two grant-related activities. An active grant through Center for Health Care Strategies involves Reducing Disparities at the Practice Site. The Practice Facilitators expand their role in ten selected practices by focusing more closely on minority patients with diabetes. A second grant has recently been awarded from the Tobacco Settlement Exchange Trust and beginning in January 2010, two additional Practice Facilitators will be focused on providing PF services to OB providers in relation to tobacco cessation measures.

IFMC has been instrumental in building this strong and comprehensive program. The daily operations and management have been detailed and complex. We have found IFMC to be sound and reliable business partners. They worked diligently through the development and start-up of the program. As we worked collaboratively through both expected and unexpected challenges in the first year, we found them to be responsive, locally and corporately, to our evolving needs in relation to the program. OHCA confidently recommends IFMC to other states as a potential health management contractor.

If you have any questions, please do not hesitate to contact me.

Best regards,

Carolyn Reconnu, R.N., B.S.N., C.C.M.
Manager, SoonerCare Health Management Program

Michael W. Herndon, D.O.
Medical Director, Health Care Management



Medical Services – Technical Proposal
IFMC Response to the Iowa Department of Human Services
Iowa Medicaid Enterprise Professional Services – RFP MED-10-001



STATE OF IOWA

CHESTER J. CULVER
GOVERNOR

SUSAN E. VOSS
COMMISSIONER OF INSURANCE

PATTY JUDGE
LT. GOVERNOR

November 5, 2009

Mr. Don Lovasz, CEO
IFMC
1776 West Lakes Parkway
West Des Moines, IA 50266

RE: IFMC Services for the Iowa Insurance Division

Dear Mr. Lovasz:

The Iowa Insurance Division has contracted with the Iowa Foundation for Medical Care (IFMC) since 1985. Some of the services performed for the Division include:

- 1) Review of all new applicants seeking a certificate of authority to provide Managed Care services from the Department of Insurance. IFMC's review is based on Chapter 40 of the Iowa Administrative Code and includes written evaluation of guidelines as listed in Chapter 40 for all Managed Care Organizations (MCOs) seeking a license.
- 2) Review and provide written evaluation of MCO expansion requests to ensure access and availability are present in counties which the MCO wishes to expand its services.
- 3) Conduct regular onsite evaluations of existing MCO's as required by Iowa Code or as requested by the Iowa Insurance Division. The written evaluations and recommendations are based on industry standards and nationally recognized health care recommendations for disease prevention and health promotion.
- 4) Special requests as determined by the Commissioner of Insurance.

We are very pleased with our long-standing relationship with the Iowa Foundation for Medical Care. They continue to provide prompt, professional, and accurate services for the Iowa Insurance Division.

If you desire any further information, please contact me at 515-281-4222.

Sincerely,

Thomas O'Meara
Deputy Bureau Chief
Market Regulation
Iowa Insurance Division

330 MAPLE STREET / DES MOINES, IOWA 50319-0065 / 515-281-5705 / Facsimile 515-281-3059
<http://www.iid.state.ia.us/>





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Medical Services – Technical Proposal
IFMC Response to the Iowa Department of Human Services
Iowa Medicaid Enterprise Professional Services – RFP MED-10-001



City of Chicago
Richard M. Daley, Mayor

Department of Finance

Steven J. Lux
City Comptroller

Benefits Management Division
333 South State Street
Room 400
Chicago, Illinois 60604-3978
(312) 747-8660
(312) 747-8661 (FAX)

<http://www.cityofchicago.org/benefits>

November 10, 2009

Mrs. Peg Mason
Iowa Foundation for Medical Care
1776 West Lakes Parkway
West Des Moines, IA 50266

RE: Encompass (subsidiary of Iowa Foundation- IFMC) for Medical Care Services for the City of Chicago (COC)

Dear Mrs. Mason:

The City of Chicago has contracted with Encompass (a subsidiary of IFMC) since 1992 to perform managed care review activities for our self funded BCBS PPO medical plans. Specific services performed by Encompass for the COC include.

1. Provide telephonic medical necessity determinations for:
 - Inpatient Hospitalizations
 - Procedure Review
 - DME Review
 - Ambulance Transfers
 - Occupational & Speech Therapy
 - Imaging Review
 - Behavioral Health (outpatient & inpatient)
 - PPO Redirection
2. Provide care coordination services which include:
 - Catastrophic Care Management
 - Maternity Management
 - Disease Management
 - Chronic Care Management
3. Provide experienced and professional Member Service Representatives who answer incoming calls from providers, facilities, and members in order to collect information to prepare cases for medical necessity reviews.

We have enjoyed a long-standing cooperative relationship with the Iowa Foundation for Medical Care/ENCOMPASS. They have provided prompt, complete, accurate and professional services to the COC and continue to meet all of our expectations.

If you need additional information, please contact me at 312-744-6725.

Sincerely,

Nancy L. Currier
Benefits Manager





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Felony Disclosures (7.2.9.4)

IFMC certifies that no owners, officers, or primary partners of IFMC have ever been convicted of a felony. IFMC understands this is a continuing disclosure requirement, and that any such matter commencing in the future must be made in writing and in a timely manner to the Department.

Certifications and Guarantees (7.2.9.5)

The required certifications and guarantees (Attachments B through J from the RFP) are presented on the following pages (immediately following IFMC's Certificate of Good Standing, i.e., IA Business License):

- Proposal Certification
- Certification of Independence and No Conflict of Interest
- Certification Regarding Debarment Suspension Ineligibility and Voluntary Exclusion
- Authorization to Release Information
- Certification Regarding Registration, Collection and Remission of State Sales and Use Taxes
- Certification of Compliance with Pro-Children Act of 1994
- Certification Regarding Lobbying
- Business Associate Agreement
- Proposal Certification of Available Resources

_____ has signed these certifications for the corporation. As Vice President of Finance and Administration, _____ is authorized to bind the organization contractually, to make binding decisions regarding prices, and to sign representations, certifications, and affirmations for the corporation.

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IOWA SECRETARY OF STATE
MICHAEL A. MAURO



Date: 04/23/2008

CERTIFICATE OF EXISTENCE

Name: IOWA FOUNDATION FOR MEDICAL CARE (504RDN - 59194)
Date of Incorporation: 5/19/1971
Duration: PERPETUAL

I, MICHAEL A. MAURO, Secretary of State of the State of Iowa, custodian of the records of incorporations, certify that the nonprofit corporation named on this certificate is in existence and was duly incorporated under the laws of Iowa on the date printed above, that all fees required by the Revised Iowa Nonprofit Corporation Act have been paid by the corporation, that the most recent biennial corporate report has been filed by the Secretary of State, and that articles of dissolution have not been filed.

Certificate ID: CS20651

To validate this certificate please visit
the following web site and enter the certificate ID.

www.sos.state.ia.us/ValidateCertificate


MICHAEL A. MAURO SECRETARY OF STATE

Attachment B: Proposal Certification

PROPOSAL CERTIFICATION

BIDDERS – SIGN AND SUBMIT CERTIFICATION WITH PROPOSAL.

I certify that I have the authority to bind the bidder indicated below to the specific terms, conditions and technical specifications required in the Department's Request for Proposal (RFP) and offered in the bidder's proposal. I understand that by submitting this bid proposal, the bidder indicated below agrees to provide services described in the Iowa Medicaid Enterprise Program Integrity Procurement RFP which meet or exceed the requirements of the Department's RFP unless noted in the bid proposal and at the prices quoted by the bidder.

I certify that the contents of the bid proposal are true and accurate and that the bidder has not made any knowingly false statements in the bid proposal.

Denise Sturm 12/2/2009

Name

Date

Vice President of Finance & Administration

Title

IFMC

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.

Denise Sturum

12/2/2009

Name

Date

Vice President of Finance & Administration

Title

IFMC

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):

IFMC 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

IFMC 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).

IFMC 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.

Denise Sturm 12/2/2009
Name Date

Vice President of Finance & Administration

Title

IFMC

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.

Dorise Sturm

Name

12/21/2009

Date

Vice President of Finance & Administration

Title

IFMC

Name of Bidder Organization

Attachment I: Business Associate Agreement

I certify that IFMC accepts and agrees to be bound by the terms of the attached Business Associate Agreement.

Denise Sturm 12/3/2009
Name Date

Vice President of Finance & Administration

Title

IFMC

Name of Bidder Organization

ADDENDUM: Business Associate Agreement

THIS ADDENDUM supplements and is made a part of the Iowa Department of Human Services (“Agency”) Contract (hereinafter, the “Underlying Agreement”) between the Agency and the Contractor (“the Business Associate”).

1. Purpose.

The Business Associate performs certain services on behalf of or for the Agency pursuant to the Underlying Agreement that require the exchange of information about patients that is protected by the Health Insurance Portability and Accountability Act of 1996, as amended by Subtitle D of the Health Information Technology for Economic and Clinical Health Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5) (the “HITECH Act”) and the federal regulations published at 45 C.F.R. parts 160 and 164 (collectively “HIPAA”). The Agency is a “Covered Entity” as that term is defined in HIPAA, and the parties to the Underlying Agreement are entering into this Addendum to establish the responsibilities of both parties regarding HIPAA-covered information and to bring the Underlying Agreement into compliance with HIPAA.

2. Definitions.

Unless otherwise provided in this Addendum, capitalized terms have the same meanings as set forth in HIPAA.

3. Obligations of Business Associate.

a. Security Obligations. Sections 164.308, 164.310, 164.312 and 164.316 of title 45, Code of Federal Regulations, apply to the Business Associate in the same manner that such sections apply to the Agency. The Business Associate’s obligations include but are not limited to the following:

- Implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that the Business Associate creates, receives, maintains, or transmits on behalf of the covered entity as required by HIPAA;
- Ensuring that any agent, including a subcontractor, to whom the Business Associate provides such information agrees to implement reasonable and appropriate safeguards to protect the data; and
- Reporting to the Agency any security incident of which it becomes aware.

b. Privacy Obligations. To comply with the privacy obligations imposed by HIPAA, Business Associate agrees to:

- Not use or further disclose information other than as permitted or required by the Underlying Agreement, this Addendum, or as required by law;
- Abide by any Individual’s request to restrict the disclosure of Protected Health Information consistent with the requirements of Section 13405(a) of the HITECH Act;
- Use appropriate safeguards to prevent use or disclosure of the information other than as provided for by the Underlying Agreement and this Addendum;
- Report to the Agency any use or disclosure of the information not provided for by the Underlying Agreement of which the Business Associates becomes aware;

- Ensure that any agents, including a subcontractor, to whom the Business Associate provides Protected Health Information received from the Agency or created or received by the Business Associate on behalf of the Agency agrees to the same restrictions and conditions that apply to the Business Associate with respect to such information;
 - Make available to the Agency within ten (10) days Protected Health Information to comply with an Individual's right of access to their Protected Health Information in compliance with 45 C.F.R. § 164.524 and Section 13405(f) of the HITECH Act;
 - Make available to the Agency within fifteen (15) days Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. § 164.526;
 - Make available to the Agency within fifteen (15) days the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528 and Section 13405(c) of the HITECH Act;
 - Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Agency, or created or received by the Business Associate on behalf of the Agency, available to the Secretary for purposes of determining the Agency's compliance with HIPAA;
 - To the extent practicable, mitigate any harmful effects that are known to the Business Associate of a use or disclosure of Protected Health Information or a Breach of Unsecured Protected Health Information in violation of this Addendum;
 - Use and disclose an Individual's Protected Health Information only if such use or disclosure is in compliance with each and every applicable requirement of 45 C.F.R. § 164.504(e);
 - Refrain from exchanging any Protected Health Information with any entity of which the Business Associate knows of a pattern of activity or practice that constitutes a material breach or violation of HIPAA or this Addendum;
 - To comply with Section 13405(b) of the HITECH Act when using, disclosing, or requesting Protected Health Information in relation to this Addendum by limiting disclosures as required by HIPAA;
 - Refrain from receiving any remuneration in exchange for any Individual's Protected Health Information unless (1) that exchange is pursuant to a valid authorization that includes a specification of whether the Protected Health Information can be further exchanged for remuneration by the entity receiving Protected Health Information of that Individual, or (2) satisfies one of the exceptions enumerated in Section 13405(e)(2) of the HITECH Act or HIPAA regulations; and
 - Refrain from marketing activities that would violate HIPAA, specifically Section 13406 of the HITECH Act.
- c. *Permissive Uses.* The Business Associate may use or disclose Protected Health Information that is disclosed to it by the Agency under the following circumstances:
- Business Associate may use the information for its own management and administration and to carry out the legal responsibilities of the Business Associate.
 - Business Associate may disclose the information for its own management and administration and to carry the legal responsibilities of the Business Associate if (1) the disclosure is required by law, or (2) the Business Associate obtains

reasonable assurances from the person to whom the information is disclosed that the information will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

d. *Breach Notification.* In the event that the Business Associate discovers a Breach of Unsecured Protected Health Information, the Business Associate agrees to take the following measures within 30 calendar days after the Business Associate first becomes aware of the incident:

- To notify the Agency of any incident involving the acquisition, access, use or disclosure of Unsecured Protected Health Information in a manner not permitted under 45 C.F.R. part E. Such notice by the Business Associate shall be provided without unreasonable delay, except where a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security. For purposes of clarity for this provision, Business Associate must notify the Agency of any such incident within the above timeframe even if Business Associate has not conclusively determined within that time that the incident constitutes a Breach as defined by HIPAA. For purposes of this Addendum, the Business Associate is deemed to have become aware of the Breach as of the first day on which such Breach is known or reasonably should have been known to such entity or associate of the Business Associate, including any person, other than the individual committing the Breach, that is an employee, officer or other agent of the Business Associate or an associate of the Business Associate;
- To include the names of the Individuals whose Unsecured Protected Health Information has been, or is reasonably believed to have been, the subject of a Breach;
- To complete and submit the Breach Notice form to the Agency (see Exhibit A); and
- To include a draft letter for the Agency to utilize to notify the Individuals that their Unsecured Protected Health Information has been, or is reasonably believed to have been, the subject of a Breach. The draft letter must include, to the extent possible:
 1. A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;
 2. A description of the types of Unsecured Protected Health Information that were involved in the Breach (such as full name, Social Security Number, date of birth, home address, account number, disability code, or other types of information that were involved);
 3. Any steps the Individuals should take to protect themselves from potential harm resulting from the Breach;
 4. A brief description of what the Agency and the Business Associate are doing to investigate the Breach, to mitigate losses, and to protect against any further Breaches; and
 5. Contact procedures for Individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, web site, or postal address.

4. Addendum Administration.

- a. *Termination.* The Agency may terminate this Addendum for cause if the Agency determines that the Business Associate or any of its subcontractors or agents has breached a material term of this Addendum. Termination of either the Underlying Agreement or this Addendum shall constitute termination of the corresponding agreement.
- b. *Effect of Termination.* At termination of the Underlying Agreement or this Addendum, the Business Associate shall return or destroy all Protected Health Information received or created in connection with this Underlying Agreement, if feasible. If such return or destruction is not feasible, the Business Associate will extend the protections of this Addendum to the Protected Health Information and limit any further uses or disclosures. The Business Associate will provide the Agency in writing a description of why return or destruction of the information is not feasible.
- c. *Compliance with Confidentiality Laws.* Business Associate acknowledges that it must comply with all laws that may protect the Protected Health Information received and will comply with all such laws, which include but are not limited to the following:
- *Medicaid applicants and recipients:* 42 U.S.C. § 1396a(a)(7); 42 C.F.R. §§ 431.300 - .307; Iowa Code § 217.30;
 - *Mental health treatment:* Iowa Code chapters 228, 229;
 - *HIV/AIDS diagnosis and treatment:* Iowa Code § 141A.9; and
 - *Substance abuse treatment:* 42 U.S.C. § 290dd-3; 42 U.S.C. § 290ee-3; 42 C.F.R. part 2; Iowa Code §§ 125.37, 125.93.
- d. *Indemnification for Breach Notification.* Business Associate shall indemnify the Agency for costs associated with any incident involving the acquisition, access, use or disclosure of Unsecured Protected Health Information in a manner not permitted under 45 C.F.R. part E.
- e. *Amendment.* The Agency and the Business Associate agree to take such action as is necessary to amend this Addendum from time to time as is necessary for the Business Associate to comply with the requirements of HIPAA.
- f. *Survival.* The obligations of the Business Associate shall survive this Addendum's termination.
- g. *No Third Party Beneficiaries.* There are no third party beneficiaries to this agreement between the parties. The Underlying Agreement and this Addendum are intended to only benefit the parties to the agreement.
- h. *Effective Date.* This Addendum is effective as of the Underlying Agreement's Effective Date.

EXHIBIT A: NOTIFICATION TO THE AGENCY OF BREACH OF UNSECURED PROTECTED HEALTH INFORMATION

NOTE: The Business Associate must use this form to notify the Agency of any Breach of Unsecured Protected Health Information. Immediately provide a copy of this completed form to (1) the Contract Manager, in compliance with the Notice Requirements of the Underlying Agreement, and (2) the Agency Security and Privacy Officer at:

Iowa Department of Human Services
 Attn: Security & Privacy Officer
 1305 E. Walnut, 1st Floor, DDM
 Des Moines, IA 50319

Contract Information	
Contract Number	Contract Title
Contractor Contact Information	
Contact Person for this Incident:	
Contact Person's Title:	
Contact's Address:	
Contact's E-mail:	
Contact's Telephone No.:	

Business Associate hereby notifies the Agency that there has been a Breach of Unsecured (unencrypted) Protected Health Information that Business Associate has used or has had access to under the terms of the Business Associate Agreement, as described in detail below:

Breach Details	
Date of Breach	Date of Discovery of Breach
Detailed Description of the Breach	
Types of Unsecured Protected Health Information involved in the Breach (such as full name, SSN, Date of Birth, Address, Account Number, Disability Code, etc).	
What steps are being taken to investigate the breach, mitigate losses, and protect against any further breaches?	
Number of Individuals Impacted	If over 500, do individuals live in multiple states?
	YES NO

Signature: _____

Date: _____

Attachment J: Proposal Certification of Available Resources

PROPOSAL CERTIFICATION OF AVAILABLE RESOURCES BIDDERS – SIGN AND SUBMIT CERTIFICATION WITH PROPOSAL.

I certify that the bidder organization indicated below has sufficient personnel resources available to provide all services proposed by this Bid Proposal. I duly certify that these personnel resources for the contract awarded will be available on and after July 1, 2010.

In the event that we, the bidder, have bid more than one component contract specified by this RFP, my signature below also certifies that the personnel bid for this component Bid Proposal are not personnel for any other component Bid Proposal. If my organization is awarded more than one component, I understand that the State may agree to shared resource allocation if the bidder can prove feasibility of shared resource.

Denise Sturm 12/2/2009
Name Date

Vice President of Finance & Administration

Title

IFMC

Name of Bidder Organization

