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**Technical Proposal
Sanitized Version
Electronic Copy**

Response to Request for Proposal
RFP MED-10-001

**Iowa Medicaid Enterprise
Professional Services**

Member Services Component

December 10, 2009



FEIN: 42-0992483



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Member Services – Technical Proposal
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Iowa Medicaid Enterprise Professional Services – RFP MED-10-001

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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), Member Services Component

Dear Ms. Tavegia:

IFMC is submitting the enclosed proposal in response to the Member 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 Member 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 Member Services contract is , 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 Transmittal Letter
Member Services

IFMC intends to partner with subcontractors . The percentage of work to be completed by IFMC as the prime contractor as measured by percentage of total proposed contract price. The estimated percentage of work to be completed by

IFMC is registered to do business in Iowa. Our 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 Transmittal Letter
Member Services

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.

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/page 36-39	Section 22.7(6)	IFMC Proprietary Information
Technical Proposal		
Tab 2/pages 2-8	Section 22.7(6)	IFMC Proprietary Information
Tab 5/pages 35-51, 63, 66, 75, 77	Section 22.7(6)	IFMC Proprietary Information
Tab 6/pages 99-100, 111, 113, 115, 120-121, 128	Section 22.7(6)	IFMC Proprietary Information
Tab 7/pages 143-146, 148-150	Section 22.7(6)	IFMC Proprietary Information
Tab 8/pages 154, 156-164, 166-172, 174-176, 178-180	Section 22.7(6)	IFMC Proprietary Information
Tab 9/pages 183-188, 191-205, 211	Section 22.7(6)	IFMC Proprietary Information

Please contact the following person regarding the confidential nature of the information:

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



IFMC Transmittal Letter
Member Services

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

Sincerely,

A handwritten signature in black ink that reads "Greg Mason". The signature is written in a cursive, slightly slanted style.

Group Vice President



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



<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 a	Tab 5, Page 23
6.1, item b, o, p	Tab 5, Pages 23 - 24
6.1, item c	Tab 5, Pages 24 – 25
6.1, item d, q, r	Tab 5, Pages 25 – 26
6.1, item e, g, h, i, j, k	Tab 5, Pages 26 - 27
6.1, item f	Tab 5, Pages 27
6.1, item h	Tab 5, Pages 27 - 28
6.1, item l, m, n	Tab 5, Page 28
6.1.1	Tab 5, Page 28
6.1.1.1, item a, b, c, d; 6.1.1.1.1, item a, b, c, d	Tab 5, Pages 28 – 30
6.1.1.1.2, item a, b, c, d; 6.1.1.1.3, item a, b, c, d	Tab 5, Pages 30 - 43
6.1.1.1.4, item a, b, c, d	Tab 5, Pages 44 – 46
6.1.1.1.5, item a, b	Tab 5, Pages 44 – 46
6.1.1.2, item a, b, c, d	Tab 5, Pages 46 – 47
6.1.2 (6.1.2.1)	Tab 5, Pages 47 – 48
6.1.2.1.2, item a, b, c, d	Tab 5, Pages 48 – 49
6.1.2.2.item a, b	Tab 5, Page 49
6.1.3	Tab 5, Pages 49 – 50
6.1.3.1, item a	Tab 5, Pages 50 – 51
6.1.3.1, item c; 6.1.3.3, item k, l, m, n, o, p	Tab 5, Pages 51 – 54
6.1.3.3, item a, b, c	Tab 5, Pages 54 – 55
6.1.3.3, item d, e, f	Tab 5, Pages 55 – 56
6.1.3.3, item g, h, i	Tab 5, Pages 56 – 57
6.1.3.3, item q, r	Tab 5, Page 57
6.1.3.3, item j	Tab 5, Pages 57 – 59
6.1.3.4 (6.1.3.4.1, item a; 6.1.3.4.2, item a, b, c)	Tab 5, Pages 59 – 60
6.1.3.4.3, item a, b	Tab 5, Page 60
6.1.3.4.3.4, item a, b, c, d	Tab 5, Pages 60 – 62
6.1.4	Tab 5, Pages 62 – 65
6.1.5, item a, b, c, d	Tab 5, Pages 65 – 66
6.1.6, item a, b, c, d	Tab 5, Pages 66 – 68
6.1.7, item a, b	Tab 5, Page 68
6.1.8, item a, b, c	Tab 5, Page 68
6.1.9, item a, b	Tab 5, Page 69
6.1.10, item a	Tab 5, Page 69
6.1.11, item a, b	Tab 5, Page 69
6.1.12, item a	Tab 5, Page 70
6.1.13, item a, b, c, d	Tab 5, Page 70
6.1.14, item a, b	Tab 5, Page 70



Professional Services Requirements Cross-Reference (7.2.3.3)

RFP Requirement	Location of Response in Bid Proposal
6.5	Tab 6, Page 72
6.5.1	Tab 6, Page 72
6.5.1, items a, b, c	Tab 6, Page 72
6.5.1.2	Tab 6, Page 73
6.5.1.2, items a, b, c, d, e	Tab 6, Pages 73 - 74
6.5.1.2, items f, 1, 2, 3, 4, 5, 6, 7, 8, 9	Tab 6, Pages 74 - 75
6.5.1.2, items g, h, i, 1, 2, 3, j, k	Tab 6, Page 76
6.5.1.2, items l, 1, 2, 3, 4, n, o, p, 1, 2, 3, 4	Tab 6, Pages 76 - 77
6.5.1.2, items q, 1, 2, 3, r, 1, 2, 3, 4, s, t, u, v, w	Tab 6, Pages 77 - 80
6.5.1.2, items x, 1, 2, 3, 4, 5, 6, y, z, aa, bb	Tab 6, Page 80
6.5.1.2, items cc, dd, ee, 1, 2, i, ii, iii, iv, v, vi, vii, viii, A, B, C, D, E, 1, 2, ix, x ff, 1	Tab 6, Pages 80 – 81
6.5.1.2, items, i, A, 1, 2, 3, 4, B, C, D, E, 1, 2, F, G, gg, hh, 1, 2, ii, i, ii, iii, jj, 1, 2, 3, 4, 5, 6, kk, ll, mm, 1, 2, 3, 4, nn, 1, i, ii, 2	Tab 6, Pages 80 – 81
6.5.1.2, items oo, 1, 2, I, 2, 3, I, ii, iii, iv, v, pp, qq, 1, 2, 3, 4, rr, ss, 1, 2, 3, 4, 5, 6	Tab 6, Page 80 – 81
6.5.1.2, items 7, tt, uu, vv, ww, xx, yy, 1, 2, 3, 4, zz, aaa, bbb, 1, 2, ccc, ddd, 1, 2	Tab 6, Pages 82 – 83
6.5.1.2, items eee, 1, i, ii, iii, iv, v, vi, vii, viii, ix, x, xi, xii, xiii, xiv, xv	Tab 6, Page 83
6.5.1.3	Tab 6, Page 84
6.5.1.3, items a, b	Tab 6, Page 84
6.5.2	Tab 6, Page 84
6.5.2, items a, b	Tab 6, Page 84
6.5.2.2	Tab 6, Page 85
6.5.2.2, items a, b, c, d, e, f, g, h, i, j, k, 1, 2, 3, 4, 5, 6, 7	Tab 6, Pages 85 – 86
6.5.2.2, items l, m, n, o, p, q, r, 1, 2	Tab 6, Page 87
6.5.2.3	Tab 6, Page 87
6.5.2.3, items a, b, c, d	Tab 6, Page 88
6.5.3, items a, b, c, d	Tab 6, Pages 88 – 89
6.5.3.2, items a, 1, 2, 3, 4, 5, 6, b, c	Tab 6, Pages 89 – 90
6.5.3.2, items d, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, e, f, g, h, i, j, k, 1, 2, 3, l	Tab 6, Pages 90 – 91
6.5.3.2, items m, 1, n, o, p	Tab 6, Page 90 – 91
6.5.3.2, items q, r	Tab 6, Page 91
6.5.3.3	Tab 6, Pages 91 – 92



RFP Requirement	Location of Response in Bid Proposal
6.5.3.3, items a, b, c, d	Tab 6, Pages 91 – 92
6.5.4	Tab 6, Page 92
6.5.4 items a, b, c, d, e, f, g	Tab 6, Page 92
6.5.4.2	Tab 6, Page 93
6.5.4.2 items a, 1, 2, 3, 4, 5, 6, b, c, 1, 2, 3	Tab 6, Page 93 - 94
6.5.4.2 items d, e, 1, 2, 3, 4, 5, f, g, h, i, 1, 2, 3, 4, j, a, k, 1, 2, 3, l, m, n	Tab 6, Pages 94 – 95
6.5.4.3	Tab 6, Page 95
6.5.4.3 item a	Tab 6, Page 95
6.5.5	Tab 6, Page 95
6.5.5.2, items a, b	Tab 6, Page 95
6.5.5.3, items a, b	Tab 6, Page 96
6.5.6	Tab 6, Page 96
6.5.6.2, items a, 1, 2, 3, b, c, d, 1, 2, 3, 4, 5, 6, e, f, g, h, i, j, k, l, m, n, o, p, r, s, t	Tab 6, Pages 97 – 104
6.5.6.2, item u	Tab 6, Page 105
6.5.6.3	Tab 6, Page 105
6.5.6.3, item a	Tab 6, Page 105
6.5.7	Tab 6, Page 106
6.5.7, items a, b	Tab 6, Pages 106 – 107
6.5.7.2	Tab 6, Page 108
6.5.7.2, items a, 1, 2, 3, b, 1, 2, 3, c, d, e, f, g, h, I, j, k, l, m, n, o, p, q, r	Tab 6, Pages 109 – 126
6.5.7.3	Tab 6, Page 126
6.5.7.3, items a, b, c	Tab 6, Pages 126 – 127
6.5.8	Tab 6, Page 127
6.5.8, items a, b, c, d, e	Tab 6, Page 127
6.5.8.2, items a, b, 1, 2, c, d, e, f, g, h, i, j, k, l, 1, 2, 3, 4, m, n, 1, 2, o, 1, 2	Tab 6, Pages 128 - 132
6.5.8.3	Tab 6, Page 133
6.5.8.3, items a, b, c, d, e, f, g, 1, 2, 3, 4	Tab 6, Page 133



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TAB 4 - EXECUTIVE SUMMARY (7.2.4)

IFMC is pleased to present this proposal in response to the Member Services component of the Department's Iowa Medicaid Enterprise (IME) Professional Services Request for Proposal (Med-10-001). We have been the Department's partner in managing Medicaid in Iowa since 1979, most notably during the last five years serving as the IME Medical Services vendor.

The re-alignment of Member Services reflected in the current procurement provides the Department with a much greater opportunity to focus on member health and improve health outcomes of the Medicaid population in Iowa. The Member Services functions specified in the RFP present numerous opportunities to engage members in the care management process and help them acquire the skills necessary to effectively manage their own health. IFMC has experience in the development and operation of similar programs for Medicaid agencies in other states. This experience will be applied to IME Member Service activities to ensure a smooth transition and successful operation of the program.

We will deploy a health-focused call center to respond to member questions and provide outstanding customer service. Our existing programs for lock-in, Disease management and Enhanced Primary Care Management (EPCM) (previously provided under the Medical Services contract) will be transitioned to Member Services and will include several enhancements:

- Professional staff have completed training as Certified Health Coaches
- Predictive modeling will be used to identify members at highest risk and most in need of care management services
- Our clinical management tool (CaseNet TruCare™) will be used to apply evidence-based guidelines to member care
- Previous tele-health program for congestive heart failure will be continued and expanded to address diabetes
- A maternal health management program has been proposed in response to IME concern of infants with low birth weight

In the dynamic IME environment, we have collaborated with all IME vendors on many tasks and projects, often taking the lead in responding to requests from the Department. We have a long history of adding value to overall IME operations beyond basic contract requirements. As the Department's choice for assisting Medicaid members with their health, IFMC has met or exceeded all performance standards and has provided the Department with an excellent return on investment.

We 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

Consistent with our work on the current Medical Services contract, as the Member Services vendor we will implement continuous innovations in programs and services, providing the Department with a solid ROI.

Features and Benefits

IFMC offers a comprehensive program for providing IME Member 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 the Department:
➤ Long term highly experienced vendor with full understanding of IME operations and objectives	➤ Seamless implementation of new contract and effective program operations
➤ Medical call center experience for a Medicaid population	➤ Proven operational procedures directly relevant to the IME population
➤ Predictive modeling	➤ Improved targeting of program interventions for members most in need
➤ Comprehensive clinical management tool (TruCare™)	➤ Application of evidence based guidelines to inform appropriate care determinations
➤ Experienced operations staff	➤ No disruption in care management program operations; maintenance of existing relationships with enrolled members
➤ Stable and tenured leadership team in place	➤ Minimal transition costs; preservation of institutional knowledge
➤ Consistently meet or exceed performance standards specified by the Department	➤ Effective program operations, increased program impact
➤ Participation in national workgroups, knowledge transfer, and learning events	➤ Incorporation of best practices into IME program design and operation
➤ Certified Health Coaches	➤ Increased member participation; improved member self-management skills



Features offered by IFMC:	Benefits to the Department:
➤ Corporate professional communication support in designing educational materials addressing health literacy concerns	➤ Effective educational materials; Medicaid population with increased self management skills and better outcomes
➤ IME experience	➤ Demonstrated collaboration in the complex IME environment
➤ Established approaches to ensure operational processes stay current with best practices	➤ Continuous quality improvement in program activities
➤ Medical focus to program operations	➤ Improved member health and clinical outcomes; reduced costs
➤ Medicare QIO for Iowa	➤ 75% federal match of state investment
➤ Long history of adding value to IME Operations beyond basic program requirements	➤ Positive ROI resulting from program activities

Overview of Services

IFMC is proposing a complete solution for the Member Services component of professional services. We have demonstrated experience in managing successful call centers for the Oklahoma Medicaid program and numerous commercial clients served by IFMC’s ENCOMPASS call center. Our innovative approach of combining assistant health coaches and customer service specialists in the call center will meet all requirements of the Member Services scope of work and provide members with a health-focused contact at their first call. Member Services functions of MHC enrollment, member inquiry and relations, education and outreach and Medicare buy-in will be completed with the attention to detail that is the hallmark of IFMC.

We will complete all managed care enrollment processes and use assistant health coaches as the first line of communication with members through voluntary completion of a brief health risk assessment (HRA). This proactive approach will successfully enlist member participation in IME care management programs.

To support this approach we have designated two additional positions (identified below) to focus on specific concerns of members and the IME objectives of having an educated, self-managed membership:

- Billing specialist – will focus on member concerns related to claims and appeals, both areas in which IFMC has significant experience
- Team trainer – will focus on skill development for our call center staff and care management teams

IFMC has successfully managed the MHEP and lock-in program for the Department for more than 18 years. We will provide the Department with a smooth transition to a new contracting period without interruption in existing services. Use of our predictive modeling tool (CareAnalyzer) will allow us to identify more members who could benefit from educational interventions and restrictions, when indicated.



Our positive relationship with many providers across Iowa has allowed us to recruit providers willing to medically manage members enrolled in lock-in.

As with lock-in, we will transition our Disease management and EPCM programs without interruption to Medicaid members.

Our disease management program will continue to focus on congestive heart failure (CHF), coronary artery disease, asthma, chronic obstructive pulmonary disease (COPD), diabetes, and complex conditions. Assistant health coaches will complete a brief, voluntary HRA with the member and begin the education and awareness process regarding effective self-management of health. Our certified health coach/care manager will continue the process of member-centric education and focus on providing self-management support to enrolled members.

Our solution also includes effective tele-health programs focusing on CHF and diabetes. IFMC's subcontractor for this activity (Pharos Innovations) has demonstrated positive outcomes for Iowa Medicaid members for the past two years. The program has proven to be an effective method for reaching members and providing timely intervention, reducing emergency department visits and hospitalizations. Based on the success of the CHF program, we received notice of a grant award from the Health Resources and Services Administration (HRSA) Office for the Advancement of Tele Health (OAT) to provide a tele-health program for members with diabetes.

Our EPCM program will continue to focus on temporary acute conditions, complex conditions that require special medical needs and reduction of emergency room utilization. We will continue to utilize our established relationships with primary care providers across the state to enhance the quality of care received by Iowa Medicaid members. Our EPCM solution includes a maternal health program developed with support from the Department and Iowa Department of Public Health. IFMC analyzed IME claims data and determined that Iowa Medicaid experienced a significantly high occurrence of low birth weight deliveries with associated high costs. Our maternal health program in five designated high risk counties is directed at member education and obtaining effective prenatal care to improve the health of mothers and babies and reduce costs related to poor outcomes.

Integration with Medical Services

The knowledge and experience of the IME Medical Services leadership team will be leveraged to mitigate risks, ensure a smooth transition, and facilitate operational excellence for Member Services. With Member Services being fully grounded in a medical model, greater opportunity is available to share expertise in focused areas. We will be able to tap into many areas of expertise as we strive to create the most informative and helpful educational materials for members.

The quality of care program managed 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 ACG Predictive Modeling application, (CareAnalyzer) developed by the John Hopkins University Bloomberg School of Public Health. The results of predictive modeling will be used to identify high-cost and high risk members to better forecast their future costs and to proactively identify individuals whose high intensity health care needs may be amenable to organized care management or expanded primary care interventions.

Medical Services and Member Services will also share use of our comprehensive care management software application (TruCare™) for all care management activities, including utilization management completed by Medical Services. The system will help us track member compliance with clinical care guidelines of particular importance to individuals in our care management programs. It will also provide reporting and analysis tools for queries that will allow the Department to ensure that members are receiving optimum quality of care in the most cost-effective manner. Sharing software and resources to manage the applications will increase the efficiency of both units.

If IFMC is not the successful bidder for Medical Services, we will still utilize the predictive modeling and care management software applications described above. Required interfaces with claims and eligibility data to support the lock-in, disease management and EPCM programs will not be impacted.

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 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 costs for the Department as well as decreased costs related to specific procedure utilization review. Operational efficiencies identified by our lock-in staff have impacted claims processing. 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.

Our medical director brings extensive experience to IME derived from his clinical experience as a primary care provider, years of managed care oversight, and the past five years as the IME Medical Director. As a member of the National Association of State Medicaid Medical



Directors, he is familiar with the leading trends of Medicaid programs across the country and directs our care management programs accordingly.

In our care management programs, our predictive modeling tool (CareAnalyzer) will be used to identify members who could benefit from active care management. The system can be used to identify high-cost persons prospectively to better forecast their future costs and to proactively identify individuals whose high intensity health care needs may be amenable to organized care management or expanded primary care interventions.

IFMC will use the TruCare™ case management application 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.

And finally, IFMC annually obtains an external evaluation of our tele-health programs. Working with Des Moines University and the Iowa Chronic Care Consortium, the effectiveness of the tele-health programs are evaluated. The evaluation includes clinical measures, patient functionality, cost of care and financial impact.

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 allows the greatest flexibility of choice for members while providing utilization oversight and provides the Department with the ability to effectively manage the health and the costs of healthcare for the Medicaid population in Iowa. While all providers are subject to the edits and restrictions in claims and authorization systems (Medicaid Management Information System - MMIS and Individualized Services Information System - ISIS), IME's PCCM program (MediPASS) provides individual patient management and promotes medical home and continuity of care.

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-wide 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.

Successful interfaces are key to the overall success of the IME multi-vendor model. Ongoing daily collaboration is needed to establish and maintain efficient interfaces that meet the needs of the Medicaid program and the Department. Contractor identity is set aside while all vendors establish effective working relationships and inter-dependencies in order to achieve overall success. All current IME vendors have learned that small changes in operations may have significant impact for other vendor operations and eventually may adversely impact Medicaid members and providers if communication and coordination do not occur.

The Department focuses on the needs of the member, provider and other stakeholders 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. Our established positive relationships will enhance operations for Member Services:

- The Department of Inspections and Appeals to efficiently process appeal responses
- The Iowa Department of Public Health to implement a maternal health program and other care management programs that will serve the needs of Medicaid members
- The Medicare and Medicaid Fraud Control Unit to collaborate regarding the lock-in program, submit referrals and complete medical review for investigations

IFMC has established positive and effective working relationships with healthcare providers statewide. These successful relationships have derived from assisting providers with claim issues, securing providers for lock-in members and care management support of primary care and specialty provider goals for members. We will leverage these relationships in our completion of Member Services responsibilities and to secure the best quality care for Medicaid members.

Stakeholders representing provider groups inform IME of trends in care, impact of program decisions on providers, collaborate for improved quality of care, and support increased access to services to members:

- Iowa Medical Society
- Iowa Osteopathic Medical Association
- Iowa Hospital Association
- Iowa Pharmacy Association
- Iowa Health Care Association
- Iowa Association of Homes and Services for the Aging



- Iowa Council of Health Care Centers
- The Coalition for Family and Children’s Services in Iowa

IFMC will continue collaboration with other stakeholders through our care management programs to facilitate quality care, increase access to care, inform clinical guidelines, and enhance services to members:

- The American Lung Association
- County Departments of Public Health
- Visiting Nurse Services
- Federally Qualified Health Clinics
- Child Health Specialty Clinics
- University of Iowa Hospitals and Clinics
- Wellmark
- Iowa Plan
- Medicare
- Community Resources

Member 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 Member 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 Member Services functions. Each project plan addresses:

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

The details of our project management plans are provided in Tab 7 of the 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. We will bring established processes with us to Member Services and avoid interruption of services to members who have established relationships with their lock-in review coordinators and disease management and EPCM health coach care managers.

The largest risk for the Department and IFMC during the transition of Member Services is assuming operation of the Member Services call center. We realize the call center is vitally important to many members who depend on this service to assist them in finding or selecting providers and obtaining needed benefit and health related information. We will leverage our experience in operating call centers for other clients to ensure the IME Member Services call center is operated effectively and efficiently. In addition, we will strive to retain the services of selected personnel from the current Member Services vendor to provide operational continuity and minimize any disruptions that may occur during the transition. All new and transitioned staff will be thoroughly trained in IFMC call center procedures.



Below are additional risks and mitigation strategies:

Risks	Mitigation Strategy
<ul style="list-style-type: none"> ➤ Previous Member Services vendor is unable to support a smooth transition; does not provide the information and other support needed to assume program operations 	<ul style="list-style-type: none"> ➤ Previous experience in securing IME operations without current operational information ➤ Close liaison with Department policy specialists knowledgeable regarding IME operations ➤ Hiring qualified staff of current vendor ➤ Leverage current knowledge of IME operations and interfaces
<ul style="list-style-type: none"> ➤ System failure; unable to obtain access to TruCare™ 	<ul style="list-style-type: none"> ➤ Business disruption 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 member functions
<ul style="list-style-type: none"> ➤ Unsuccessful procurement of Medical Services 	<ul style="list-style-type: none"> ➤ Experienced medical director and tenured staff implement Member Services operations in collaboration with new vendor for Medical Services

Additional risks identified during transition and operations will be addressed through regular status meeting with the Department. We will continue to collaborate with other vendors at status meetings 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.

To further mitigate transition risks, IFMC will utilize “go live” readiness procedures such as practices with normal operations and systems as well as simulated enactment of business disruption plans. We will work with the current contractor in a respectful way to secure all needed protocols and information to facilitate a seamless transition for Medicaid members and providers.



TAB 5 - GENERAL REQUIREMENTS (7.2.5)

General Requirements for All Components (6.1)

Co-location with Other Vendors (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 identified a delay in initiating lock-in restrictions and worked in collaboration with DDM to develop a protocol allowing appropriate members of our 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, which was delaying implementation of restrictions.

Communication (6.1.b, o and p)

IFMC has cooperated and collaborated with all other 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 enhancing our communication. 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 for communicating within 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. All communications protocols will be reviewed upon implementation of the Member Services contract. As necessary, we will work with the Department and other vendors to ensure that our processes are collaborative and support the needs of all IME parties. Any revisions to protocols will be reviewed with our full Member Services team.

Our Member Services team will 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. Examples of the meetings we will actively support and participate in include:

- 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

Collaboration (6.1.c)

The Department has contracted with IFMC for utilization management and quality management since 1979. We have successfully managed the MHEP and lock-in programs for more than 18 years including five years under the current IME contract. We began our work for the Department in disease management in a pilot project in 2003 and for the past five years have included enhanced primary care management in our work. IFMC has formed many partnerships and collaborative relationships with Department staff, other state government agencies, stakeholder organizations, and IME vendors.

During the past five years, we have demonstrated our cooperative, collaborative efforts at IME. Our Member Services management team will be composed of staff who have been a part of the Medical Services management team at IME. The relationships built and collaborative efforts from the past will facilitate a successful transition of workflow with all IME vendors. Examples of collaborative efforts as an IME vendor include:

- 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 face-to-face provider training
- Core – reviewing and updating codes and edits to ensure current coding and edit accuracy
- SURs - audits of suspected provider misconduct related to waiver certification and data provision for provider feedback
- Pharmacy Medical – coordinating criteria for similar prior authorizations
- Point of Sale – co-creating timely override process for providers serving lock-in members
- Provider Cost Audits - 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)
- Data Warehouse – queries and analysis regarding quality improvement opportunities for Medicaid members and Medicaid Value Management (MVM)



- 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
- Iowa Department of Education – facilitating eligibility reports for Medicaid school based services
- Wellmark – collaborating on psychiatric medical institutions for children (PMIC) and prior authorization (PA) activities
- Des Moines University – implementation of a tele-health program for Medicaid members

Interface and Updates with IME Systems; Access to External Systems (6.1.d, q and r)

During the past five years as the IME Medical Services contractor, we have met all interface requirements with IME data systems. During the implementation phase of IME operations, we collaborated with the Core vendor to develop an effective process flow in OnBase for medical prior authorization. We continue to innovate processes to make the best use of the OnBase workflow management system. In our current work, we have implemented numerous additional OnBase workflows, directly interacted with multiple MMIS files and have effectively used COLD reports. IFMC staff effectively communicates with the Core vendor and Department policy specialists to ensure the IME data systems are accurate and efficient. Since the second year of operations, at the suggestion of the Core vendor, our staff have had update access to MMIS for the process of annual updating of procedure codes. In an effort to improve efficiency and accuracy, we gained update access to SSNI for direct provider assignment for lock-in members.

As the Member Services contractor, we intend to continue the necessary interfaces with all Department systems. We will use our current expertise with multiple OnBase process flows to enhance current Member Services' capability and efficiency. Our familiarity with MMIS files: Claims Inquiry, Procedure/Drug/Diagnosis, Provider Charge, Text and Exception Control, Provider Subsystem, Recipient Subsystem, Prior Authorization, MARS subsystem, and MHC will be valuable in the re-alignment of Member Services requirements.

During IME operations, we have also worked with the Core and ISIS management to provide automated performance measure reporting. We have implemented the CareAnalyzer predictive modeling software including electronic interfaces with IME data systems. We will implement use of care and quality management software (TruCare™) and will support all needed interfaces for automated performance reporting.



Anticipated data interfaces and methods for supporting the interface are highlighted in the following table:

System	Data	Method
TruCare™	Data warehouse – Claims, Eligibility, Providers	Secured ftp
CareAnalyzer	Data warehouse – Claims, Eligibility, Providers	Secured ftp
ISIS	Case Manager; Prior Authorizations	View Only
IMERS	Claims	View Only
SSNI	Lock-in providers	Manual updates
MMIS	Managed Care	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 IME Medical Services as well as a number of other federal, state and commercial clients. 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.

Response to Queries, Requests, Reporting (6.1.e, g, i, j and k)

Under our 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.

Examples of data queries have included:

- Major diagnostic category of claims reflecting missing or unknown diagnoses
- Use of high tech radiology procedures
- Children receiving NICU services following identification of low birth weight
- Preventive quality indicators for Iowa’s Medicaid population
- Inpatient quality indicators for Iowa’s Medicaid population
- Preventive care for persons with diagnoses of intellectual or developmental disability

Our requests under our Member Services contract will be coordinated by a designated primary contact who has been with IFMC’s Iowa 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.

In our role as the Member Services vendor, we will manage both general requirements and member 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 have selected the TruCare[™] case management solution for our care management activities. The system's real-time reporting and analysis tools 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. These applications will assist the Department in ensuring 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.

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

Flexibility in Responding to Changing Program Needs (6.1.f)

As the Member Services contractor, 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, quality assurance, implementation and operations, systems security, communication systems, compliance specialist, communications, and marketing. All of these resources are available to support Member Services activities.



Meeting Our Areas of Responsibility (6.1.h)

We will continue to manage both general requirements and member 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.

In disease management and EPCM, we went beyond performance standards by implementing a tele-health program for members with CHF, conducting depression screenings on each enrolled member with follow up referrals to the Iowa Plan when indicated and implementation of a maternal health care management program. The Department has chosen to include this as a requirement in this IME Professional Services reprocurement.

System and Operational Changes and Documentation of Changes (6.1.i - n)

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 system problems and necessary system changes and relaying this information to the Department. We will continue to use the established processes of OnBase Change Requests (OBCRs), system action memos (SAMs), and change management requests (CMRs) that suggest system enhancements to the Department. We have found these processes to be efficient tools to document requested changes.

All staff are required to participate in a process or quality improvement plan annually and have specialized training in this regard. This has helped us identify possible changes in operational procedures to impact cost-effectiveness and improved customer service.

Using the established OnBase OBCR process, we identified necessary changes to OnBase workflows for the MED00 Correspondence Research workflow. These changes reduced the time on task by one to three hours daily for all IME vendors. We will use our OnBase workflow expertise to propose additional enhancements to the Member Services' use of the Department systems.

We will review current operational procedures for Member Services and will submit any proposed changes to the Department for approval.

We currently maintain detailed operation procedure manuals in the format designated by the Department. We have consistently updated operational procedures up to ten days prior to the deliverable due date. We have found keeping operational procedures current is essential in maintaining efficiently trained staff, as well as program continuity, and we will continue to follow these established protocols.



STAFFING (6.1.1)

Named Key Personnel (6.1.1.1 and 6.1.1.1.1)

The following key personnel for Member Services are all current members of our IME management team and have 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.

, MS, CPHQ, will serve as the account manager for Member Services. reports directly to , Senior Director. Ms. Sims will be responsible for ensuring all contractual obligations are met. is a certified professional in healthcare quality and has over 11 years of experience working with Medicaid review and quality management programs. has had management and fiscal responsibility for the Iowa Medicaid program since 1998.

will also serve as the transition manager. She brings experience to this role as she served as the implementation manager for IFMC Medical Services in 2004-2005. She has directed the programs and supervised IFMC staff responsible for enhanced primary care case management, disease management, MHEP and lock-in, rehabilitative treatment, PMIC, claims pre-pay, prior authorization, quality of care, EPSDT, long term care nursing facilities and waivers, and other medical support services.

, DO, has committed to remain with IFMC as the medical director for Member Services. will provide medical leadership for Member Services. As the current medical director for IME, brings his experience of IME and his membership in the National Association of State Medicaid Medical Directors to his role as medical director of Member Services. will collaborate with the IME chief medical director.

IFMC will have two operations managers for this contract. The operations managers have been working in this capacity for six years with the IME medical services management team. They hire, train, motivate, and evaluate professional and support staff. The operations managers include:

, RN, will continue to manage the day-to-day operations and technical assistance for the IME EPCM, disease management, MHEP, and lock-in programs.

, LBSW, will have responsibilities for the Member Services call center and activities of MHC enrollment, member inquiry and relations, member education and outreach, member quality assurance, and Medicare Part A and Part B buy-in. Call center staff will be composed of LPNs, social workers, and customer service specialists who are knowledgeable in Medicaid program rules.

Both and have extensive experience in managing Medicaid programs.



The following table illustrates the qualifications, start date, and any special requirements for our proposed key personnel:

Name and Role	Start Date	Special Requirements	Qualifications
Account Manager	Currently employed by IFMC	100% at contract signing Will serve as transition manager and account manager.	11 years managing staff and Medicaid, prior experience with IME; MS, CPHQ
Medical Director	Currently employed by IFMC	15% 30 days prior to start date	6 years as Medicaid medical director; DO
Operations Manager	Currently employed by IFMC	20% at contract sign, 100% 30 days prior to start date	5 years Medicaid experience with call center and care management; certified health coach, RN, BS
Operations Manager	Currently employed by IFMC	50% at contract sign, 100% 30 days prior to start date	4 years Medicaid supervisory experience with lock-in program; LBSW

Key Personnel Resumes and References (6.1.1.1.2 and 6.1.1.1.3)

The following resumes for our key personnel include relevant and recent (past five years) employment history, education, professional certifications and affiliations and professional references within the past five years.

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EDUCATION

ADDITIONAL TRAINING/CERTIFICATIONS



REFERENCES

WORK EXPERIENCE

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EDUCATION

ADDITIONAL TRAINING/CERTIFICATIONS



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EMPLOYMENT HISTORY

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ADDITIONAL TRAINING/CERTIFICATIONS

ACTIVITIES

- American Osteopathic Association
- American Academy of Osteopathic Family Physicians
- Iowa Osteopathic Medical Association
- Iowa Medical Society
- Iowa Academy of Osteopathic Family Physicians
- Polk County Medical Society
- Member, Prairie Meadows Grant Committee

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 staff. We are familiar with and accept the Department's right of prior approval for all individuals proposed for key positions.

We acknowledge that any changes to key personnel and/or to the number and 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 personnel 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 we are 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. Resumes and references for proposed replacement key personnel will be provided to the Department.

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/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.

We 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



[Redacted]	
Position	Number of FTEs

When there are staff vacancies in Member Services, we will recruit current 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 their duties 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 staff carry current licensure for Iowa. Established policy and procedures ensure that appropriate licensure/certification is in place for all appropriate personnel.

When a candidate is conditionally offered a position with IFMC, a pre-employment, post-offer background check is conducted. We use a third-party agency to conduct background checks to verify the accuracy of job-related employment, educational, and credential information included on the candidate’s resume and application form, and to conduct criminal background checks and credit checks, as applicable. Background checks are conducted in compliance with all federal and state statutes, including the Fair Credit Reporting Act (FCRA).

We review all medical staff credentials and licensure prior to hiring. 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
- Copy of liability
- Data bank query

Recredentialing is completed every two years and encompasses the same credentialing process.

This page contains confidential information.



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

We have an established and comprehensive system of cross-training and job rotation that builds a level of redundancy to our operations. Our IME team/staff are familiar with and competent in multiple roles. We will leverage cross-training and job rotation to ensure all Member Services functions are fully and consistently executed during the absence of staff. 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 for sensitive positions when the primary team member is absent. The designated staff will be fully trained and able to competently and professionally address the responsibilities of the sensitive positions they are supporting. 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)

Permanent Facilities (6.1.2.1)

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 IFMC Member Services team, with the exception of field staff, will be located at the permanent facility during the Operations and Turnover phases of the contract.



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

Position description	Number of staff

State Responsibilities (6.1.2.1.1)

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 Member Services field staff)
- Desks, chairs, and cubicles (except Member Services field staff)
- Network infrastructure and network connections
- Personal computers
- Telephones and facsimile (fax) machines (except Member Services field staff, who will receive a voice mailbox)
- Access to photocopiers and copier paper (except Member Services field staff)
- Access to network printers (except Member 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

Contractor Responsibilities (6.1.2.1.2)

We will provide the commercially available software, (Care Analyzer and TruCare™) to conduct care and quality management programs for Member Services. Although both Care Analyzer and TruCare™ have been approved by the Medicaid Director for activities under our current medical services contract, we will seek approval from the Department for use under the Member Services contract.

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



We provide all general office supplies for our IME personnel, excluding copier paper and envelopes. Office supply needs are supported by our 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 Member Services staff will be provided by IFMC. During the past five years, we have provided ergonomic equipment to IFMC IME staff at no cost to the Department. The special needs equipment provided includes, but is not limited to:

- Desk chairs
- Specialized keyboards
- Specialized computing mouse

Courier Service and Mailings (6.1.2.2)

We will use 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 our current IME staff to ensure necessary documents and materials are delivered to the Capitol complex and the U.S. Post Office in a timely manner.

In addition, we have contracted with a delivery service to provide daily courier service between IME and the IFMC corporate office. This allows for expedited delivery of documents and/or materials intended for IME staff that are mistakenly sent to the corporate office.

We use the IME mailroom for all daily mail and small-volume mailings. We have established an effective process with the mailroom management to schedule small volume mailings and will continue this process for Member Services.

Our staff has collaborated with the IME mailroom to schedule large-volume mailings with identified entities. We will continue to work with the Department to identify the most cost-effective way to print and mail large volume mailings.

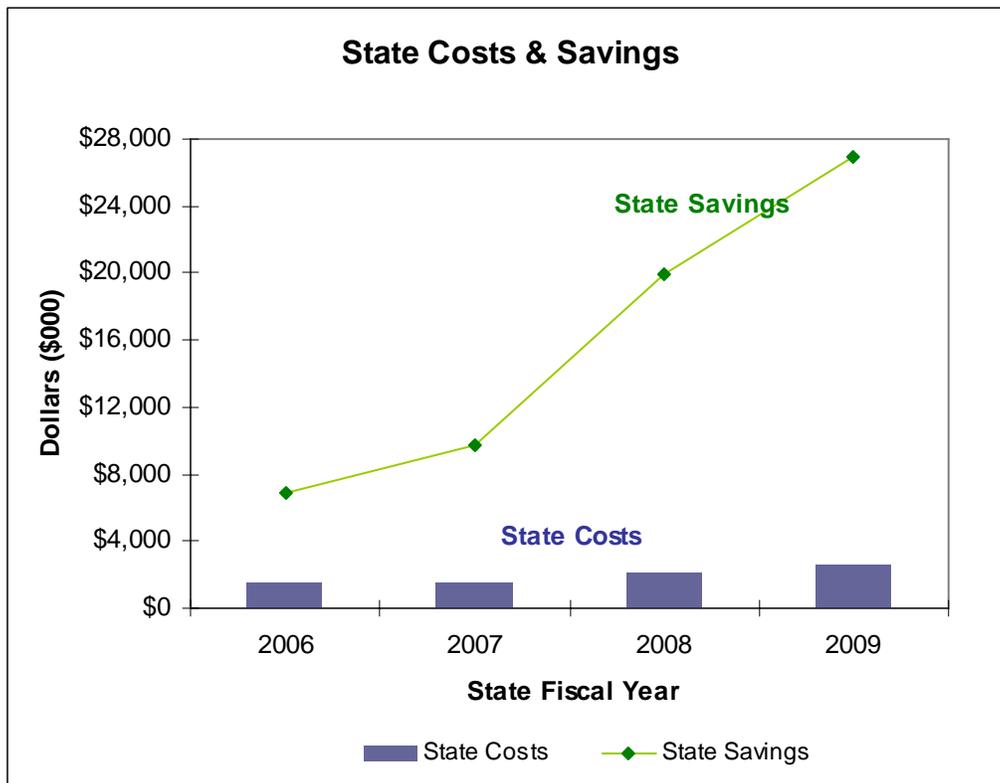
We will provide a print-ready copy of all documents for printing to the entity selected by the Department for large-volume printing. We currently provide print-ready education materials and brochures to the print shop in the Hoover Building for large volume printing.

We understand the Department pays for all postage and external mailing costs. We will not direct charge any mailing costs to the Department.

CONTRACT MANAGEMENT (6.1.3)

IFMC recognizes the State of Iowa has mandated performance-based contracts, and that payment to the contractor is tied to meeting performance standards identified in the contracts awarded through this RFP. IFMC will report to the Department on all Member Services performance measures.

During the past five years, IFMC has reported monthly, quarterly, and annual score cards as a tool for oversight by the Department. These reports demonstrate our commitment to providing results to the State of Iowa and the Department. 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.

Performance Reporting and Quality Assurance (6.1.3.1)

IFMC understands that performance standards outlined in this RFP clearly define the expectations of the Department. We will report quarterly on our performance compared to standards that measure timeliness, accuracy and completeness of numerous operational functions.



We will submit our performance standards quarterly report card within the time frames determined by the Department. We will continue the practice of providing quantifiable performance standard measures in a timely manner.

We anticipate automated reports will be produced by the telephone system, OnBase, and TruCare™. We will collaborate with the Department to ensure reports clearly describe performance measures and provide transparency of Medicaid operations and programs.

We understand the Department may select a subset of the standards for quarterly narrative reporting purposes. We will report the standards as requested by the Department.

We will work with the Department in finalizing specific performance updating measures. Our experience in assisting the Department will be a benefit as we work toward establishing the measures that will inform the Department and the public of our performance in key service areas.

We are committed to continuous quality improvement. We apply an improvement focus to our internal activities and the services we provide to our customers. Our continuous quality improvement program is discussed in more detail below.

We understand after the first full year of operations, the Department can 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. In our five years as an IME contractor we have not incurred liquidated damages.

Quality Assurance (6.1.3.1.c and 6.1.3.3.k - p)

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 Member 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 Member Service programs. 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 ER services and total claims cost
- Internal quality control such as call center response times, number of clients engaged, health literacy assessments and care plan goals

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. 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.

Performance Standards We develop internal "proxy measures" to assess interim performance. 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 IME contract.

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 both within the Member 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 BPIs 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.

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
- 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 changes 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 IME team members.



The BPIs identify workflow concerns, action plans developed, objectives defined and measured, interim results, and BPI final documented results. We will continue to promote staff identification of potential opportunities for improvement.

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

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.

We use 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 use tools such as Root Cause Analysis, PDSA, Cause and Effect Diagrams and Failure Mode and Effects Analysis. We have 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.

Contractor Responsibilities (6.1.3.3)

Reporting (6.1.3.3.a-c)

We maintain data regarding contract management activities within the Department's OnBase software system and our care management software. All reports to the Department are 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. IFMC will provide access to written and electronic records as necessary for the Department, as well as state and federal auditors. IFMC will retain records according to timeframes and guidelines detailed by the Department.

IFMC currently produces monthly, quarterly, and annual reports and scorecards describing compliance with all program performance standards and contract requirements. A sample of these reports is shown below. These reports are completed in a timely manner and according to the Department's needs and requests. We will also use TruCare™ to provide detailed reports regarding MHEP, lock-in, EPCM, and disease management performance standards and



requirements. The performance standards and other contract requirements will be reported to the Department at the timeframes determined by the Department.

A sample scorecard is presented below.

Contract	Performance Measurement	Scoring Rules	Possible Points	Points Received
Financial				
Customer				
#1	Upon referral, initial member contract for case management services shall be completed for ninety five percent (95%) of the members within five (5) business days.	Award 30 points if initial member contact was completed within five (5) business days for ninety five percent (95%) of the members. Otherwise, deduct one (1) point for each member not completed within five (5) days.	30	30
#2	Update case management manual within three (3) business days of DHS approval of a change or DHS request for a change.	Award 5 points when manual is updated within 3 business days of approved change. Deduct 1 point of every 5 business days change not made.	5	5
#3	Identify and correct any errors with case management activities within three (3) business days of the error detection.	Award 10 points for each error corrected within 3 business days of error detection. Deduct 1 point for every 5 days error is uncorrected.	10	10
#4	Send a satisfaction survey to member every 6 months of enrollment.	Award 10 points if a satisfaction survey is sent to members at 6 months intervals on the 15th of the month. Otherwise, deduct one (1) point for every survey not sent.	10	10
#5	Complete required reports accurately and timely.	Award 25 points when all reports are completed timely. Otherwise, deduct 10 points for each report completed late.	25	25
#6	Maintain an average enrollment of fifty (50) members.	Award 20 points when an average of fifty (50) members, per case manager are enrolled. Otherwise, deduct one (1) point if enrollment falls below forty (40) for any given month.	20	20
Internal Business Processes				
Learning & Growth				
Total Points			100	100

We also currently provide the Department with monthly, quarterly, and annual reports that describe contractor activities. These reports provide the information in an aggregate format with contract year-to-date activities including review results.



We will develop report formats to propose to the Department and will work with the Department to finalize the most appropriate content and format for all reports.

Operational Procedures, System Changes (6.1.3.3.d-f)

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 system problems and necessary system changes and relaying this information to the Department. We will continue to use the established processes of OBCRs, SAMs, and CMRs that suggest system enhancements to the Department. We have found these processes to be efficient tools to document requested changes.

Our staff are trained in the IFMC process of identifying process improvement opportunities. All staff are required to participate in a process or quality improvement plan annually and have specialized training in this regard. Therefore, they frequently identify possible changes in operational procedures to impact cost-effectiveness and improved customer service. We will review current operational procedures for Member Services and will submit any proposed changes to the Department for approval.

We currently maintain detailed procedure manuals in the format designated by the Department. We have consistently updated operational procedures up to ten days prior to the deliverable due date. 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.

Communication Protocols and Progress Updates (6.1.3.3.g-i)

Communication with Department staff and other IME vendors is and will continue to be a priority. As a current IME 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 within IME are 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 Member Services team.

Our Member Services team will 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.

During the current contract, we provided consultation to the current Member Services vendor regarding member educational materials. As the Member Services contractor, we will seek additional ways for Member Services to further collaborate with Medical Services and other vendors. We understand that open communication has greatly contributed to the success of IME and we will not take any action that would reduce open communication.

We have found the regular meetings among the account managers, the Department, and vendor representatives to be helpful to identify interfaces and to proactively problem solve to ensure seamless services for members and providers. The Member Services account manager will follow this established effective system to further identify opportunities to improve Member Services and IME performance.

Responding to the Department (6.1.3.3. q, r)

As part of our customer service orientation, we will provide a written response to all Department requests and questions within two business days. One recent example was providing the Department with rationale to revise family therapist qualifications within the CMH waiver program. All responses will include a description of the issue and resolution.

Emergency requests are a priority and will be responded to within one business day. On [redacted], our care management team received an inquiry from the Department regarding [redacted]. We immediately followed up with the child's case manager and by reviewing waiver assessment information. The medical director provided updated information to the Medicaid Director within one business day,

Our lock-in team was asked on [redacted], to assist the Department in responding to request for information from [redacted]. We immediately responded (within one business day) and continued to collaborate with Department policy specialists until the final draft was completed. It is always our team's priority to respond to urgent requests immediately.

Security and Privacy (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, Email 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.

We provide 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 with 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 not 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.

Performance Standards (6.1.3.4)

Reporting Deadlines and Documentation (6.1.3.4.1 and 6.1.3.4.2)

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

Description		July	Aug	Sept	1 st Qtr
Summary of case management activities and services authorized for members. (Medical Services does not authorize)	Due				
	Sent				
Comparison of services and funding prior to and after receiving case management.	Due				
	Sent				
Summary of satisfaction survey for members.	Due				
	Sent				
Length of time that individuals receive case management.	Due				
	Sent				

As the Member Services vendor, we will implement similar processes including those needed to report member enrollment and education activities as well as the MHEP and lock-in, disease management, and EPCM required reports in a timely manner.



Upon contract implementation we will review operational procedures and recommend changes to the Department, if needed. If changes are approved by the Department we will update the 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 will also be posted to the IME Universal drive. We will also maintain desk level procedure manuals documenting processes and procedures. We agree to follow the Department's timeliness, 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 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.

We 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 TruCare™ and will be specifically identified in documentation.

Annual Performance Reporting (6.1.3.4.3)

We understand the goals of the IME to effectively manage the health and the costs of healthcare for 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. 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. We will operate and manage the Member Services contract in a manner that enables us to achieve all performance standards defined for the Member Services component of the IME.

We will develop and submit an annual report including cost savings and performance standards in a Department-approved format. The format will provide the Department with aggregate data for release without jeopardy to individual or personally identifiable health information. We will 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.

Member Services (6.1.3.4.3.4)

We will subcontract with Essman Research to conduct the Member Services satisfaction survey. The survey process will assess member satisfaction with and awareness of Member Services. The survey outline will be submitted to the Department for approval. We will use the SFY 2010



survey as a baseline. Our staff will be trained in listening skills and responding to needs expressed by the caller. We will promote awareness of Member Services availability in all educational materials and on the IME Member Services website. This focus on member needs will assist us in achieving the overall satisfaction rating of 3.85 and subsequent yearly increases of 2 percent or more. All IFMC staff have an aptitude for responsive customer service and each has a performance goal associated with customer satisfaction. Staff are provided performance feedback during quarterly coaching sessions.

Member satisfaction surveys have been conducted for other programs IFMC manages. The Pacific Health Policy Group conducted an independent member survey for the Oklahoma Health Care Authority, surveying members of IFMC’s SoonerCare Health Management Program. Impressive results were noted in the summary of finding.

“The SoonerCare HMP is viewed very favorably by both Tier 1 and Tier 2 engaged members (participants)...” The Pacific Health Policy Group, September 2009

During the past four years, IFMC has conducted provider satisfaction surveys for IME vendors using Essman Research, an independent marketing research firm in Des Moines, Iowa. The firm’s collaboration with IME vendors has produced annual reports to assess the overall level of satisfaction. Using a Department-approved survey instrument and methodology, member satisfaction with administrative services and awareness of Member Services functions will be measured. We will use our experience along with the results of this survey to inform us of the impact of our current processes and areas where improvement is needed.

In accordance with URAC standards, IQC has been completed and will continue to be a focus for IFMC. IFMC has maintained an IQC process for all programs provided at IME. The IQC process is completed monthly using a statistically valid sample as determined by our statistician. For all member communications, management will review sample responses as documented in Workview, through taped telephone calls, as well as listening to live telephone calls to ensure customer service excellence. Scripts will be developed as appropriate to promote consistency and accuracy. Written member communication will have an IQC process of proofing and ensuring appropriate enclosures. We will maintain 99 percent IQC compliance.

IFMC has met every IME cost savings and cost avoidance performance measure to date and we have a strategy to meet the Department’s required cost savings in SFY 2010 through SFY 2013. Our MHEP and lock-in programs have already established a track record of significant cost savings for the Department. Use of CareAnalyzer will assist us in accomplishing review of a larger number of Medicaid members and will increase our focus on utilization of emergency room services and selected targeted services prone to overutilization.

Our Disease management and EPCM programs will also benefit from the predictive modeling process through improved identification of members with high utilization potential. We have



increased the number of our health care coaches who will provide education to members and assist them in effectively managing their health concerns. We have targeted education programs that will also positively impact appropriate utilization of Medicaid services.

As the current Medical Services contractor, we have demonstrated our ability to achieve savings for the state through programs that are now components of Member Services.

For examples, the following results were achieved in SFY 2009:

Total Savings for Selected Programs SFY 2009	
MHEP and lock-in	\$6,226,745
Care Management	\$2,650,587

We will meet the required measurable state savings as described. We will develop a performance dashboard to document clinical improvement and program cost savings for the department's review annually.

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.

IFMC has a structured approach to training that includes all facets of operations. Following is an abbreviated orientation checklist used for administrative training. A similar checklist is used for specific software and systems training.



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				

Through our interactions in the MVM project, we have interacted frequently with DW/DS staff to design data queries. We will participate in 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) provided needed guidance and supervision as staff gained competency.

IFMC IME managers developed a detailed orientation checklist for all new employees. Each manager follows the checklist to ensure new employees are trained in system, security, and operational tasks.

Hiring activities focus on a variety of professionals with specific cultural awareness of the population they serve. Each candidate will meet or exceed education and work experience requirements as outlined in the job descriptions. Leveraging current staff with expertise will be a valuable bonus in our training program.

Position specific training and associated curricula will be developed during the contract transition period. All staff will receive basic information about existing programs and Medicaid. Their training will include IME specific policies and procedures as well as specifics as follows:

Health Coaches for Disease management, EPCM, MHEP, and lock-in

- Current evidence-based guidelines for relevant diagnoses
- Associated co-morbidities
- Potential barriers to medical adherence
- Appropriate interventions to increase adherence
- Self-management strategies
- Cultural sensitivity
- Safety
- The Chronic Care Model
- Health literacy

Call Center Assistant Health Coaches/Customer Service Specialists

- Telephone etiquette
- Use of information systems
- Eligibility/enrollment verification
- IME program purposes/features
- Referral information sources
- Follow-up procedures
- Call types referred
- Documentation of activities
- Maintenance of member confidentiality



- Health literacy
- Member benefits
- IME vendors' responsibilities

Management training specific courses provided

- Conducting Effective Performance Reviews
- Essentials of Leadership
- Leading Change
- Developing Others
- Coaching for Success

Our performance evaluation tools are designed to measure demonstrated success in improving participant outcome measures related to health literacy and management, effectiveness of judgment, attention to detail, analytical thinking, relationship building and flexibility. Our employee appraisal process routinely evaluates the customer service skills of our employees.

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 the 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.

We understand that Member Services operations will present us with new IME opportunities for training and development including telephonic customer service. IFMC has tenured call center managers and staff at our subsidiary ENCOMPASS and through our Oklahoma Medicaid contract, who will be available to assist with necessary training. We will implement a similarly detailed orientation checklist, procedures for confirming competency, and an ongoing emphasis on employee development.



OPERATIONAL PROCEDURES DOCUMENTATION (6.1.5)

We will review operational procedures used by the current Member Services vendor and will modify as necessary to enhance customer service, Disease management, EPCM, and lock-in performance and increased cost savings requirements. We will use the Department approved format to document all operational procedures at a detailed level to ensure program continuity and will provide that level of direction to our staff.

We have consistently updated operational procedures in a timely manner. Training on new procedures is provided 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 placed on the IME Universal drive.

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 will comply with all naming and numbering conventions as directed by the Department. We will comply in our documentation of Member Services procedures. We will not reference our corporate name in any of the documentation.

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 that field staff 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/or email system.

Workstation security practices include:

- Password/PIN security
- Locking computer when unattended
- Leaving computer on restart at the end of the workday

We will provide the Department with a quarterly HIPAA compliance report. This report will include:

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



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

We understand the importance of protecting member and provider information and have processes in place to promote confidentiality and security and to protect records from loss, theft, or destruction. IFMC follows all state and federal statutes and regulations to maintain the privacy and safety of protected health information. Processes include a confirmation script for callers, use of a step-by-step RightFax process to minimize errors, use of window envelopes to avoid breaches in confidentiality, and protocols for securing and transporting records. Protected health information that is transported by courier to peer reviewers is double-wrapped to ensure security in the event of a car accident. New employees learn the policies and procedures of the company, as well as federal and state regulations that affect the work we do (i.e., HIPAA, security). The staff will understand the importance of privacy and security and be trained through our performance excellence program.

As described previously, 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.

We maintain protocols in the event of a security breach that include identified personnel who are notified within specified timeframes.

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.

Access is limited to system hardware and software applications to only those who require access to perform job functions. Secure passwords are maintained on each hardware application.

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 nondisclosure agreement
- IME employee identification access policy
- Systems security access forms (as needed)
- Vehicle registration form



➤ Building access form

We will continue with all procedures described above and implement additional processes 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.

Backups of the TruCare™ system will be performed five nights a week, four nights of incremental backups 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 are 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 operate on a fiscal year that runs concurrently with the calendar year, beginning on January 1, and ending on December 31.

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)

IFMC will follow all Department directives regarding the receipt of checks and money orders. Our approach to this process will include logging all received funds on the day of receipt and delivering them to Revenue Collections for daily deposits as well as implementation of redundancy in processes for continuity and quality assurance.

We will be an active participant in the maintenance and updating of the existing check classification code processes as directed by the Department.

IFMC will comply with all Department requirements regarding the receipt of checks or money orders and the reconciliation of the monthly Title XIX Recovery bank account. Processes ensuring security of funds and accurate documentation will be developed and followed.

PAYMENT ERROR RATE MEASUREMENT (PERM) PROJECT (6.1.9)

We understand the importance of the PERM project and will participate in any required activities including audits of the eligibility of the member for Medicaid and enrollment in a managed care plan.

As the Member Services vendor, we will support the PERM project and participate in any assigned activities.

SUBCONTRACTORS (6.1.10)

We will subcontract with _____ for
Member Services satisfaction surveys.

We recognize the responsibility to provide strong, effective team leadership and to accept full responsibility for the performance of IFMC and subcontractor staff. We will oversee all IFMC and subcontractor efforts, and will remain fully and directly responsible for the quality and responsiveness of all project deliverables and overall project performance.

We have previously worked with each of the subcontractors proposed for the Member Services contract. This prior history provides a baseline of trust, commitment, and common responsibility to this project between colleagues that have established mutual respect. Regular communication will be scheduled with each subcontractor to ensure compliance with all RFP requirements.

REGULATORY COMPLIANCE (6.1.11)

All IFMC employees are required to annually attest to understanding and following security and HIPAA requirements. The IFMC confidentiality policy requires the protection of all patient identifiable and proprietary corporate resources. 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.



IFMC has a corporate suspected breach procedure in place which defines the security and privacy policies to be followed to minimize the risk of breaches and sets forth actions to be taken in the event of a confidentiality, privacy or security breach. Employees who suspect that a breach may have occurred must complete and route a Suspected Confidentiality Breach report to their manager. The employee must also complete the Department's breach reports. All reports are forwarded to the Unit Manager.

The TruCare™ system meets all HIPAA requirements for transactions, code sets, 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 policies and procedures regarding conflict of interest that are strictly followed. 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 will 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)

We are not aware of any potential or actual provider conflicts of interest that would conflict, or appear to conflict, in any manner or degree with our 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 or IFMC subcontractor and the provider also provides services for the Department. IFMC currently has
- 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.



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TAB 6 - PROFESSIONAL SERVICES REQUIREMENTS

Member Services (6.5)

CUSTOMER SERVICE AND HEALTH FOCUS

IFMC's solution to fulfilling the requirements of the Member Services procurement will focus on customer service and directly impacting the health of Iowa's Medicaid members. The re-alignment of the care management programs with the traditional Member Services responsibilities creates the opportunity to provide more effective member education through additional contact points and to enlist member participation in the care management programs, increasing opportunities for members to learn and implement effective self management skills.

MANAGED HEALTH CARE ENROLLMENT BROKER (6.5.1)

Enrollment Interfaces

The enrollment process begins with receipt of the MHC eligibility file from Core/MMIS that identifies enrollees in the fee for service program and those who must enroll in the PCCM program known as MediPASS. We will follow Iowa Administrative Code (IAC) 441-88.42(2) to determine categories of participation/exclusions for MediPASS. Membership materials will be prepared for each enrollee type.

Member choices will be entered into each open panel and our customer service staff will meet member needs by interfacing with Provider Services to open a closed panel when specific member needs are identified. We understand that panels may only be open by provider request. The interface with Provider Services continues as we send the file back for closing. The Department's OnBase workflow management system will be used to complete all processes.

The customer's need for information is central to the call center responsibilities. Benefit and program requirements are complex. We will respond to member questions and requests for information at the time they place the call, reducing the need for returned calls and avoiding missed calls. All information will be available electronically to our assistant health coaches and customer service specialists in easy to access formats allowing our staff to provide fast and accurate answers.

Selections of MediPASS providers are limited to physicians classified as general practitioners, family practitioners, pediatricians, internists, obstetricians or gynecologists, unless otherwise approved by the Department. Specialty providers are approved by the Department, on a case by case basis in order to maintain existing patient/physician relationships; in the absence of other MediPASS providers in the medical service area; when there is an exceptional need by a member for a specialist's care due to a particular health condition; or when a physician who is classified as a specialist maintains a general practice.



Contractor Responsibilities (6.5.1.2)

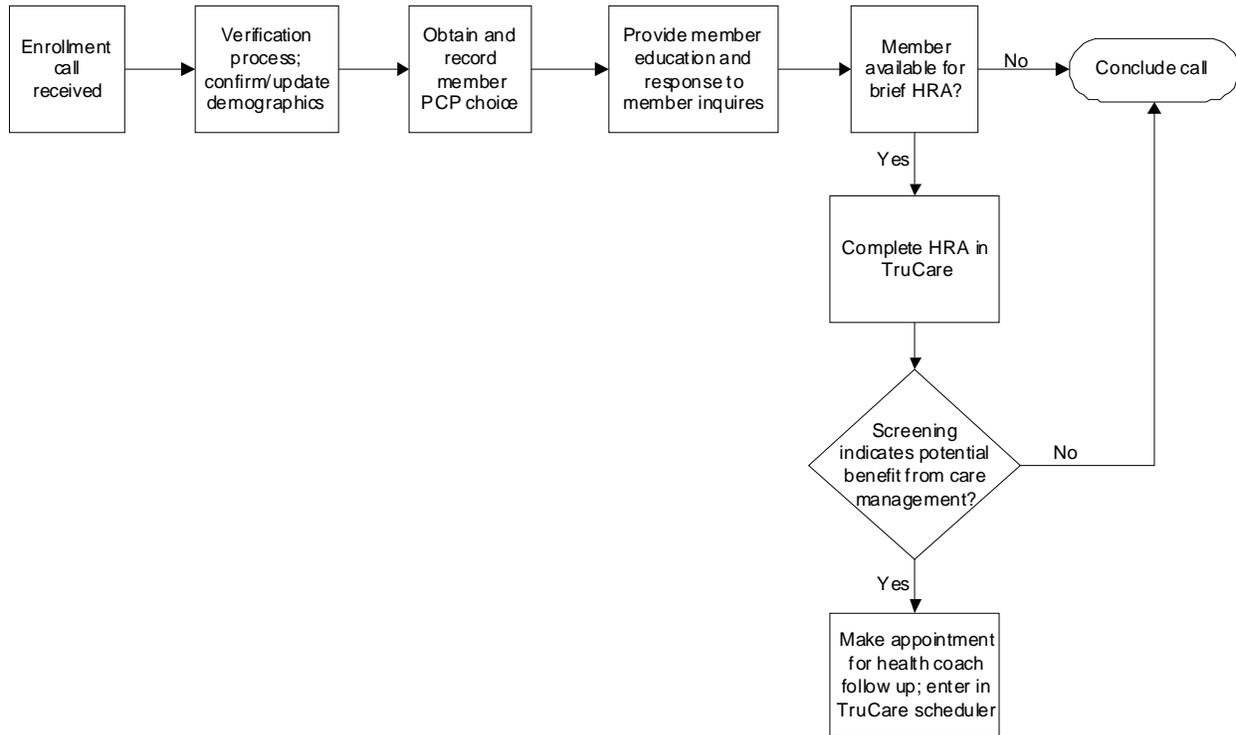
MHC Enrollment Process

Our call center staff will complete all MHC enrollment and disenrollment for members. As we complete our caller verification process, we will use the efficient online card replacement application (OCRA) process to immediately notify the member's Income Maintenance Worker (IMW) of any demographic change. This process facilitates having the most current member information available to all Medicaid functions as the IMW updates SSNI which informs MMIS of pertinent member information. Although the OCRA process was designed to facilitate notification of a member's need for a replacement card, it has other valuable uses as a communication tool with IMWs. The Member Services contact with the member presents an opportunity to obtain current and accurate contact information for the member.

We will create an enrollment packet for each member advising them of the provider who has been selected as their MHC provider. All membership materials will be written in easily understood language at the fourth to sixth grade reading level and provided in English, Spanish and other prevalent languages as directed by the Department. Our response to 6.5.1 y describes IFMC's process to ensure that written materials are clear and easy to understand. The MediPASS member handbook will be included in the mailing and members will be encouraged to make an informed choice. We will collaborate with the mailroom staff to send these mailings.

Materials will be selected for mailing depending on the member's status as a new MHC enrollee or a returning one. We recommend changes be made to the Your Choice booklet to include information on disease management and wellness again using our process to develop user friendly materials. We will include a short HRA to be completed and returned to Member Services. Returned HRAs will be an additional opportunity for member and health coach engagement.

MHC Enrollment and Care Management Screening



Our assistant health coaches will take an additional step of calling members who have not made selections to allow them further opportunity for primary care provider selection, education and assistance in managing their health care decisions. Members who do not make a selection of a primary care provider will be enrolled with the provider selected by the MMIS algorithm. Per current protocols, we will contact members again in six months by letter offering the opportunity to change MHC provider.

Our call center staff will listen attentively and track concerns expressed by members regarding access to providers. Our experience as the vendor for the Quality of Care program will inform our coordinating efforts with Medical Services and requests for provider change.

Member Call Center and Education

IFMC has demonstrated experience in managing successful call centers for the Oklahoma Medicaid program and numerous commercial clients served by IFMC’s ENCOMPASS call center.

IFMC will operate the Member Services call center during business hours of 8:00 a.m. to 5:00 p.m., Monday through Friday. Our call center staff will have a customer service orientation and



will seek to assist members by processing MHC enrollment changes in accordance with Department rules. Our call center staff will use an online tool with search capabilities to assist members with their questions. This will allow all call center staff to provide accurate, consistent and timely responses. Using online reporting features, we will complete all required reports regarding MHC activities including monitoring enrollment files provided by Core and reinstatement of members with previous providers in compliance with MHC rules.

Our trained call center assistant health coaches and customer service specialists will answer member questions regarding program policies, compliance with MHC rules and provider selection. As members are asked their choice of a primary care physician, they will also be asked if they would participate in a brief HRA as described above.

Ongoing member education will occur upon request from the member and as part of specified targeted education outreach programs as described in 6.5.3.2. Our staff will provide individual member education and document each interaction. Education topics will be directed at specific disease state concerns expressed by the member or general preventive and wellness oriented practices:

- Smoking cessation
- Alcohol moderation
- Exercise
- Depression screening
- Well child screenings
- Childhood immunizations
- Flu vaccinations
- Mammograms
- Colorectal screening
- Cholesterol screening

Our previous experience with the MHEP and lock-in programs will facilitate a seamless collaboration for enrollments and disenrollments in MediPASS as members move in or out of the restrictions of the lock-in program. As a member cannot participate in the MediPASS and lock-in programs simultaneously, we will disenroll the member in MediPASS in MMIS File 16 one month prior to the lock-in start date to ensure the lock-in restriction will begin timely and re-enroll the member in MediPASS following successful completion of lock-in.

Our MediPASS Quality of Care experience will also promote a successful collaboration with Medical Services to facilitate referrals for consideration of special authorizations.



Provider Updates

Our approach to the provider update functions will include collaboration with Core and Provider Services to maintain current provider lists specific to locales for inclusion with the enrollment mailing. We are familiar with eligibility rules and will follow all protocols for inclusion or removal of a member from a MediPASS provider's member list, thereby opening more slots for other members. Documentation to support the smooth functioning of the MediPASS program will be maintained in workflow systems.

We will translate our customer service experience of mass changes for Remedial providers and home health agencies to the tasks needed for implementing mass changes in MediPASS enrollment. We will assign provider specific customer service specialists who will communicate with providers, secure detailed information about their transition situations, and enter the information as needed in Department systems. IFMC's established relationships and collaboration with Provider Services and Core will ensure a smooth and timely transition for providers and Medicaid members.

Our data management will ensure duplications are resolved, overlapping enrollment segments are eliminated and data tables are updated annually.

Communications and Reports

IFMC's approach to mailing materials always includes IQC processes of ensuring correct address information and inclusion of the correct enclosures. We will assemble materials for enrollment packets with instructions to the mailroom staff on the requirements of each mailing. IQC review will be completed on a sample of each mailing, with expansion of the sample if problems are found. The same processes will be followed when members are provided written information informing them of the option of changing providers after each six month period.

Our medical staff remain apprised of healthcare trends, best practices and state and federal regulations through our contact with cutting edge organizations. Our medical director and program staff will advise Department policy specialists of needed changes in the Medicaid program that will promote quality care and member health, reduce costs and facilitate compliance with state and federal regulations. We will also use the information to create effective educational materials following the principles outlined in our response to 6.5.3 and 6.5.3.2.

Some of the resources IFMC routinely review through webinars, white papers, and research study reports 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

IFMC will listen to members and the provider community. Results of member assessments and our interactions with members and their providers will also provide information that will assist the Department in providing a Medicaid program that promotes compliance with current health care standards.

IFMC will leverage our experience in assisting the Department with state and federal audits to respond to any reviews or audits that require Member Services' participation. Our approach includes assigning an audit team lead, reviewing audit requirements, creating checklists of required materials and submitting all materials within required timeframes.

IFMC will continue to meet all timeframes for required reports. Our system includes the creation of a table tracking all required reports. This process assists us in tracking report due dates and submitted dates. Operations managers complete all required reports, submit them to the account manager for final review, post reports on IME universal drive, update the tracking log and inform the respective policy specialists of the availability of the completed reports.

Conflict of Interest Safeguards

IFMC understands today's concerns regarding conflicts of interest and the Department's obligation to ensure program transparency. Our approach outlined below assures the Department that safeguards are in place to complete member enrollment activities free from potential conflicts of interest.

IFMC is independent of any managed care organization, prepaid health plans, primary care case management or other health care provider. We will not utilize a subcontractor to act as an enrollment broker.

It is the policy of IFMC to avoid any conflict of interest or appearance thereof between an employee's own personal, professional or financial interests and the interests of IFMC, in any and all actions taken by the employee on behalf of IFMC including activities completed as part of IME operations. In the event that any IFMC employee or a member of his or her immediate family has any direct or indirect interest in, or relationship with, any individual or organization which is in or proposes to enter into any business transaction with IFMC (representing the Department), then such employee shall complete a Conflict of Interest Disclosure Form and refrain from acting upon the particular business transaction in which he/she has an interest or attempt to influence a decision in the business transaction.

All staff working on the member services team will be screened for potential conflicts of interest with Iowa Medicaid. Our detailed orientation process further delineates examples of potential conflicts of interest and requires attestation by the employee that no such conflicts exist. This



attestation is reviewed by the operations manager and employee annually at the performance review and the employee is required to again attest that no conflicts of interest exist.

Our staff will comply with all requirements including 41 USC 423 and 42 CFR 438 and ensure that they will not benefit from any choice a member may make regarding selection of a primary care physician. For members who do not choose a primary care physician during their enrollment period, the default assignment will be made using an automated process completed by Core.

IFMC staff will provide unbiased assistance to members who call to inquire about the MHC programs and to register their patient care manager selections. Our call center staff will enroll members with the provider of their choice in the order in which they apply. Call center training will include identification of enrollment concerns that would indicate improper enrollment activity. IQC activity will include monitoring calls for prevention of discrimination against potential enrollees on the basis of health status. Ongoing IQC will also screen for signs of improper activity.

If an employee is aware of potential conflicts of interest that exist elsewhere, the employee is encouraged to submit a report through the IFMC Compliance Hotline, a confidential option for any whistle blower activity. IFMC corporate management will then report anonymous concerns to the IFMC Member Services account manager for appropriate follow up with the Department.

IFMC ensures that no representative of IFMC has been excluded from participation under Title XCVIII or Title XIX of the Social Security Act, has been debarred by a federal agency, or has been or is subject to civil money penalties under the Social Security Act.

IFMC forbids discrimination in all aspects of our work including enrollment activities carried out on behalf of the Department. Continued monitoring will take place through IQC review of enrollment activities to ensure that discriminatory actions do not take place.

IFMC administers a corporate compliance program to insure compliance with all applicable federal, state and local laws and regulations.

Enrollment Functions and Communications with Members

Health insurance programs can be complicated and it is our job to assist Iowa's Medicaid members in understanding their rights and responsibilities as health care consumers. Our approach to effective member communication either through calls or written materials is described below.

IFMC's call center training will enable our staff to effectively engage members by listening to their concerns regarding primary care provider selection and other benefit related questions. We also support our call center staff by providing online scripts to enable them to provide courteous, helpful, accurate and consistent responses to member requests for assistance. Scripts will also



assist our call center staff in providing unbiased assistance to members who are requesting help in selecting a MediPASS primary care provider.

If during the course of communication with members it is determined that English is not the member's primary language and effective communication in English is not possible, we will access either the Spanish speaking assistant health coach onsite or the language line for interpretation services. We will also access the telecommunications device for the deaf (TDD) line for members who are hearing impaired. Members will not be charged for these services.

Importance of Health Literacy

Health literacy is a focus of IFMC and our approach to member interactions. Without complete understanding of medical directions, members are not able to make good decisions regarding their health care and, subsequently, are not able to give informed consent. Language barriers, hearing impairments and the inability to understand written communications impact the member's ability to apply important information to their health related decisions.

Our call center staff and health coaches will assist members with understanding the Medicaid program and health related information. People who struggle with reading have many ways of avoiding written materials. Responses such as, "I broke my glasses" or "reading gives me a headache" will be clues to our call center staff and health coaches that the member may need materials to be read to him or her.

As we strive to promote health literacy, IFMC will provide written information to members in a format that is easy to understand and helps them with their concerns. Written information will also be made available in Spanish and additional languages as requested by the Department.

We will use plain language communication that users can understand the first time they read it. According to the U. S. Department of Health and Human Services' Office of Disease Prevention and Health Promotion, key elements of plain language include:

- Organizing information so that the most important points come first
- Breaking complex information into understandable chunks
- Using simple language and defining technical terms
- Using the active voice

Our Member Service activities will provide an opportunity to promote health literacy. We have attended health literacy conferences and have researched methods of creating effective educational materials. Medline Plus, a service of the U. S. National Library of Medicine and the National Institutes of Health (NIH) suggests the following strategies in creating written materials:

- Keep within a range of a fourth to sixth grade reading level.
- Focus on a few key concepts.



- Use a clear topic sentence at the beginning of each paragraph. Follow the topic sentence with details and examples. For example, "Proper use of asthma inhalers helps you breathe better. Here are reasons why." Then give reasons.
- Use the "you" attitude. Personalization helps the reader understand what he or she is supposed to do.
- Do not make assumptions about people who read at a low level. Maintain an adult perspective.
- Find alternatives for complex words, medical jargon, abbreviations, and acronyms. When no alternatives are available, spell complex terms and abbreviations phonetically and give clear definitions.
- Keep most sentences short. Use varied sentence length to make them interesting, but keep sentences simple.
- When possible, say things positively, not negatively. For example, use "Eat less red meat" instead of "Do not eat lots of red meat."
- Use colors that are appealing to your target audience. Be aware however, that some people cannot tell red from green.
- Use pictures and photos with concise captions. Keep captions close to graphics.
- Balance the use of text, graphics, and clear or "white" space.
- Use bolded subheadings to separate and highlight document sections.

Department approval will be obtained prior to dissemination of materials.

Providing Information to Member

Although IME’s managed care model is not unduly complicated, it can seem so to new Medicaid members. IFMC’s approach for providing important information to members will meet the Department’s requirements for transparency, compliance with federal regulations and effective member communication. The following table summarizes the features and benefits of our approach:

Features	Benefits
Written communication in plain language	Informed members better able to make effective health care related decisions
Phone assistance regarding MediPASS benefits, rules, restrictions and grievances	Timely assistance to members’ most pressing questions
Experience in working with previous managed care entities in Iowa	Informed processes for assisting members
Annual informing in accordance with 42 CFR 438.10 (f) and advanced directives as specified in 42 CFR 438	Compliance with federal regulations and facilitation of an informed membership



Features	Benefits
Processes of timely and effective responses to member concerns, inquiries and appeals/grievances	Compliance with informing requirements of right to a hearing, method to obtain it, representation rules, timeframes, availability of assistance, toll-free number, continuation of benefits and potential requirement to pay
Experience with Quality of Care program applied to good cause disenrollments	Disenrollment only in situations of untimely service, inaccessible provider, insufficient quality of care, specialty care need not being met, member move, or religious/moral conflicts with providers
Health literacy concerns addressed: Availability of non-English speaking providers; information explained at the time of member call or in response to an email or letter or available in other forms	Informed membership capable of making good choices and proactive health care related decisions

Currently the Department does not have Medicaid MCOs, PIHPs, or PAHPs. The PCCM program is available in 95 counties, although there are a few MediPASS counties without participating primary care providers. Annually, we will provide notification to all PCCM members regarding:

- Benefits
- Disenrollment rights
- Rights and procedures to obtain information about covered services and available provider lists (i.e., including non-English speaking providers)
- Restrictions on choice of providers
- Enrollee rights, responsibilities, and protections
- Grievance reporting
- Out-of-network benefits (i.e., family planning services)
- Emergent situations and procedures for after-hour and emergency services

Timing is important to enable potential MHC enrollees to make informed decisions and to take advantage of the opportunity to enroll with a PCCM. Members will be given MHC information at the earliest opportunity of either the option for voluntary enrollment or, if required, mandatory enrollment.

Member Services will work closely with Medical Service’s quality of care team as they prepare the annual MCO/PCCM report card. This comparative information will be made available in an easy to understand format for members. Enrollment information will also be provided to members in an easy to read format that allow them to compare providers and to make the most informed decision possible.



Support of Medical Home and Disenrollment with Cause

IFMC's approach to member enrollment and disenrollment is based on our understanding of the importance of maintaining a relationship with a primary care provider (i.e., medical home). We support members remaining with primary care providers they trust and with whom they have established a relationship. Our member education advises members to select one primary healthcare provider to ensure quality of care and avoid inadvertent harmful outcomes resulting from lack of care coordination.

We will prioritize enrolling members with a provider with whom they have a previous history. Changes may be made to expand the capacity of a particular provider panel upon request by the provider in order to preserve the continuity of the doctor patient relationship. Default assignments and exclusions will be completed as needed by the MMIS algorithm. However, our call center staff will know the specific criteria excluding members from mandatory enrollment allowing them to note any discrepancies as we process members selected for enrollment.

We understand from our current experience in enrolling and/or disenrolling lock-in members that each monthly deadline must be met for the assignment to be effective in the following month. We will process requests for disenrollment when Department rules allow or when good cause criteria are met:

- Untimely service
- Inaccessible provider
- Insufficient quality of care
- Inadequate care
- Need for specialty care not met
- Member moves out of the service area
- Religious/moral conflict with the provider
- Department imposed sanctions

Changes in PCCM may be made within the first 90 days of enrollment and we will facilitate all member requests. Our staff will provide members with any needed assistance in choosing a new provider and facilitate the change to minimize disruption to the member. Written requests will receive a written response.

IFMC's proactive approach to provider selection and enrollment will serve to minimize requested changes by facilitating members making informed decisions initially regarding choice of PCCM.

Requests for disenrollment may also be submitted by providers. Providers will not be allowed to disenroll members due to a change in a member's health status, increased utilization of services, or disruptive behavior attributable to special needs. Exceptions will be granted when it is determined that the PCCM's ability to provide services to the member or other members is seriously impaired.



Written notifications will meet all timeliness requirements including notice of the disenrollment option at least 60 days prior to the six month disenroll/enroll period. Members will be provided appeal rights when a determination is made that good cause disenrollment criteria are not met.

Member Rights and Responsibilities

As the Member Services vendor, we understand that the Department has delegated important responsibilities to us including ensuring that members are informed of their rights and responsibilities. Our focus on health literacy supports our efforts to inform members in a timely manner through clear communication. We understand the importance of informing members of their rights to:

- Be informed of the basic rules and benefits available in a manner that the member can understand
- Be treated with respect and with consideration for privacy
- Receive information on available treatment options and alternatives in a manner that the member can understand
- Participate in decisions regarding health care, including the right to refuse treatment
- Be free from any form of restraint or seclusion used as coercion, discipline, convenience, or retaliation
- Request and receive a copy of his or her medical records and request that they be amended or corrected as specified in 45 CFR 160 and 164
- Receive timely, appropriate and accessible medical care
- Obtain a second opinion
- Choose a provider from the available managed care providers or change a provider as allowed by program policy
- Appeal any adverse action
- Be treated without discrimination with regards to sex, age, race, national origin, creed, color, physical or mental disability, religion, or political belief
- Receive health care services in accordance with MHC rules
- Exercise rights without adversely affecting the way the providers or Department treat them

Members will be informed of all of the above rights and encouraged to exercise their rights on the basis of informed consent. In our communications with members, we will place special emphasis on describing member rights and responsibilities.

Performance Standards (6.5.1.3)

IFMC will obtain Department approval of a report card format tracking compliance with all performance standards.



Upon receipt of the daily update file, designated staff will assemble enrollment packet mailing materials. IFMC will mitigate disruption to completion of this task by cross training staff and reassignment of staff as needed.

Our billing specialist will complete daily assignments to staff to validation activities of provider enrollment overrides. Again, staff will be cross trained to ensure timely completion of tasks and reassignment will be completed as needed to ensure business continuity.

MEMBER INQUIRY AND MEMBER RELATIONS (6.5.2)

IFMC understands the importance of effective customer service:

- Understanding member concerns
- Accuracy and timeliness of response

Our approach to the Member Inquiry and Member Relations functions will illustrate our commitment to customer service and the benefits of having informed membership. Our Member Services team will include a billing specialist to support member claims inquiries. This specialist will resolve member inquiries regarding claims, complete coverage certifications, data entry, and file updates. Our team will also include five assistant health coaches and five customer service specialists. These team members will conduct call center activities, responding to member inquiries, MHC enrollment, member outreach, member screening, educational mailings, Medicare Part A and B buy-in and file updates. We will apply our experience with current OnBase Workview and Cisco reporting capabilities to produce accurate and timely reports regarding all member inquiries, enrollment and education activities.

We also are focused on providing the Department the most complete information to use in making decisions for the Medicaid program. Member perceptions and responses will inform IFMC and the Department of possible program enhancements to better serve Medicaid members.

“Every time I’ve needed help you guys have been there. I thank you so much on all you’ve done. Great job from all of you!”
Comment from Medicaid member, SoonerCare Member Survey, July 2009

Contractor Responsibilities (6.5.2.2)

Customer Service

Members and their representatives will have questions about Medicaid benefits, liability for claims and access to care. IFMC processes will provide accurate, documented responses to member inquiries. The following table summarizes the features of our customer service approach and the benefits to the Department and individual members:



Features	Benefits
Research completed by experienced staff; IFMC experience with claims processes	Best information provided to members
Scripts provided for frequent inquiries	Accurate and consistent responses
Compliance with URAC standard of response within one business day unless additional research is required	Prompt attention to member concerns
Actions tracked in Workview	Department oversight through activity reports
Follow up calls made within two business days	Increased opportunities for successful resolutions
IFMC familiarity with Cisco phones and reporting capabilities	Complete, accurate and timely reports
IFMC knowledge of Long Term Care Programs	Members have accurate information to make service choices

Member inquiries will be tracked from receipt through resolution. Cisco telephone system and Workview reports will assist us in identifying any steps that exceed timeliness guidelines and taking corrective measures, as appropriate.

The following is a sample tracking and report format for member calls. The suggested format will be presented to the Department for approval.

Member Calls	
Measures	Results
Number of calls received	
Calls answered	
Calls abandoned	
Calls answered after time threshold	
Calls abandoned after time threshold	
Service level	
Percent answered	

Information of value to the Department regarding member perceptions and needs will also be reported. Reports will be created utilizing drop down boxes for topical identification of member call reasons and staff responses. Member concerns will be tracked and trended.



Privacy and Caller Validation

We will assist all customers through the member call center within the specified hours of 8:00 a.m. to 5:00 p.m. on IME business days. Calls will be received from Medicaid and IowaCare members, their representatives as determined by case identification protocol, as well as Department personnel. We will also accept calls from people who are currently not members but want to know the steps to becoming a Medicaid member. A message will be recorded to greet after hours callers (in English and Spanish) and inform them of the call center availability.

Our trained call center staff will follow established protocols of caller verification to ensure the member's privacy. Demographics displayed in MMIS member eligibility file 10 will be verified and changes reported to the member's IMW using the OCRA system.

Our claims specialist will review MMIS claims for inquiries that require additional research and contact providers if needed to assist in resolving claim-processing problems. Written responses will be made to members providing them with information to support a potential appeal. Standard content of all written notices will be forwarded to the Department for approval.

Our trained staff will respond to member inquiries without transferring the call. When additional research is needed, we will respond to members within two business days. If the member can not be reached by telephone within two business days, we will provide a written response to the inquiry.

Designated staff will be assigned to complete daily certifications of coverage within Department timeframes. IQC will be completed on a sample of letters ensuring compliance with HIPAA guidelines. A form letter, approved by the Department, will be sent upon request. All certificate activities will be tracked and reported.



Member Concern Solutions and Reports

As we provide customer service, we will become better informed about member perceptions and needs. Member access to information is vitally important. IFMC will use data obtained from our interactions with members to assist us in developing recommendations for program improvements that will lead to increased member access.

All member inquiries will be tracked in OnBase Workview and will include the ability to pend entries until the issue has been resolved. We will maintain call logs identifying the reason for the member's call and how the inquiry was resolved. Logs will be populated by selection of drop down menus. All written correspondence will be retained in OnBase and tracked through reporting mechanisms.

Daily reports will be produced from the telephone system indicating the type of inquiry based on member selection of telephone prompts. Daily reports will provide us with proxy measures to help us continuously evaluate our compliance with performance standards.

We will have Spanish speaking staff who will receive calls as directed by the telephone system menu prompts selected by the member. Members requiring other languages will receive a response through translation services available from the Language Line. Our trained call center staff will also access TDD capabilities for members who are hearing impaired.

Written responses (in plain language) will be sent to members regarding bill inquiries within 20 business days of receipt of the initial inquiry. Form letters will be approved by the Department. IFMC's IQC processes require that letters receive a second level of review to ensure accuracy of information prior to dissemination.

Collaboration with other involved parties has been a consistent part of our care management programs. In response to the Member Inquiry and Member Relations functions, we will communicate with member IMWs and case managers to ensure continuity of care for Medicaid members. We will also communicate with providers who inquire on behalf of members.

Performance Standards (6.5.2.3)

The following is a sample report format for tracking compliance with all performance standards.



We will obtain Department approval before finalizing the report format.

Member Concern Solutions Performance Standards	
Measures	Results
Complete 95 percent of telephone inquiries within 48 hours (otherwise forward to the Department)	
Provide written response to bill inquiries within 20 business days	
Maintain service level of 80 percent or higher	
Respond to written inquiries within five business days of receipt (interim response if not able to fully respond, subsequent responses every five days)	
Provide final resolution to written responses within 15 business days	

Strategies to ensure successful completion of performance standards include:

- Cross trained staff for required functions
- IQC processes for written and telephonic responses
- Automated system reporting through phone and OnBase reports
- Proxy measures alerting us about needed corrective action to improve performance

MEMBER OUTREACH AND EDUCATION (6.5.3)

Members are our most important data source. Member inquiries, comments and results from the Member Quality Assurance survey will provide us with data needed to evaluate member perceptions of Medicaid services. The results of the survey will drive our development of member outreach and education activities.

IFMC’s approach to member outreach and education focuses on providing information to members assisting them with appropriate utilization of Medicaid services. Outreach and education materials will be developed in an easy to read format and will be targeted at health concerns of specific population groups.

We will promote the use of the Member Services website to members who call or write with inquiries. Member access to computers and websites is increasing; members may access the IME website through their local public libraries. We will inquire regarding the member’s access to the IME website and offer to provide the link on each call. We will collaborate with the IME webmaster to maintain the IME member website with helpful information and for member access.



Contractor Responsibilities (6.5.3.2)

Outreach and Education Objectives

Having an informed member population is a pre-requisite for achieving improved health status for IME members. Our solution to the outreach and education requirements supports the Department objectives of having informed, educated members empowered to make health lifestyle and health care choices. A summary of the features and benefits of our approach is provided below:

Features	Benefits
Health literacy evaluation of all written materials	Informed members make healthy choices and avoid costly services
Education focused on choosing one primary care provider and pharmacy	Coordinated care avoids unintended outcomes and potentially harmful drug interactions; reduced costs
Education regarding complying with follow up appointments and medication instructions	Successful interactions with providers; cost avoidance related to non-compliance

IFMC will represent IME Member Services on behalf of the Department. External entities may include other departments such as the Iowa Department of Public Health, CMS, or OIG auditors.

We will send publications to members to promote increased knowledge of the Medicaid program and compliance with established health practices. Information will also be provided through the IME member website and upon approval from the Department.

Information on the member website will include helpful links. The current section entitled “Getting the Most Value from Medicaid” has good content, but is not user friendly and does not address health literacy concerns. We will re-design this page to catch member attention:

- Each tip will lead with a headline message that is emphasized with font size and color
- Sentences will be shorter and less complex
- Make a visible entry on the Member Services link highlighting Ask Me 3, a national program of consumer education assisting people in receiving more effective health care provider instructions and increasing compliance

Department publications will be evaluated annually for compatibility with member health literacy. In addition, IFMC will obtain input from provider representatives, such as the Medical Services Clinical Advisory Committee. Any recommended changes will be submitted for Department approval.



IFMC will create and publish a provider directory for members and promote the website link that enables members to search for a provider online. All member publications will be completed in collaboration with the mailroom staff at IME. Copies of all publications will be available to members in the lobby of the IME building.

As an added benefit, a pamphlet developed by our maternal health care management program will be included with each Healthy Start mailing.

Our staff have collaborated to produce articles for inclusion in the member newsletter and we welcome this opportunity to provide members with needed information about their insurance as well as information to help them be better informed health care consumers. Potential articles include:

- Ask Me 3 questions for health care appointments
- Preventive care
- Influenza vaccinations
- Use of over-the-counter medications
- Common cold prevention
- When it is time to go to the emergency room
- Dental care
- Choosing a primary care provider

Our seasoned medical staff will glean additional ideas for member education from their daily interactions with members.

Department reports detailing member communication activities, including website interactions and publication mailings, will be provided and include recommendations for improvements in member education modes and materials.

We understand the importance of communicating with member IMWs and case managers. We will use the OCRA process to communicate with IMWs. Based on our experience with ISIS, we will obtain the identity of the member's case manager and his/her email via the hover function.

Monthly communication activities will include welcoming members into the Program of All-Inclusive Care for the Elderly (PACE) program by sending the introductory booklet and cover letter.

Monthly reports will be completed on or before the fifth business day of the month. The reports will include Member Services activities (i.e., number of mailings, number of calls received, types of calls, calls answered or abandoned, etc.).

Information for the member website will be submitted to the IME webmaster within three business days of securing approval by the Department. As described previously, website information will be re-designed in accordance with health literacy standards.



Targeted Education

The Department’s re-alignment of Member Services functions promotes increased opportunities for effective health related education. Our medical staff will submit recommendations to the Department for implementation of educational programs targeted at specific member populations. Possibilities include:

Targeted Population	Educational Opportunity
Parents:	Well child screenings; vaccinations
Persons 55 years of age or older:	Preventive care
Women 40 years of age or older:	Mammograms
Men 50 years of age or older:	Prostate exams
Persons with diabetes:	Diabetes education
Persons with asthma:	Asthma education
Adults:	Depression symptoms

Our care management programs will implement targeted member education programs addressing topics such as:

- De-stressing mental health strategies
- Healthy eating for persons with diabetes
- Mental health screening for the elderly
- Effective management of asthma
- Heart healthy exercise

All targeted education programs will receive Department approval prior to implementation.

Performance Standards (6.5.3.3)

Member information and education are priorities for our health management programs. Education activities will be directed by our medical director and carried out under the supervision of operations managers. Performance standards will be tracked by operations managers using methods previously described.

We will submit information for the member website within three business days of approval by the Department.

We will present no fewer than six recommendations annually to the Department with the objective of broadening the scope of field communications. Written materials must be catchy and easy to read with color and white space.



Possible topics include:

- The national Ask Me 3 campaign addressing health literacy
- An over-the-counter medication guide
- A checklist for making a decision about accessing emergency room care
- Vitamins from food
- Signs of depression

Our medical staff will present educational information at a minimum of two provider association meetings annually. Possibilities include home health providers, case managers, remedial providers, nursing home associates, federally-qualified health centers, and Provider Services education seminars.

Our medical staff will develop at least six recommendations for member educational programs targeted at specific member populations. We will seek Department approval of all proposed programs. Targeted populations will be selected from our care management programs (lock-in, disease management, EPCM) or claim queries based on recent diagnosis or procedures.

Possibilities include:

- Exercise for the elderly
- Recovery from surgery
- When to call the doctor about your child
- Managing allergies

MEMBER QUALITY ASSURANCE (6.5.4)

IFMC will provide the Department all necessary support in the management of quality oversight for IME programs. Our approach to quality assurance activities will include subcontracting with a recognized expert in surveys and data collection. Essman Research, an Iowa-based company, will be retained to conduct the Member Services satisfaction survey. Essman Research has experience with IME in conducting the provider survey. They will advise the Department and IFMC on the appropriate measures for member satisfaction with administrative services and awareness of Member Services functions. Department approval will be obtained for the survey and research protocols. Additional information about Essman Research is included in Tab 8.

Contractor Responsibilities (6.5.4.2)

Member Survey and Recommendations for Improvement

Medicaid members are IME's most important customers. We will collaborate with the Department and our subcontractor, _____, to produce a member survey to measure satisfaction with access to care, quality of care, quality of customer service, and responsiveness of IME. The survey will be constructed in an easy-to-follow format and will be written at a fourth to sixth grade reading level.



Our plan for the annual survey includes a statistically valid sample of members including managed care and fee-for-service groups. All data sources will be used to determine relevant and appropriate questions. In particular, call center reports will inform us of member concerns, such as:

- Patient manager quality of care
- Access to providers
- Language barriers
- Transportation
- Continuity of care
- Specialty access

As described previously, member complaints will be recorded in the OnBase Workview system. Complaints received from member in-bound communications of calls and letters will have trend analysis and will be used to inform us of member concerns. Other sources of information will include MARS reports, claims, and encounter data.

Annual survey tools will be developed in collaboration with the Department and utilize the expertise of . Questions will be selected on the basis of their relevance and reliability. Each question will be correlated to a specific measure.

We recommend that the annual survey take place each year in March. This is a time of year (before the school year ends) when members may be less distracted by other obligations. It would allow time for member response, analysis of results, compilation of reports, and inclusion in the annual report that is due October 15. Implementation of the survey will occur in accordance with Department-approved protocols. Survey results will be tabulated in a database and relate results to predetermined measures. A sample of survey results will receive IQC review for accuracy in tabulation.

We will use the expertise of the survey vendor to evaluate the results of the annual survey and assist us in providing the Department with informative and valuable reports. Responses will be tabulated and reported in a Department-approved format. The report will include an analysis of the results and recommendations for improvement to the Medicaid program to more effectively serve members and achieve positive health outcomes. In addition, the results will be used to help IFMC improve our Member Services activities.

A Complete Solution for Quality Assurance

As the QIO for Iowa and Illinois, IFMC brings vast experience to quality assurance activities. Our quality assurance solution will ensure the Department has needed information to make program management decisions that facilitate quality care for members, a fair return for providers and wise management of financial resources. The following table provides a summary of the features and benefits of our approach:



Features	Benefits
Experience with Quality of Care MHC reporting	Facilitated report completed accurately and in timely manner
Call center OnBase reports and member reported complaints	Data informs of member perceptions and concerns
Evaluation of claims and encounter data and MARS reports	Provides additional support information regarding quality of Medicaid program
Stratified data regarding member responses from managed care and fee-for-service populations	Assists the Department in defining program guidelines and ensuring adequate services for multiple populations
Track and trend any differences using statistical comparisons	Provides the Department with evidence of findings and grounds for possible changes
Experience in responding to federal and state reviews	Successful partnership with the Department; audit support
Experience with IME interfaces	Informed Department staff and case managers promoting member support
PACE annual survey	Department evaluation of services
Annual member quality assurance assessment report compiled and including survey results	Informed Department regarding member perceptions, quality measures and potential improvements to enhance IME program

The member quality assurance assessment process will be the basis for recommended improvements. IFMC’s process improvement methodology dovetails with the Department’s desire for an assessment and improvement process. All recommended changes will be submitted to the Department for approval.

The annual member quality assurance assessment report will be submitted at the end of each calendar year or at a specified time as directed by the Department. Monthly meetings will be held with Department staff to review assessment activity and issues identified.

Performance Standards (6.5.4.3)

IFMC will manage and perform its responsibilities under the Member Services contract to ensure that we receive a rating of satisfactory or above on all member satisfaction survey questions related to timeliness of responses from the member call center and receipt of requested information. We anticipate that satisfaction surveys will confirm member satisfaction and awareness with IFMC’s services. If unsatisfactory ratings are received, IFMC will complete an action plan to address default areas. Member comments will be evaluated. Proxy measures through telephonic surveys may be implemented upon Department approval.



*Child Health Specialty Clinic nurses recognized the professional customer service provided by IFMC support staff. Their prompt facilitation of requests and making referrals to case managers allows the CHSC team to work more efficiently.
 May 2009*

MEDICARE PART A AND PART B BUY IN (6.5.5)

We will perform all required functions for the Medicare Part A and Part B buy-in. As dual eligibles, Medicaid members’ premium payments for Medicare A and B will be paid by Medicaid. We understand the importance of accuracy in verification of eligibility and validating members’ inclusion on CMS reports. IFMC’s approach includes reliance on our IQC sampling activities to ensure accurate and timely entries are made.

Contractor Responsibilities (6.5.5.2)

Designated staff will be trained in the Medicare buy-in processes and responsibilities. We will respond to all inquiries regarding Medicare buy-in issues, tracking caller representation and issues. We will utilize our call center IQC process to ensure accurate information is provided to all inquiries.

Errors noted on the Medicare buy-in report will be resolved within required timeframes and at the direction of the Department.

Performance Standards (6.5.5.3)

IFMC will meet all performance standards related to the Medicare buy-in operations. We will obtain Department approval of a report card format tracking compliance with all performance standards. The following is a sample report card for Medicare Part A and B buy-in performance standards. A sample report format is provided below:

Medicare Part A and B Buy-In Performance Standards	
Measures	Results
Complete 95 percent of requests regarding resolution of buy-in issues within five business days.	
Complete 100 percent within 15 business days.	
Complete resolution of monthly error reports within 30 days.	



Strategies to ensure successful completion of performance standards include:

- Cross trained staff for required functions
- IQC processes for responses
- Automated system reporting
- Proxy measures alerting us about needed corrective action to improve performance

LOCK IN (6.5.6)

IFMC has successfully managed the MHEP and lock-in program for more than 18 years including five years under the current IME contract. Although we have significant experience with this successful program, we continue to seek and find ways to improve it and secure increased value for the Department. Our approach offers the following enhancements to the current MHEP and lock-in program:

Features	Benefits
Certified Health Coach Review Coordinators	Increased facilitation of member healthy self-management; reduced wasteful use of resources
Predictive modeling process supplements claim algorithms	Improved identification of outlier utilization and members able to benefit from intervention
TruCare™ clinical care management software	Co-morbid conditions identified with appropriate clinical guidelines for appropriate care; improved quality of care and reduced waste
Current experienced vendor	Transition without disruption to members and providers

Contractor Responsibilities (6.5.6.2)

Improve Care and Health of Members

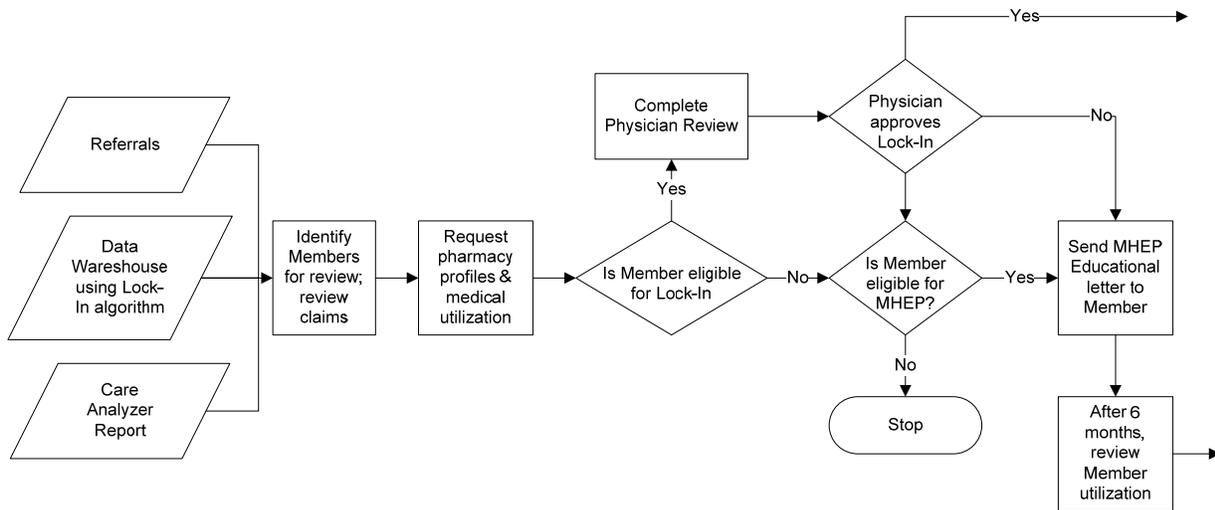
Our goal for the MHEP and lock-in program is to promote high quality health care and prevent harmful practices for MHEP and lock-in members. As in our other programs, we provide education to members directed at appropriate use of their Medicaid health care benefit by using one primary care provider who coordinates all their care and one pharmacy which oversees their prescription needs. These practices help members receive quality care and avoid potentially harmful drug interactions from receiving multiple prescriptions from multiple prescribers.

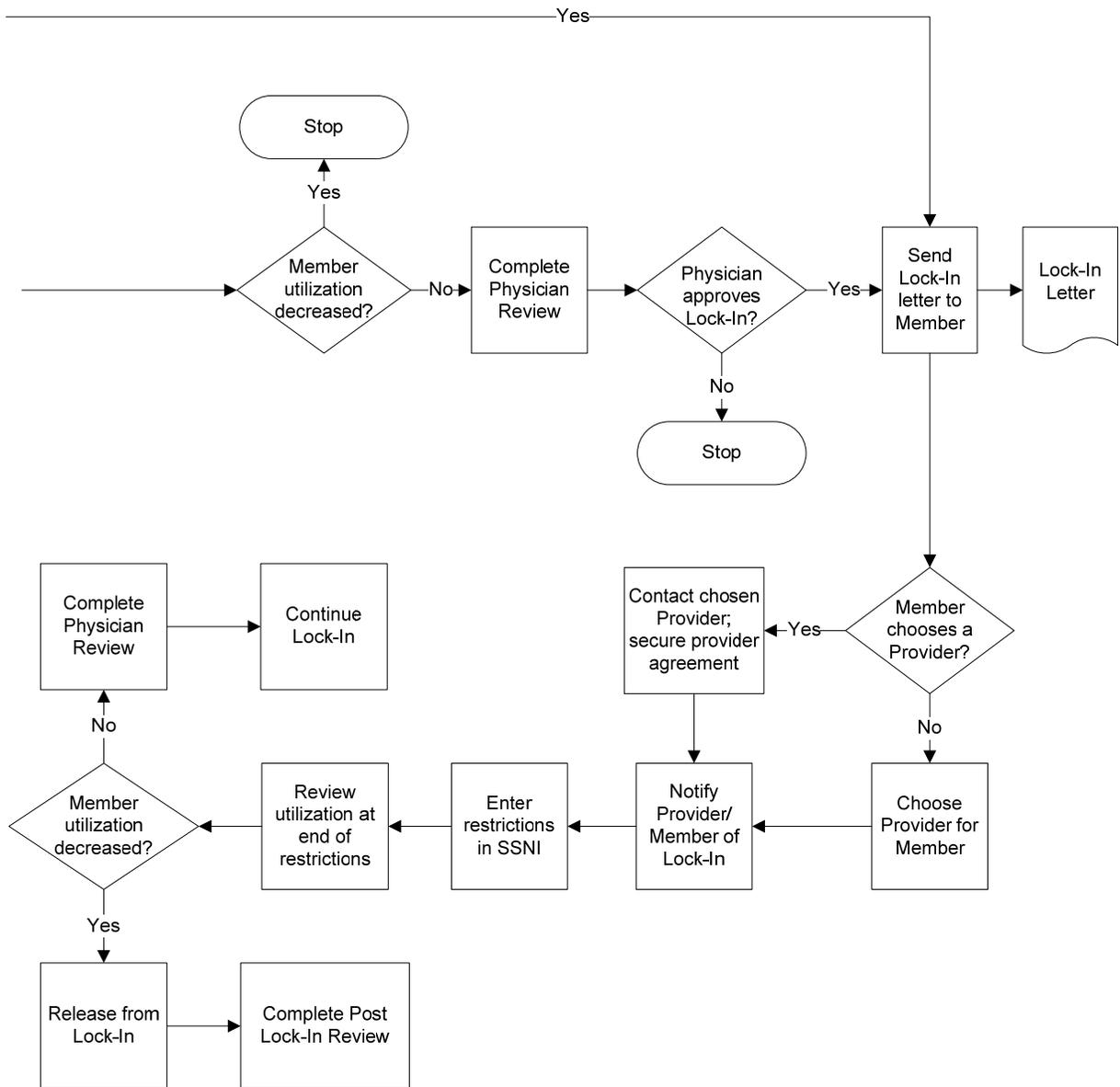
IFMC’s approach supports the goal of improved care and health through the use of trained health coaches. The focus is on serving a central role in implementing practices that improve the health of members with chronic conditions. Using evidence-based care, health coaches encourage members to lead healthy lives through self-management support. Health coach training is designed to enable care managers to become effective change agents and leaders through

understanding personality styles (their own and the member’s) and assist them with adopting better ways to approach their work. Participants in health coach training are required to pass a written and practical competency assessment before being awarded a certificate of successful completion.

The health coaches will use the TruCare™ member-centered database to track all member interactions. This will allow them to identify specific healthcare quality issues related to each member and provide targeted member education. Using this information, the Member Services medical director will provide consultation on best practices, preventive care, standards of care, and utilization. Communication and interaction will focus on securing member compliance with MHEP and lock-in rules as well as eliciting the commitment of the member to assume an active and positive role in managing his or her own health care and medical outcomes.

Below, a high level process flow describes the MHEP and lock-in program.







Selection Process

IFMC uses a combination of methods to identify potential members for MHEP and lock-in. We extract claims from the data warehouse based on an algorithm that evaluates the volume of utilization for each member for the following services and produces a weighting:

- Outpatient visits in a six month period
- Prescribing providers
- Prescriptions
- Controlled medications
- Pharmacies utilized
- Emergency room visits

Additionally, we will use CareAnalyzer for predictive modeling for the MHEP and lock-in program. The predictions from CareAnalyzer will be used to identify high-cost members whose health care utilization may be influenced by enrollment in the MHEP or lock-in program. The CareAnalyzer screen shot below illustrates one scenario. Selection of the Poly-Rx Management Report provides us with a report of members and conditions with high prescription utilization. Although most of these conditions are serious, the condition “ears, nose, throat/acute minor” with an average of five prescriptions may indicate potential concerns. Clicking on the report produces a list of 131 members including details regarding diagnosis, utilization, prescriptions and prescribers.



**DSTHS CareAnalyzer™
Poly-Rx Management**

Reporting Period: 01/01/2008 to 12/31/2008
 Line of Business: Medicaid
 Product Type: All
 Group Type: All
 Group: All

Code Type = RxMG, Product = Medicaid, Product Type = All, Group = All, # Chronic Conditions >= 1, Dollar Cutoffs = All

Condition	Member Count	Average Total Current (\$)	Average Total Predicted (\$)	Average Rx Current (\$)	Average Rx Predicted (\$)	Average # Scripts	Average # Prescribing Providers
Allergy/Immunology / Acute Minor	28,700	8,397	7,773	2,362	1,922	34	5
Allergy/Immunology / Chronic Inflammatory	37,790	6,401	6,380	1,478	1,321	22	4
Allergy/Immunology / Immune Disorders	86	52,432	36,498	20,268	8,273	69	7
Allergy/Immunology / Transplant	293	33,694	30,093	8,177	8,437	66	7
Cardiovascular / Chronic Medical	13,428	11,360	12,460	2,538	2,453	48	4
Cardiovascular / Congestive Heart Failure	1,911	24,143	24,279	4,629	4,176	77	6
Cardiovascular / High Blood Pressure	22,538	11,771	11,100	3,323	2,717	48	5
Cardiovascular / Hyperlipidemia	8,612	14,335	15,251	4,645	3,817	70	6
Cardiovascular / Vascular Disorders	2,637	24,342	21,644	4,879	4,094	75	6
Ears, Nose, Throat / Acute Minor	10,261	7,678	6,627	1,839	1,412	26	5
Endocrine / Bone Disorders	981	17,580	17,816	6,749	4,295	86	6

Our staff also accepts referrals from providers, pharmacies, and other Medicaid programs. Review is completed on 100 percent of referrals received.

Provider Recruitment

Our staff have developed positive relationships with Medicaid primary care providers across the state enabling us to effectively secure providers to serve as primary care physicians for lock-in members. After being selected for lock-in enrollment, members are offered the opportunity to identify the physician, hospital, and pharmacy they prefer. If the member does not identify a preference, a review coordinator health coach will assign providers based on member claims history and providers used most frequently. Our staff contact the providers to inquire about becoming a care provider for a particular member and to educate them about the lock-in program if they are new to the program. We have worked collaboratively with providers to ensure an excellent quality of care for members in the lock-in program and to support the providers that agree to participate with the member.

It is our experience that during the course of a member’s enrollment in the lock-in program, a provider may request removal as the restricted provider for a member or may no longer be able to serve the member. When this occurs, our review coordinator health coaches notify the



member that a new provider must be selected. If the member does not select a provider within three business days, we will recruit a replacement provider.

Our staff work on a daily basis with many providers who render services to members in lock-in. We participate in the Drug Utilization Review (DUR) committee meetings. The committee is comprised of physicians and pharmacists across the state of Iowa who may be used as resources when unable to locate a primary care provider. We also have been successful with recruiting providers from Federally Qualified Health Clinics. The current IME structure also facilitates collaboration between units and the ability to secure assistance from Provider Services.

Member Appeals

A member placed in lock-in has the right to an administrative appeal. When the appeal has been approved for a hearing by the Department, the Department of Inspections and Appeals is responsible for conducting the hearing and notifying IFMC in writing when the appeal hearing is scheduled. We prepare a summary and gather documents to support the decision to restrict the member to certain providers. Information that we used to make the restriction decision is submitted and provided to the member.

Our management staff and medical director and/or assistant to the medical director attend all administrative hearings via telephone and provide testimony regarding the lock-in selection and review process.

Complete documentation is essential to the appeal process to support the decision made by our physician reviewer to restrict the member to certain providers. We will assemble complete case information for each appeal hearing and provide this information to all parties, thereby reducing delays in the appeal process. Since 2007, there have been 16 appeals filed by members enrolled in the lock-in program. We have represented the Department in all cases and to date have decisions on all but two of the cases appealed. Since beginning IME operations, we have only received two decisions that were reversed by the administrative law judge. In all other cases the decision to restrict the member to certain providers has been upheld.

Education and Reviews

Upon identification of members who are over using medical services, our initial intervention is to provide member education about the appropriate use of their Medicaid health benefit:

Choose one doctor you trust and respect. By using one doctor you will receive better care to help prevent duplicating medications and treatments.

- If you need to see a specialist, your doctor will make a referral and arrange an appointment time.
- Follow your doctor's advice regarding diet, lifestyle and return visits.
- Take your medicine as your doctor prescribes.
- See your doctor when you are ill, but avoid unnecessary visits.



- Call ahead to make appointments. Be courteous and polite when making your appointment and when you are in the doctor's office.
- Notify the doctor's office 24 hours prior to your scheduled appointment time, if you must cancel your appointment.

Choose one hospital for outpatient and emergency services.

- Use emergency room services for treatment of potentially life threatening injuries or conditions only.
- If you are unsure if the severity of your illness/injury requires emergency room care, contact your doctor's office to help you decide what to do.

Choose one pharmacy.

- The pharmacy staff will be able to inform you about potential medication interactions, or any potential side effects that may occur.

See your dentist twice a year for check-ups.

- Follow your dentist's instructions for dental care.

The following are tips for practicing wellness. Always keep in mind any limitation your doctor may have recommended.

- Rest and relax regularly.
- Exercise every day; walk, swim, bicycle, or do stretching exercises for five minutes twice a day.
- Get outside in the fresh air and allow the inside of your home to get fresh air.
- Eat a well balanced diet that includes fruits, vegetables, breads, cereals, lean meat or fish.
- Drink plenty of fluids every day.
- Avoid alcohol, cigarettes and duplicated medications.

Members are informed that the goal is to provide information and education so they receive the highest quality healthcare services possible and that their utilization of all Medicaid medical services will continue to be monitored. Members are provided with a phone number so that they may contact the health coach review coordinator with their questions.

Member utilization is reviewed after the educational intervention, prior to ending the lock-in restriction and post restrictions. It is also our experience that documenting all lock-in activity is a key component to achieving success with the member. All communication with the member will be entered into the TruCare™ system so that ongoing communication may be tracked. This practice facilitates effective care coordination.



Reports to the Department include the following:

Lock-in	1 st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Year to Date
Selected for potential review					
Reviewed from selection process					
Referrals-pharmacists, physician (100% reviewed)					
Lock-in enrolled members reviewed (Quarterly)					
Post lock-in reviews (Discharged 6 months previously)					
Review Completed					
Closed without intervention					
Received MHEP intervention without planned follow-up					
Received MHEP intervention with planned follow- up					
New members enrolled in lock-in					
Discharged from lock-in					
Total enrolled in MHEP and lock-in					
Estimated Cost Savings in State dollars					

Interfaces and Collaboration

One of the process enhancements that we achieved over the last contract period was to enable our staff to update SSNI to correctly restrict the member to specific providers. Our staff initiates the update in the SSNI system regularly to ensure timely enrollment and restrictions. SSNI then interfaces with MMIS and claims are denied if the member is not using an assigned provider or if they do not have a referral from the assigned primary care physician.

Our staff have implemented efficient processes in collaboration with Point of Sale to complete claim overrides in a timely manner allowing pharmacy providers to continue service delivery and meet member needs. We continue to look for innovations in processes and IME collaborations to enhance the lock-in program.

Program Savings

Our lock-in program has proven to be an effective cost savings program for the Department with consistently increasing savings year to year. Over the past four years at IME we have reported to



the Department a total cost savings of \$13.3 million. Cost savings are calculated by comparing utilization costs prior to a lock-in intervention to utilization costs after the lock-in intervention, combined with cost savings realized from denied claims due to the use of non-lock-in providers or early refills of prescriptions.

State Fiscal Year	State Cost Savings
2006	\$1,450,679
2007	\$2,633,126
2008	\$3,037,072
2009	\$6,226,745

All medical review staff are professionally licensed (RN, LISW, LMHC, LPN, LBSW) and credentialed for the tasks performed. In accordance with URAC standards, our corporate Organizational Development verifies all education credentials. We also have a thorough vetting process for peer and medical consultants.

IFMC’s medical director for Member Services is _____, DO, and his credentials are described in Tab 5 of this proposal. All peer reviewers and any replacement for _____ would be subject to the credentialing procedures outlined below:

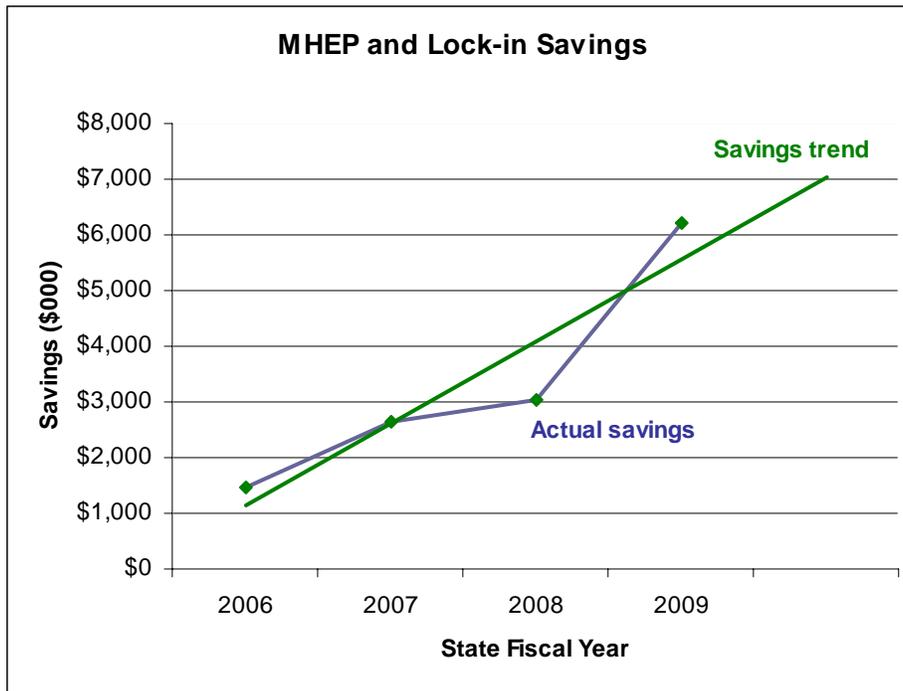
- License review is completed on Iowa Board of Medicine, Iowa Dental Board or Iowa Department of Public Health websites
- Potential disciplinary is screened by clicking on “Public board action information on file”
- Application materials are completed attesting to no loss of privileges, substance abuse concerns, felonies or fraud
- Attestation is completed for conflict of interest, confidentiality, malpractice insurance and compliance with URAC standards
- Primary source verification is completed through user agreements with National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank and CertiFACTS

Performance Standards (6.5.6.3)

IFMC has achieved measurable growth in each of the eighteen years of our MHEP and lock-in program management. Our approach to the MHEP and lock-in program for this procurement includes additional features that will facilitate greater return on investment for the Department.

On a quarterly basis we report to the Department the number of members enrolled in MHEP and lock-in including the growth rate of the programs. We will also report total savings achieved as a result of MHEP and lock-in interventions, calculated by comparing the member’s monthly average costs prior to the intervention to the monthly average cost after the intervention. The amount saved from denied claims as a result of member utilizing providers other than their designated lock-in providers or due to early prescription refills is also reported. All duplicate claims are removed prior to this calculation. The total cost savings will include the costs avoided

as a result of the intervention plus the amount saved as a result of denied claims due to the lock-in restriction. Federal participation is calculated to evidence state dollars saved. Claims detail and methodology are available to the Department for verification of program growth and cost savings.



As the MHEP and lock-in provider under the current Medical Services contract, IFMC’s performance demonstrates a trend of consistently increasing savings for the Department.

DISEASE MANAGEMENT (6.5.7)

IFMC’s disease management program is an organized proactive approach to health care. We utilize national quality indicators, predictive modeling data, HEDIS data, and HRAs to identify members for engagement and enrollment. IFMC has adopted the evidenced-based guidelines promoted by the American Diabetes Association; National Heart, Blood and Lung Institute; American Heart Association; and the Global Initiative for Chronic Obstructive Lung Disease.

As participants in the AHRQ Knowledge Transfer Learning Group Workshop for care management, we directed our disease management program to focus on the concepts of adult learning and the Wagner Chronic Care Model. The Wagner Chronic Care Model identifies the elements of a healthcare system that work together to promote quality care management. The elements include the community, the health system, self-management support, delivery system design, decision support, and clinical information systems. Our utilization of this model is discussed in more detail later in this proposal.



All of our certified health coach care managers have participated in extensive training directed at eliciting maximum participation by the member in self-management of his or her disease. Using evidence-based guidelines, health coaches encourage members to lead healthy lives through self-management support. IFMC's disease management program also incorporates the Health Belief Model (HBM) which states people respond best to messages on health promotion or disease prevention when they perceive they are susceptible (at risk) and that if the risk is serious and barriers not too great, they will receive benefits from behavior change.

To change behaviors, health education interventions are likely to be more effective when the intervention addresses the member's perceptions. A member's belief that change is doable is influenced by the way the topic is presented. Health coaches have a solid understanding of the importance of members knowing what they can change and how. The health coaches use a scale of one to ten to assess a member's desire to change. Strategies are used to build the member's skill and self-confidence.

***A member sent a letter commending an IFMC health coach on her professionalism, kind and concerning voice, and her assistance in improving the member's health. He stated that there must be numerous individuals that have medical conditions and it would be wise for them to take advantage of this program .
June 2009***

IFMC's disease management solution includes the device-free remote patient monitoring (RPM) program which targets Medicaid members with congestive heart failure (CHF). IFMC is in the second year of the program, which proved to be an effective method for reaching members and providing timely intervention, preventing ER visits, and hospitalizations. We received national recognition for this program.

As a result of IFMC's success with the CHF program, we received a grant award from HRSA OAT to conduct a demonstration project using the for adults with diabetes.

We will continue to collaborate with the Department to identify populations that will benefit from disease management protocols, education, and intervention. Our experienced medical director will continue to direct our program with regard to utilizing cost-effective guidelines and recognized practice guidelines. IFMC understands the importance of collaboration with members' primary care providers to ensure the most effective education and positive health outcomes.



Contractor Responsibilities (6.5.7.2)

Wagner Chronic Care Model

IFMC currently provides disease management services for Medicaid members with chronic conditions. Our care management program offers a continuum of services for members with single or multiple chronic diseases and other complex care needs. Our participation with the Department in the AHRQ Knowledge Transfer Learning Group Workshop for care management since July 2006, has informed our approach to disease management. This learning group focused on the concepts of adult learning and the Wagner Chronic Care Model. IFMC's implementation of the Chronic Care Model is illustrated below:





In line with the chronic care model, IFMC's health coaches focus on providing self-management support to our members. We emphasize the member's central role in managing their own health. We facilitate the member taking a more active role in self-management by alternating education and practice opportunities in our member interactions. The interactions with our health coaches provide members with knowledge and emotional support resulting in the member having increased confidence and the ability to take greater responsibility for their own health and to establish more effective relationships with their primary care providers.

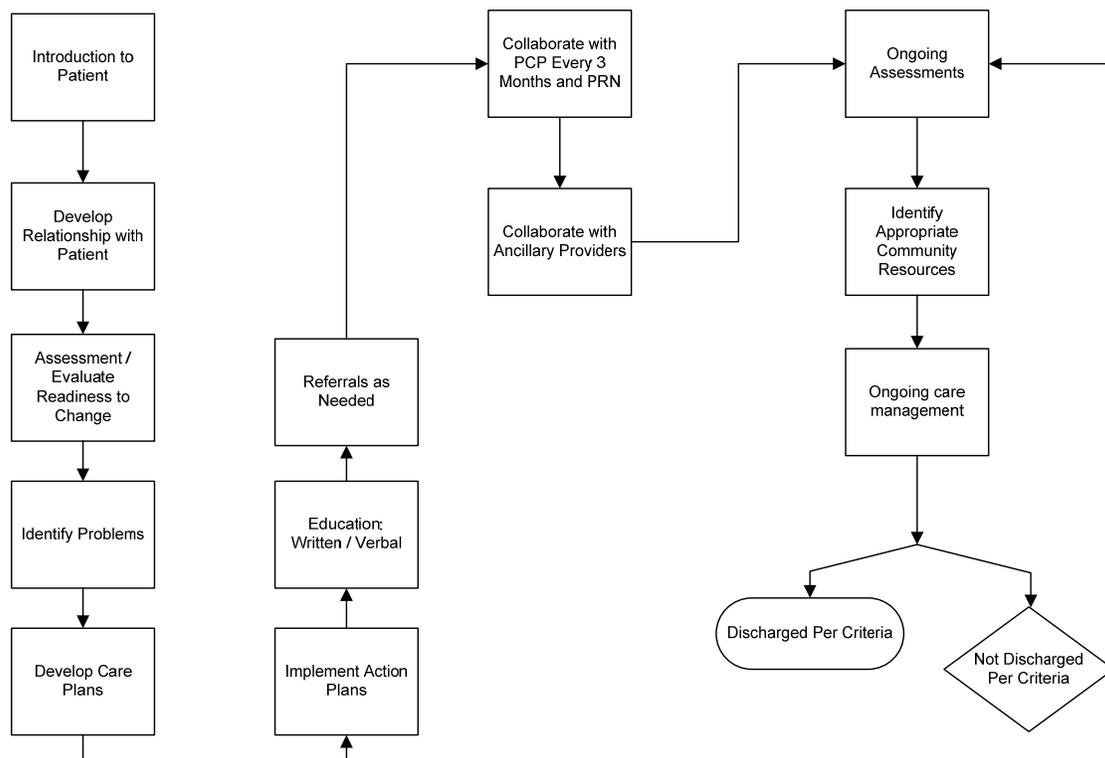
As part of the chronic care model, we take a proactive approach and focus on keeping our members as healthy as possible. Our interventions provide the member with information about what is needed for preventive care. We monitor the member's compliance with influenza immunizations, colon screening, and mammography screening in accordance with best practices and follow up with the member at regular intervals to ensure that care episodes meet the member's goals.

We coordinate with the member's primary care provider to assist in reaching their goals regarding the member. Our interactions with the member include facilitating member compliance with primary care provider directions.

Care Management Process

IFMC's care management process begins with identification of members whose medical condition indicates potential benefit from improved self management. As part of implementation of the Health Belief Model, our health coach care managers assess the member's ability and willingness to change using standardized assessment tools from the Prochaska Stages of Change Model. The care management process flow below illustrates our approach including the important step of evaluating member readiness to change.

Care Management Process



Member Selection

To maximize enrollment of Medicaid members appropriate for disease care management services, we use CareAnalyzer predictive modeling software to identify candidates for member enrollment. Claims from the data warehouse are loaded and processed monthly to identify highly high cost members with complex needs who may benefit from participation in our Disease management program.

CareAnalyzer processes the claims and classifies each member into a resource utilization band (RUB) based on their concurrent resource use. This provides a way for separating the population into broad co-morbidity groupings as follows:

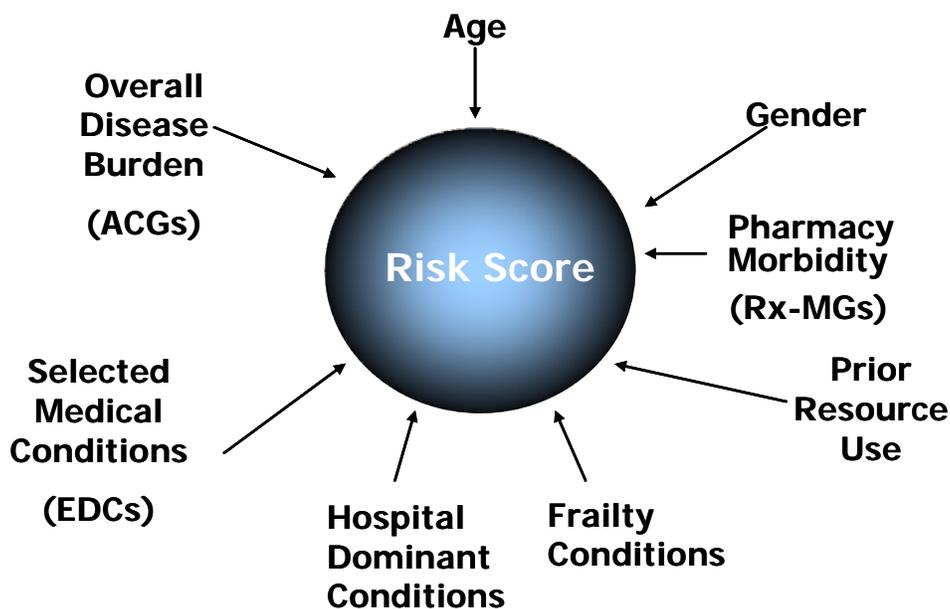
- Healthy User - RUB = 1
- Low - RUB = 2
- Moderate - RUB = 3
- High - RUB = 4
- Very High - RUB = 5

Members with a RUB value of five are those with the highest concurrent resource utilization and are expected to be the highest cost and highest risk members based on their co-morbidities, gaps in care, prescription patterns, risk for hospitalization, number of treating physicians, and many other variables within the predictive model. These members with a RUB value of five are considered to need high touch intervention.

Similarly, members with a RUB value of four also have high concurrent resource utilization and are expected to be high cost and high risk members but their expected resource use is less than the clients with a RUB value of five. Members with a RUB value of four are considered to need moderate intervention.

Members with a RUB value of one, two, or three have moderate to minimal co-morbidities and are currently low-cost, low-risk clients with low-resource utilizations. However, some of these members could have conditions that may increase their risk for high-cost utilization in the future. Using the probability of high total cost parameter within the predictive modeling system, we can identify members from this subgroup who have a 40 percent or greater probability of becoming high resource utilization members in the future. These members are also identified for enrollment in the disease management program.

The above strategy provides a method to not only identify and stratify members that are currently high cost and high risk but also to identify members that are not currently high cost and high risk but have a high probability of becoming high cost members in the future. As the figure below shows, there are a number of factors that are taken into account in the generation of predicted risk and resource use for a client.





- **Age and gender** are included to assess age-related and gender-based health needs.
- **Overall morbidity burden** is measured using the categorization of morbidity burden. The variable in the model includes three groupings of low resource intensity categories and 24 individual categories that are the most resource intensive morbidity groups.
- **High-impact chronic conditions** were selected for inclusion in the predictive model because when they are present, they have a high impact on resource consumption. They are common chronic conditions that are associated with greater than average resource consumption, uncommon diseases with high impact on both cost and health, complications of chronic disease that signify high disease severity (e.g., diabetic retinopathy) or conditions that are major biological influences on health status (e.g., transplant status, malignancy). In the model, we only included conditions for which the evidence linking health care to outcomes is strong. A subset of the Expanded Diagnostic Clusters (EDCs) is used to identify the high impact conditions in the model.
- **Hospital dominant condition markers** are based on diagnoses that, when present, are associated with a greater than 50 percent probability among affected patients of hospitalization in the next year. All these diagnoses are setting-neutral. For instance, they can be given in any inpatient or outpatient face-to-face encounter with a health professional. The variable is a count of the number of morbidity types with at least one hospital dominant diagnosis.
- **Pregnancy without delivery** is included because of the high use of resources associated with delivery that will occur in the subsequent assessment period.
- **Medically frail condition marker** is a dichotomous (on/off) variable that indicates whether an enrollee has a diagnosis falling within any 1 of 11 clusters that represent medical problems associated with frailty.
- **Prior costs** can be added to the model as a measure of demand and need for services not captured by the treated morbidity information available in diagnostic codes. The model uses either prior pharmacy costs or total health care costs depending on the outcome of interest.
- **Rx-defined morbidity groups (Rx-MGs)** are the building blocks of pharmacy risk. Each generic drug/route of administration combination is assigned to a single Rx-MG. We found that generic drug/route of administration combinations within therapeutic classes were sometimes logically assigned to different Rx-MGs, which further reinforced the need make assignments at the individual drug level.

Since IFMC implemented use of the predictive modeling software, enrollment in disease management has increased 18 percent monthly. Our enrollment strategy will be further enhanced through the initial contact with members by our assistant health coaches in the Member Services call center. Our call center staff, with member permission, will complete a brief health risk assessment. Results the HRA may provide additional relevant data informing the enrollment process. Any member with a chronic disease will be automatically enrolled upon receiving their approval.



Our enrollment process will continue to utilize other sources of referrals including primary care physicians, hospital providers, Department staff, other IME staff, home health providers, and other stakeholders.

In an effort to extend the disease management program, IFMC worked with [redacted] disease management program for Medicaid members with CHF. We are in the second year of this program, which has proved to be an effective method for reaching members and providing timely intervention, preventing emergency department visits, and hospitalizations.

The Iowa Medicaid Medical Director was asked to present at two national conferences regarding our successful collaboration with Pharos Innovations on our [redacted] for congestive heart failure. Our medical director presented at The Forum 08, the 10th Annual Meeting of DMAA: The Care Continuum Alliance in November 2008, and at the American Telemedicine Association Fourteenth Annual International Meeting and Exposition in April 2009. Both presentations were positively received.

[redacted] is a device-free RPM platform that provides proactive, daily, exception-based, and actionable monitoring that encourages clients to become active members in their own care. [redacted] unique approach eliminates the need for costly and hard to use equipment and promotes engagement of hard to reach members, such as older adults, the disadvantaged, and those living in rural areas.

Once enrolled, members use their current health measurement tools (i.e., standard bathroom scale, glucometer) and any available telephone (land line, cell phone, and pay-phone) or Internet connection to report basic symptom and biometric information through a brief set of daily, customized survey questions. [redacted] ongoing, daily participant monitoring includes:

- Comprehensive program workflow, care management, and ongoing technical support.
- Daily client monitoring and data access. Enrolled members have daily access to the system through toll-free telephone or Internet access. IFMC care management staff and engaged providers also have daily real-time access to real-time monitoring data.
- Depression screening using the PHQ-2 and/or PHQ-9.
- Medication adherence monitoring utilizing the Morisky Questionnaire.
- Member satisfaction monitoring in which all enrolled members are surveyed for program satisfaction at customizable levels.
- Customized educational messages designed to reinforce key health lesson at the end of each member call.



After each member engagement with the _____ program, the information is processed and sent real-time to IFMC’s disease management staff. Members identified by algorithms as having medical deterioration or additional service coordination needs are “flagged” for attention. This allows for immediate IFMC intervention when our clinical team can make the greatest impact and reduce the likelihood of an avoidable emergency department visit or hospital admission.

The _____ program augments the member assessment and HRA completion, provides automated screening opportunities, reinforces member self-care learning, and drives greater relevant health and self-care education.

An external third-party completed evaluations for the CHF demonstration project. The results documented significant positive outcomes as described in the following table:

Third-Party-Validated Results Compared to Baseline Include:	
➤	72 percent of Medicaid clients reported the program helpful for being in better communication with their physician
➤	24 percent reduction in hospital admissions Compared to 22 percent increase for the matched cohort
➤	22 percent decrease in total bed days Compared to 33 percent increase for the matched cohort
➤	Nearly \$3 million savings from reduced health care service utilization Compared to \$2 million increase for the matched cohort

As documented by these results, the demonstration program was highly successful. The CHF program continues today as a component of our overall care management and disease management program for Iowa Medicaid.

As a result of IFMC’s success with the CHF program, we received a notice of grant award from HRSA OAT to provide a demonstration project _____ Program for adults with diabetes. The grant provides direction and coordination of the demonstration project with communication and reporting activities among project partners and to HRSA OAT. It also includes training for care coordinators and project partners on all aspects of demonstration project deployment, data management, outcomes measurements and collection, and timely reporting.

As an added value, IFMC contracts with _____ to conduct an annual external evaluation of our _____. The evaluation includes clinical measures, patient



functionality, cost of care and financial impact. The evaluation methodology will be submitted to the Department for approval.

Developing Protocols

Medical home principles combined with the chronic care model set the foundation for IFMC’s protocol design. Our focus has been on diseases that are amenable to positive intervention (CHF, COPD, coronary artery disease, asthma, and diabetes). Protocols for successful management of chronic diseases are created using clinical guidelines and are directed by our experienced medical director. A key component in the protocol design is to ensure the member understands their disease process and realizes his or her role as a self-manager. Decision support is based on guideline based care and targets for clinical goals.

Condition	Clinical Measure
Coronary Artery Disease	Reduced ER visits Reduced inpatient stays Medication compliance ACE/ARB Echocardiogram Lipid testing Lipid testing BMI Compliance with treatment plan Improved quality of life/functional improvements Depression Screening Behavioral screening Smoking Flu vaccination Pneumococcal vaccination Blood pressure
Diabetes	HgbA1c testing HgbA1c value Reduced ER visits Reduced inpatient stays Reduced re-admissions Lipid testing Lipid testing MicroAlbumin Foot exam Eye exam Compliance with treatment plan Improved quality of life/functional improvements Depression Screening Behavioral screening Smoking Flu vaccination Pneumococcal vaccination
Asthma	Reduced ER visits Reduced inpatient stays Reduced re-admissions



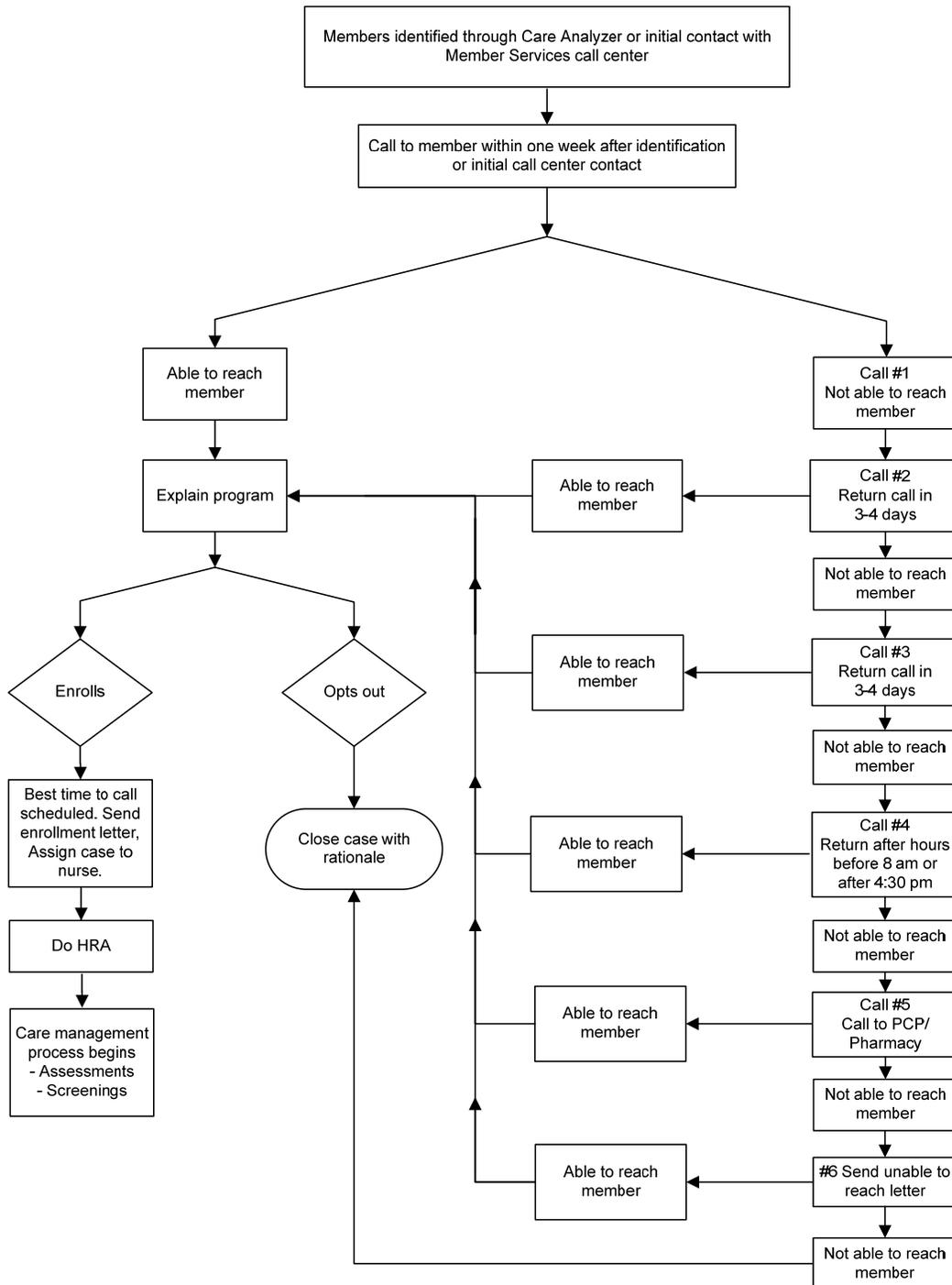
Condition	Clinical Measure
	Medication Compliance ACE/ARB Peak flow meter use Action plan Compliance with treatment plan Improved Quality of Life/Functional Improvements Spirometry Depression Screening Behavioral screening Smoking Flu vaccination Pneumococcal vaccination
COPD	Symptom management BMI Compliance with treatment plan Improved Quality of Life/Functional Improvements Blood pressure Depression Screening Behavioral screening Smoking Flu vaccination Pneumococcal vaccination

Engaging Members

Once members are identified as candidates for our disease management program, the social worker/health coach contacts the member for enrollment. Engaging members in care management requires excellent communication skills. We have found licensed independent social workers frequently have the listening and motivational interviewing skills that lead to successful engagement.

Members who engage with the program are sent a welcome packet which includes a letter describing their rights and responsibilities and reinforces the benefits of the program. The letter includes the health coach care manager’s business card with telephone number. Staff promote the benefits of participation in the program stressing the value of feeling better and enjoying improved health and functionality.

Care Management Engagement





We have found that delaying attempts to call until mid morning and into early evening helps reach members at home. For continued contact, nurses ask the member for their cell phone numbers with a promise to only contact the member's cell phone if we cannot reach them on their home phone. This minimizes the use of the member's cell phone minutes. The care manager always provides a choice of time for the planned future call which builds trust by following up with the member in a timely manner.

Research regarding resources and services of interest to each member is completed and reported to the member at the next call. We find that until the member has adequate food, shelter, and security they are not able to focus on the disease and improving health. We have also found that members often alternate between addresses. In situations where the address has changed or the telephone is no longer in service, communication with the member's IMW is effective in locating the member. The member's primary care provider also serves as a resource.

Health coach care managers encourage members to involve significant others, personal care workers as well as the primary provider as part of the care delivery and support needed to sustain healthy practices. The health coach care manager has the role of identifying barriers and involving other supports as necessary to address barriers. Our program has social workers to assist in the process of identifying community resources that will address member needs.

Interventions

Clinical triggers inform our interventions with members. They are collected and monitored in the TruCare™ including key metrics, initial and follow-up assessments, and imported data (i.e., HRA). Alerts assist our health coach care managers to recognize the need for intervention. Member-specific rules can be configured in the system for use in prioritizing trigger events and associated severity scoring. For example, a member with diabetes who has not had glycosylated hemoglobin value entered within the last six months in their record or who has an elevated value entered for the test will trigger a clinical alert to the health coach care manager who will then follow up with the member to provide timely intervention.

We are able to design custom queries to identify members and specific health status measures (i.e., all members younger than 65 with diabetes and high blood pressure); define actions needed once a member is identified by a query; and the frequency at which a query should be completed.

Each member enrolled in the disease management program receives a depression screening within 10 business days of enrollment. IFMC uses the Patient Health Questionnaire-9 to assess depression which is concomitant with chronic conditions. Referrals to mental health services are completed when indicated by the screening score. We have developed working relationships and protocols with the staff at the Iowa Plan that have streamlined processes and made member transition for behavioral assessment and treatment seamless. Our social worker and Iowa Plan staff have weekly meetings to discuss referrals and any follow-up needed.



The Iowa and Oklahoma Medicaid teams received acknowledgment in the Agency for Healthcare Research and Quality's (AHRQ) Care Management Update (March 2009). The update stated that IFMC assesses behavioral health conditions by administering the PHQ-2 depression screening tool to every member enrolled in the Medicaid care management program. Depending on the score, the IFMC care manager coordinates with the mental health contractor to arrange for services. March 2009

IMERS enables our health coaches to stay current with a member's service history. IMERS provides IME staff and Medicaid providers access to a Medicaid member's utilization of services, providers, and diagnoses. Information obtained through IMERS is valuable in assessing member data, providing a pathway for interventions, communication with providers, and care plan updates.

In our communication with members, we stress the importance of having a medical home and the value of receiving coordinated care and treatment. Members are taught skills necessary for healthy communication with a primary care provider and utilize community supports to resolve barriers to establishing a medical home. Skills are practiced in role plays to develop confidence. Examples include the Ask Me 3 questions:

- 1. What is my main problem?*
- 2. What do I need to do?*
- 3. Why is it important for me to do this?*

An integral part of improving member health status is conducting outreach activities and implementing member-centric interventions. Over 11,000 outreach activities were provided to members and providers in SFY 2009. This includes written enrollment communications with physicians, home health agencies, members, community resources, and referrals to agencies for services and educational materials. IFMC obtains Department approval on educational materials distributed to members and providers.

The following is a sample report format for education and clinical guidelines interventions.



Report Dates:

Activity	Member Primary Diagnosis					
	CHF	Diabetes	COPD	Asthma	Complex Care	CAD
Member Interventions						
Education						
Goal setting						
Care planning						
Consultation						
Nutrition						
Exercise						
Wellness						
Social supports						
Total Member Interventions						
Provider Interventions						
Gaps in care						
Care planning						
Care concerns						
Clinical indicators						
Total Provider Interventions						
Referrals						
Mental health						
Food bank						
Housing						
Transportation						
Chronic care education group						
Financial assistance						
Other Medicaid programs						
Total Referrals						
Total All Activities						

Results: Improved Health Status and Reductions in Cost

IFMC has improved the health status of members by promoting member self-management skills and educating members on appropriate use of services to improve quality care. This has led to the reduction in duplication of services and costs. Reductions in hospital admissions, emergency department visits, and inpatient days, along with increased compliance with monitoring and preventive care indicate the improved health status of members.

A review of 246 members enrolled in SFY 2009 with conditions of diabetes, asthma, COPD, coronary artery disease and complex conditions had significant reduction in utilization from baseline (B) to remeasurement (R):

- Reducing the number of member admissions by 64 percent (B = 111, R = 40)
- Reducing the number of emergency department visits by 42 percent (B = 156, R = 91)
- Reducing the number in inpatient days by 79 percent (B = 1,483 days, R = 311 days)



Measures	Baseline - SFY 2008		Remeasurement - SFY 2009	
	Enrolled Members (246)	Cost Per Member	Enrolled Members (246)	Cost Per Member
Inpatient Costs	\$115,446.24	\$469.29	\$7,108.99	\$28.90
Medical/Physician Costs	\$3,561,695.29	\$14,478.44	\$1,884,056.28	\$7,658.77
Outpatient Costs (including ER)	\$999,456.35	\$4,062.82	\$134,845.65	\$548.15
Total Costs	\$4,676,597.70	\$19,010.56	\$2,026,010.70	\$8,235.82

The costs for the enrolled members decreased during the remeasurement period by 57 percent. Based on the overall costs at baseline compared to remeasurement, a cost avoidance of \$2,665,660.60 was realized. Our interventions impacted the results of the program and reduced costs.

Diabetes represents the highest percentage of members in the program and has shown to be very amenable to interventions. Five clinical guidelines were selected due to their importance and their ability to be measured.

The data below displays members enrolled in the program with a diagnosis of diabetes increased their rates of compliance with tests indicated by evidence-based guidelines following interventions by our health coaches.

	Indicated Tests				
	Microalbumin	Lipid Profile	LDL	HgbA1c	Cholesterol
Baseline	12%	43%	3%	69%	0.8%
Remeasurement	15%	43%	5%	79%	1%

As noted previously, our success with the award of a HRSA OAT grant to provide a Medicaid adults with diabetes. We expect to see greater improvement in compliance results under this expanded program.

CHF demonstration has resulted in demonstration project for Iowa

Collaboration with Primary Care Providers

IFMC’s health coach care managers maintain contact with the providers participating in the disease management protocols to problem solve care coordination issues. We understand the value of the disease management program to providers. We want primary care providers to understand our role in supporting them in achieving their goals relating to each member’s health status.



We consult the primary care provider of each enrolled member to secure approval of our involvement with the member. To support the primary care provider, our health coach care managers provide education to members regarding the value of a medical home. Providers caring for members are often unaware of treatments received from other providers. Health coach care managers contact all providers to problem solve care coordination issues.

The member’s primary care physician receives a copy of the member’s enrollment letter, rights and responsibilities, the health coach’s contact information and a copy of the care plan.

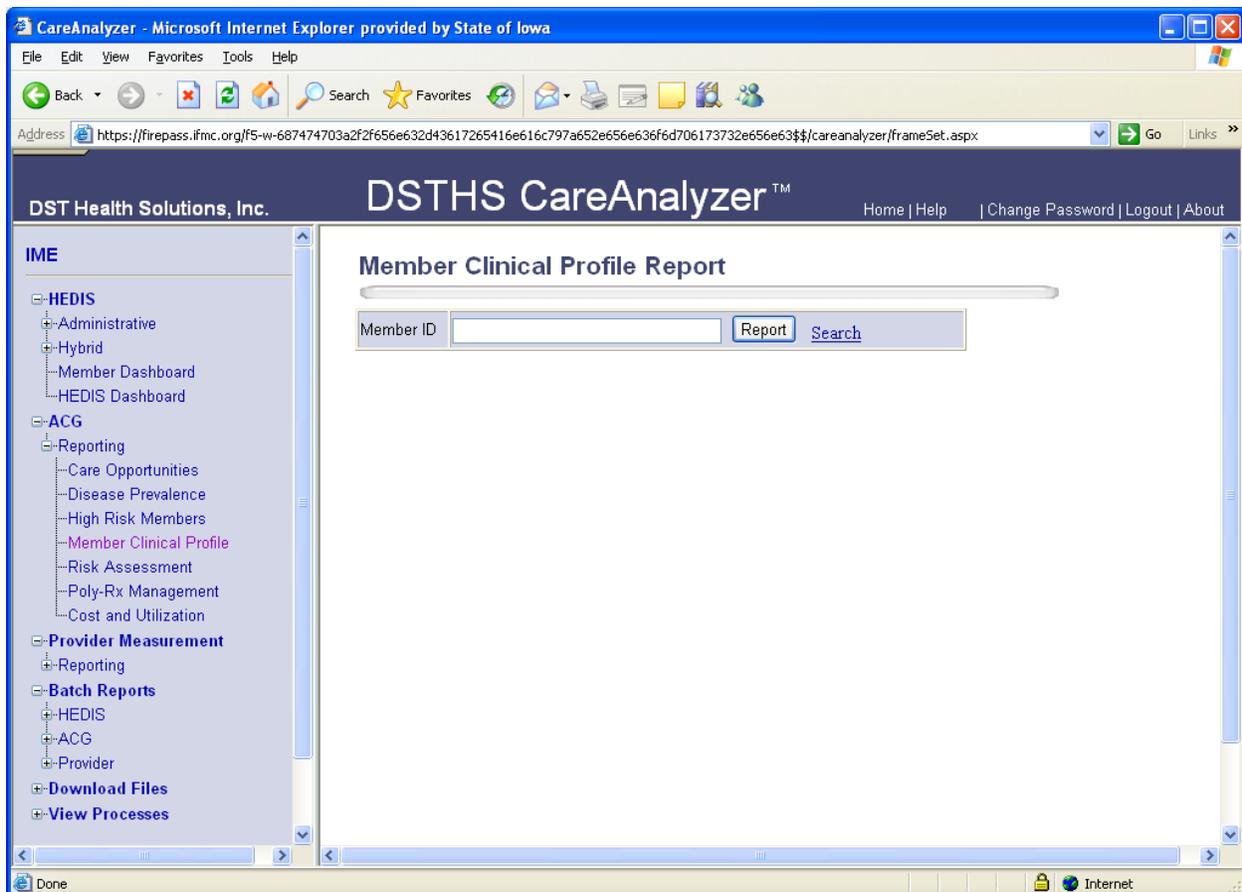
Problem	Goal	Intervention	Generates Task
Knowledge deficit related to diabetes diet	Member will verbalize the importance of diabetic meal planning	Educate member on importance of diet in maintaining a healthy weight and normal blood glucose level	X
	Member will verbalize appropriate meal plan and comfort with diet adherence	Refer member/caregiver to dietician for diabetic diet/nutrition counseling	X
		Assist member in identifying eating patterns and how they affect management of his/her diabetes	
		Encourage member to keep a food diary for XXX days. Compare results to prescribed dietary plan	
		Assess barriers to member following prescribed diet	X
Knowledge deficit related to blood pressure relationship to diabetes	Member verbalizes an understanding of the importance of blood pressure control and how to monitor blood pressure	Instruct member/caregiver on reading food labels and making healthy food choices	
		Educate on importance of blood pressure control	X
		Discuss symptoms of high blood pressure and when to contact physician	
		Encourage regular monitoring of blood pressure	
		Provide information on the importance of home blood pressure monitoring and what blood pressure parameters should be reported to physician	
		Provide information on blood pressure medication(s) prescribed (name, purpose, dosage, possible side-effects) and to not stop taking without speaking with physician first	X
		Provide information on how vascular changes related to diabetes can affect blood pressure	
	Explain the importance of keeping a log of blood pressure readings & taking to physician visits		

Use of CareAnalyzer assists us in engaging providers to deliver evidence-based care based on the compliance of their members with specific measures. We provide disease management interventions in collaboration with the member and the member’s providers.

Studies and Evaluation

Our solution includes methodology for studies to develop new disease management programs. A recent example of a study was the assessment of maternal health in the state of Iowa completed by IFMC in collaboration with the Iowa Department of Public Health. As a result of the study, IFMC initiated a care management program for Medicaid members at high risk for premature delivery.

CareAnalyzer’s report tools will be used to identify potential studies of Iowa’s Medicaid population. Customizable queries, such as the Disease Prevalence Report will provide initial data for evaluation. This report is listed along with other available reports. The left side of the screen shot below indicates the menu of reports available in CareAnalyzer.





CareAnalyzer provides reports of gaps in care identified using HEDIS measures as well as the Care Opportunities report which provides a summary of the compliance rates of members on acute, chronic, and preventive measures.

Our clinical software, TruCare™, will assist in assessing the effectiveness of the disease management program. The methodology for the analysis will address the number of emergency department visits, costs per member per month, adherence to evidence-based guidelines, and utilization of hospital and physician services. The Department will have access to all data to confirm report results.

Condition-specific metrics and co-morbidity information will be included in both the monthly and annual program reports provided to the Department. Specific metrics to be included will be identified jointly by IFMC and the Department. These metrics will include but not be limited to quality of care indicators.

The TruCare™ outcomes module includes a variety of quality and behavioral change outcome metrics. Examples of pre-defined queries include:

- Members with coronary artery disease and no lipid profile in last 12 months
- Members with diabetes and no HgbA1c in last 6 months
- Members with a body mass index greater or equal to 35
- Members whose last LDL cholesterol result was greater than 130 mg/dl
- Women 50 to 69 years of age with no mammogram in the last 12 months

TruCare™'s flexible platform and configuration tools will allow us to add specific queries/requirements based on different rules related to state, contract, accreditation and organization compliance, and ad hoc reporting needs. Information can be shown at the program, group and individual member levels.

Proposed standard reports for the disease management program include:

- Call activity
- Monthly program report
- Performance metrics
- Outreach activity report
- Communication report
- Program challenges
- Member metrics
- Member recruitment
- Member enrollment
- Member intervention



- Provider recruitment and enrollment
- Provider intervention

Performance Standards (6.5.7.3)

IFMC will obtain Department approval of a report card format tracking compliance with all performance standards. The following is a sample report format.

Health Status Assessments Performance Standards	
Measures	Results
Complete initial health status assessments for each member within 30 days of enrollment	
Complete health status assessments on all members who have been enrolled for at least one year within 30 days of the anniversary date of the member’s enrollment	
Make recommendations for at least six studies that the Department agrees are valid	

Strategies to ensure successful completion of performance standards include:

- Completion of initial health status assessment at time of enrollment – eliminates need for call backs; eliminates unsuccessful attempts to complete assessment
- TruCare™ scheduler populates annual assessment on health coach schedule; automated reminder will not disappear until assessment is complete
- CareAnalyzer reports will provide study opportunities

ENHANCED PRIMARY CARE MANAGEMENT (6.5.8)

EPCM is a member-centric program focused on the management of temporary acute conditions and complex conditions that require special medical needs. It is service-oriented to help the member move through an episode of illness, life threatening injuries or a temporary admission to an institution (i.e., hospital, long term care, skilled care). EPCM also addresses and redirects inappropriate utilization of services.



IFMC’s approach to establishing an effective EPCM program includes:

Features	Benefits
Identification of high need and/or high cost utilizers with CareAnalyzer reports	Reduced costs
Collaboration with hospitals to identify members needing transitional coordination; knowledge of long term care programs	Successful transition planning; quality of care for members
Diverse staff of nurses and social workers, all certified health coaches	Ability to match member with needed social, environmental and medical supports
Member self-management education and skill development	Reduced ER visits

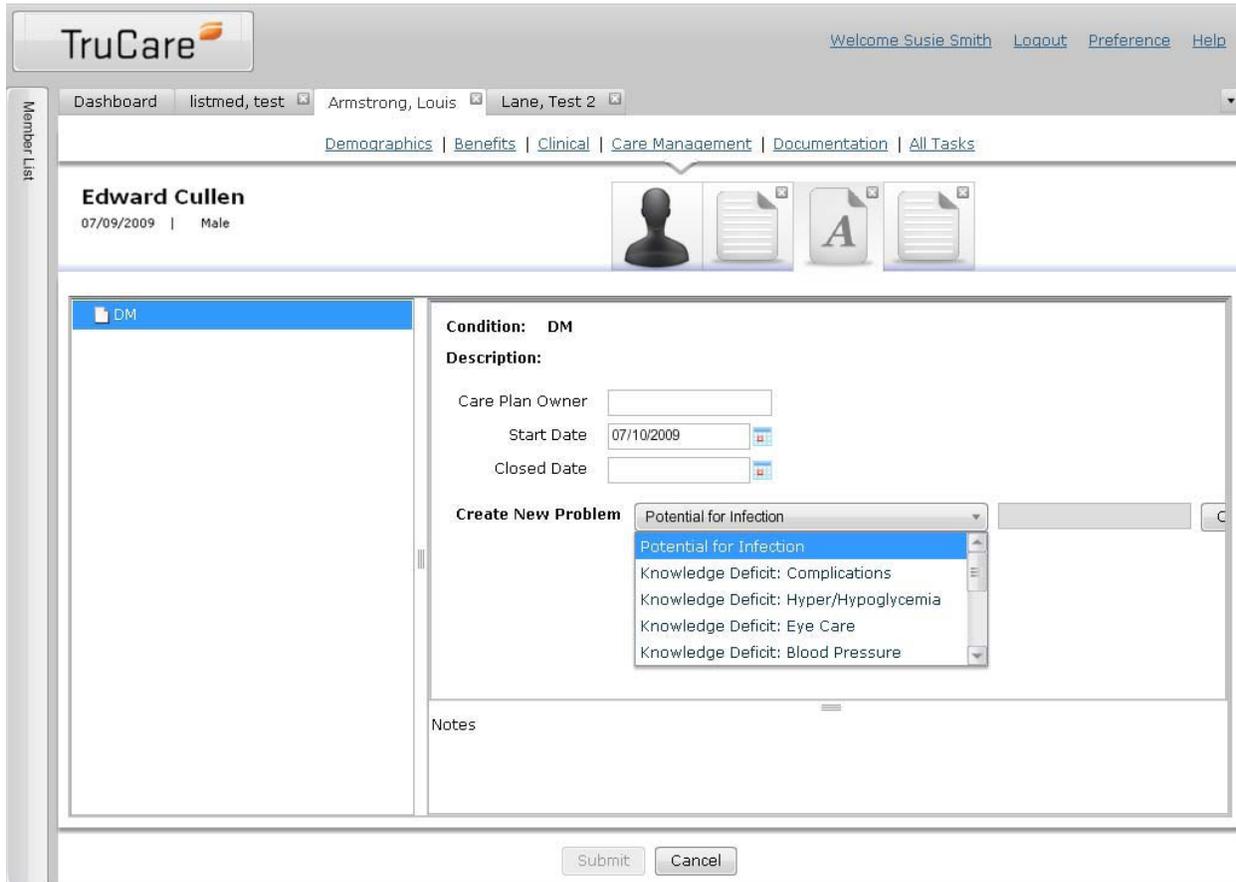
Contractor Responsibilities (6.5.8.2)

Member Selection and Enrollment

Members will be identified for enrollment in the EPCM program by referral, completion of an HRA when the member has contacted the Member Services call center, or through use of CareAnalyzer identifying high cost, high risk members.

The sample report, High Risk Members, lists members, their RUB category weighting and cost impact weighting along with other demographic and clinical information.

TruCare™ features allow customizable profiles and care plans based on clinical entry of concerns and member goals. Below is an example of condition driven problem identified in a member’s clinical information:



The screenshot displays the TruCare web application interface. At the top, the TruCare logo is on the left, and user navigation links (Welcome Susie Smith, Logout, Preference, Help) are on the right. Below the header, there are tabs for 'Dashboard', 'listmed, test', 'Armstrong, Louis', and 'Lane, Test 2'. A navigation bar includes links for 'Demographics', 'Benefits', 'Clinical', 'Care Management', 'Documentation', and 'All Tasks'. The main content area shows a member profile for 'Edward Cullen' (DOB: 07/09/2009, Male) with icons for a person, documents, and a large letter 'A'. A sidebar on the left is labeled 'Member List'. The central panel is titled 'DM' and contains a 'Condition: DM' section with a 'Description:' field. Below this are input fields for 'Care Plan Owner', 'Start Date' (07/10/2009), and 'Closed Date'. A 'Create New Problem' dropdown menu is open, showing options: 'Potential for Infection' (selected), 'Knowledge Deficit: Complications', 'Knowledge Deficit: Hyper/Hypoglycemia', 'Knowledge Deficit: Eye Care', and 'Knowledge Deficit: Blood Pressure'. A 'Notes' section is at the bottom of the panel. At the very bottom of the interface are 'Submit' and 'Cancel' buttons.



Collaboration

The primary care provider drives the medical care for the member. The IFMC care manager collaborates with the primary care provider to develop a treatment plan individualized for each member. EPCM care managers also support the primary care provider through care coordination that enhances collaboration and communication. We focus on access to care, coordination of care, appropriate utilization of care and quality of care. EPCM care managers support the role of the primary care provider to:

- Enhance the health status of Medicaid members
- Improve care based on evidence-based guidelines
- Improve appropriate utilization of services
- Promote member involvement through self management
- Promote the medical home model of health care delivery

Family members are a vital part of EPCM and play an integral part in the member's recovery. Care managers will reach out to family members and others who are involved with the member and who have responsibilities of coordinating care for the member.

We also collaborate with other important persons such as the member's Department service worker, care manager, community resources, and other Medicaid providers. Member permission is obtained prior to conducting interviews with support persons.

***IFMC's care management team collaborated with KCI (Kinetic Concepts, Inc) to care manage members with wound care needs. We have the first year's evaluation and it has been determined Iowa's average length of therapy is 38 days compared to the national average length of therapy of Medicaid is 47.6 days. We are one of the best in the US.
August 2009***

IFMC EPCM health coach care managers provide transitional care interventions for hospitalized members and care coordination following hospitalization. Our health coach case managers have a sound knowledge of long term care (LTC) policies, waiver criteria, and required needs post discharge. Successful intervention requires establishing relationships with discharge planners, primary care providers, and visiting nurses to facilitate post discharge care and follow through with care instructions.

Members currently enrolled in the program have various needs, some more complex than others. Health coach care managers provide resources for services such as facility care, waivers, medical equipment, obtaining a dental provider, and medications. The ultimate goal is to improve access to care, provide care planning, and assist members in accessing services that are medically necessary.



Maternal Health

IFMC learned from an MVM project that Iowa Medicaid experienced a significant number of low birth weight deliveries and associated costs were high. The Iowa Department of Public Health and IFMC developed a task force to study the concern. The solution developed was to implement a maternal care management program for IME. The features and benefits of this program are provided below:

Features	Benefits
Assessment of appropriate pre-natal care using the Adequacy of Prenatal Care Utilization Index	Classifies prenatal care as inadequate, intermediate, adequate, and adequate plus providing a fast and accurate determination of need
Member goals established for appropriate prenatal wellness and application of self-management strategies.	Member becomes an active, educated consumer of health care
Education directed at importance of adequate prenatal care, how to make informed decisions, promotion of self-management skills, importance of adhering to the physician’s prescribed treatment plan	Improve quality of care for mom and baby
Support for self-management of co-morbid medical conditions.	Improved member health; reduced costs related to high risk conditions
Educational materials supplied each trimester	Keeps connection with member
Regular health assessments	Early detection of potential problems
Depression screening	Identification of emotional concerns that may impact healthy pregnancy

Members at risk are identified through CareAnalyzer which will stratify members according to their risk, assessing maternal high risk factors, previous pregnancy history and current risk factors.

If there is a history of inpatient utilization or home care services, members may be managed more aggressively with frequent follow-up and collaboration with the attending physician as needed. Members found to have current risk factors or past obstetrical complications are contacted at least monthly, and receive ongoing education and support.

If a member has one or more risk factors or a history of complications during past pregnancies, the case would be considered as high risk. Risk specific educational materials are provided, and comprehensive assessments are done monthly unless otherwise specified.



Care plans will be developed for each member directed at individual needs. A healthy pregnancy and baby rests on the collaboration of member, family support, and physician intervention.

Cost-effectiveness will be measured by the reduction in low birth weight babies, reduction of pre-term labor, and the management of high risk factors.

Special Projects, Satisfaction Survey and Reports

IFMC has frequently supported the Department on special projects. We are active participants in the foster care study group. We collaborate with the Iowa Plan to provide data for psychotropic medication review.

We will continue to send enrolled members a satisfaction survey at the sixth and twelfth months of enrollment. Program evaluation and the need to improve processes will be informed by results from member satisfaction surveys. We will obtain Department approval of any satisfaction survey utilized.

Proposed reports for the EPCM program include but are not limited to the following:

- Call activity
- Monthly program report
- Performance metrics
- Outreach activity report
- Communication report
- Program challenges
- Member metrics
- Member recruitment
- Member enrollment
- Member intervention
- Provider recruitment and enrollment
- Provider intervention

Frequency and format of reports will be developed according to the Department recommendations. Ad hoc reports will also be provided upon request by the Department.



Performance Standards (6.5.8.3)

The following is a sample report format for care management services. We will obtain Department approval before finalizing the format for tracking compliance with all performance standards.

Care Management Performance Standards	
Measures	Results
Complete initial member contact for care management services for 95 percent of the members within five business days.	
Maintain a minimum enrollment of 50 members.	
Send enrolled members a satisfaction survey within 10 business days of the member’s sixth month of initial enrollment and annually on the anniversary of their enrollment	
Contact 95 percent of the care-managed members within one business day following discharge from hospital	
Demonstrate cost-avoidance through a decrease in emergency room visits annually for members enrolled for at least 11 of 12 months.	
Demonstrate cost avoidance	

Strategies to ensure successful completion of performance standards include:

- CaseNet scheduler will alert health coaches of deadlines for member contacts at initial contact and upon discharge from the hospital
- CareAnalyzer selected reports will identify high use/high cost members with conditions amenable to intervention
- Focus on member health education regarding appropriate use Medicaid services; proactive problem solving to find alternative sources of health care attention
- Securing baseline data on emergency room visits with proxy measures throughout the year



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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. Our expertise with effectively connecting with Medicaid members to increase their knowledge of available benefits will ultimately improve their healthcare outcomes. Our program management approach is focused on meeting core deliverables and achieving and exceeding performance measures.

Key objectives of our project management approach include:

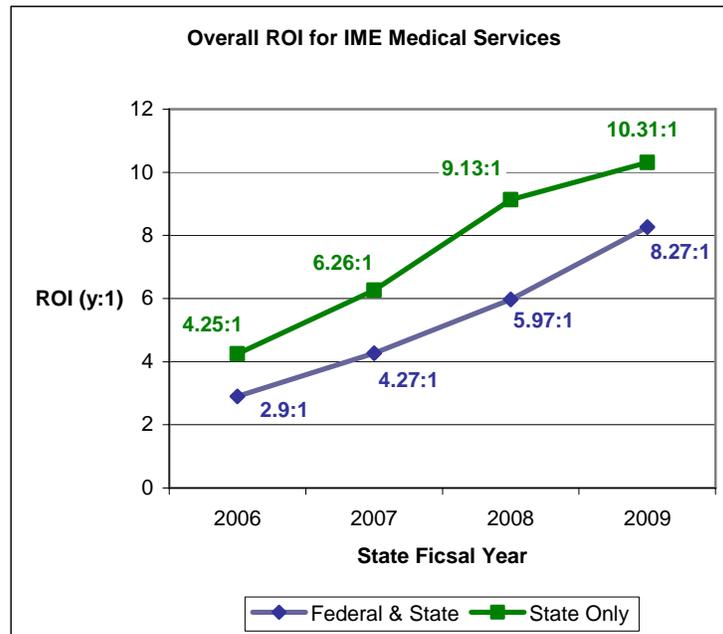
- Align tasks to achieve goals
- Provide triggers for risk and decision- making
- Enable transparency into project processes and staffing barriers
- Automatically adjust and prioritize work
- Provide graphic reports

We understand that planning is essential to contract success. IFMC has developed and included high-level project plans for transition, operations, and turnover phases with this proposal. All project plans will have detailed steps with timelines and are specific to Member Services functions. The plans are included in their respective sections.

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. For example, the following chart demonstrates our commitment to producing significant cost savings for the State.



IFMC offers the Department a demonstrated track record of continuously increasing ROI.

Transition Phase

We will be assuming new activities of MHC enrollment, member inquiry and relations, member outreach and education, member quality assurance, and Medicare Part A and Part B buy-in. We currently operate the lock-in, disease management, and EPCM programs under the existing Medical Services contract. There will be changes in these programs when they are transferred to Member Services beginning with the new contract.

During the transition phase, our Member Services 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. We will review the turnover plan developed by the outgoing vendor and establish priorities for data transfer and information about the status of member outreach activities. We will provide the Department electronic access at any time to our transition progress report which will be updated a minimum of two times weekly. This report will include real time data and information to support transition activities.

We will meet with the outgoing vendor under the direction of the Department. Our staff will demonstrate professional respect in our interactions with the former vendor and will take all steps necessary to coordinate knowledge transfer and ensure a successful transition.

Coordinating meetings will also be held regarding interfaces with OnBase Workview for Member Services functions and Cisco phones. Interfaces will be developed and tested for full



functionality. Other interfaces such as MMIS, IMERS, ISIS, and SSNI will already be in place. The lock-in and disease care management programs will use CareAnalyzer and TruCare™ software which require file transfer of eligibility and provider files. Currently IFMC has a secure process for completing this interface.

Our project plan for assuming operations of Member Services includes detailed task lists, all with begin and end dates. We specify the FTE resources needed and the amount of time needed to complete each task. IFMC will remain flexible to changing needs and priorities of the Department. Our plans will be updated as processes and priorities evolve.

Transition Project Plan



Operations Phase

During the operations phase, IFMC will meet all performance standards and complete all required reports. 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

We will meet with Department staff as requested or as specific needs are identified. We believe the current coordination that occurs in the IME unit meeting is effective and we will continue to participate in all necessary activities to ensure that IME delivers quality service to its members.



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

Operations Phase Project Plan



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



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 until the effective date of contract performance by the successor contractor
- Plans to communicate and cooperate with the successor contractor
- Proposed approach to transition technical support to the successor contractor
- Transfer of all relevant information to ensure successful transition of operational activities including:
 - Data in a file extract of all members enrolled in EPCM, disease management, and lock-in programs during the requested timeframe
 - 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



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



COMMUNICATIONS MANAGEMENT

We understand that program success does not depend on IFMC alone. Close collaboration and communication between the Department, IFMC, and other IME vendors will be necessary at all times. Our project management plan approach emphasizes clear feedback and communication with relevant representatives from the Department, other vendors, members and providers. Our



team members document processes and results using standard templates (e.g., process flow charts, team meeting minutes, dashboard reports, etc.). We will create real time access to our dashboard reports as a communication tool to ensure transparency of our processes and results to the Department.

QUALITY MANAGEMENT

IFMC employs several strategies to ensure our processes consistently deliver the desired results. Our detailed employee orientation requires demonstrated proficiency prior to staff being able to work independently. We have an ongoing Internal Quality Control process to ensure the accuracy of the information we collect and the decisions we make are based on program requirements and/or policies. Our inter-rater reliability process helps ensure accuracy with decision-making through a sample of cases reviewed by management or other team members. Results are compared and feedback is provided to the staff being evaluated. Agreement rates less than 90 percent result in education and/or corrective action.

As an organization dedicated to performance excellence, we are proficient in various quality improvement methodologies including rapid cycle PDSA; Root Cause Analysis/Failure Mode and Effects Analysis; and Lean. We have developed process improvement templates which provide our staff with a framework for identifying concerns, developing measures, implementing business process improvements and measuring results.

We utilize standard templates to document policies, processes and procedures. Documentation of and adherence to standard policies, processes and procedures helps us to do our work more efficiently and produce the desired results with a high degree of reliability.

RISK MANAGEMENT

Successful implementation of the Member 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; staff able to report to work will be reassigned to call center
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 Member Services component are presented in the Executive Summary (Tab 4) of this proposal.

TIME MANAGEMENT

Our project management plan approach is highly effective in handling both concurrent and sequential tasks. The plan relies on key milestones and identification of interim steps to achieve overall goals. We use the management plan to compare expect results with actual results. These comparisons can be expressed in terms of dates, volume, rates, etc. When variations are identified, we implement one or more quality improvement methods (e.g., PDSA, Root Cause Analysis, etc.) to identify the barrier and implement the corrective action. Using real time data and information allows us to intervene sooner when variations are minor before they become more widespread problems.



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 or national level. We will rely on this experience to insure the successful transition of activities from the current Member Services vendor.

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 a seamless transition and 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, we have 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 ten years. We will follow this approach when working with the Department for IME Member Services.

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 Member Service activities.

Our proposed staffing plan for Member Services, as described in Tab 5 of this proposal, meets all requirements specified by the Department. The plan includes a full-time account manager for Member Services who will also serve as the transition manager responsible for coordinating all activities surrounding the transition from the current Member Services vendor. We have also proposed a medical director who will provide protocol guidance and coordinate all activities with the IME chief medical director, supplied by the Medical Services vendor. We have also proposed two operations managers. All key personnel identified in the staffing plan for Member Services are currently employed by IFMC.



Organization Charts (7.2.8.1)

TRANSITION PHASE

IFMC has a long history of successful implementation of new contracts, many of which involved a transition from a previous vendor. This experience will help insure a smooth transition of the IME Member Services contract with minimal disruption in operational activities and member support.

Our transition team will be led by _____, Account Manager. The team will include technical staff, program operations personnel, a project assistant, and two operations managers. In addition, clinical support and direction will be provided by our medical director to ensure our lock-in, disease management, and EPCM programs are structured on evidenced-based guidelines and appropriate to meet the needs of Medicaid members.

As the Member Services contractor, IFMC will assume responsibility for a variety of medical programs and support services that will manage quality health care services for members. Our staff who worked on the lock-in, disease management, and EPCM programs under our previous IME Medical Services contract will be transferred to a new team supporting these programs under the new Member Services contract. We believe that knowledgeable and experienced staff will be an asset to the successful transition of program operations from the previous vendor.

The objectives of our proposed staffing plan for Member Services include:

- Leadership to ensure collaboration with the health care providers and IME vendors
- Medical knowledge to ensure on-going development of disease management, EPCM, and lock-in programs that enhance the management of 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

Primary transition tasks will include:

1. A review of the operational procedures for Member Services used by the current vendor
2. Revising current procedures to incorporate new program components and align with IFMC operational plans
3. Ensuring ongoing interface with other IME vendors who will have an impact on Member Service activities
4. Testing systems that will be used for Member Services with other IME vendors
5. Submitting operational procedures for Department approval
6. Hiring and training staff to fulfill all Member Services functions
7. Readiness preparations for the transition of customer service and administrative support from the previous vendor



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 personnel during the transition phase of the contract.

Key Personnel	Level of Effort	Number of Staff	Responsibilities
Transition Manager	100%	1	Primary tasks include creating and implementing all project plans for transition, operations, turnover, and staffing of each phase; coordination of communications with Department staff and IME vendors for call center, lock-in, disease management, and EPCM programs; coordination of interface needs; oversight of hiring and training of staff; managing resources; maintaining communications with IFMC corporate staff and community partners; oversight of contractual obligations; and QA coordination.
Medical Director	10%	1	Review Member Services operations and protocols for medical guidance for lock-in, disease management, and EPCM programs and member education; maintain medical consultants; work under the guidance of the IME chief medical director
Operations Manager	50%	2	One manager will coordinate transition milestones for call center operations; develop protocols for call center and outreach staff; write operational procedures; develop training manuals; hire and train staff; facilitate specialized training; and facilitate call center system interfaces. The other manager will coordinate milestones for lock-in, disease management, and EPCM operations; revise protocols for health coaches; revise operational procedures; revise training materials; hire and train additional staff; and facilitate specialized training



Position: Director, Program (Transition Manager)

Position Summary:

Essential Functions:

Requirements:

Additional Comments:



Physical and Mental Demands:



Position: Medical Director

Position Summary:

Essential Functions:

Requirements:

Physical and Mental Demands:



Position: Manager, Quality and Accountability (Operations Manager)

Position Summary:

Essential Functions:

Requirements:



Physical and Mental Demands:

Position: Team Lead, Call Center

Position Summary:

Essential Functions:



Requirements:

Physical and Mental Demands:



Position: Programmer

Position Summary:

Essential Functions:

Requirements:



Physical and Mental Demands:

Position: **Assistant, Project**

Position Summary:

Essential Functions:



Requirements:

Physical and Mental Demands:



OPERATIONS PHASE

We have experienced personnel who have supported the lock-in, disease management, and EPCM programs during our tenure as the Medical Services vendor. These staff will continue to support these programs under the new Member Services contract. This will help ensure minimal disruption in member support and continuity in program operations.

In addition, we have extensive experience managing call centers, managing over 5,000 inbound and outbound calls per day. Our ENCOMPASS call center supports over 175 different health plans representing over two million covered lives nationwide. We also operate a call center for the Oklahoma Medicaid program providing care management support to over 4,000 Medicaid members in that state.

Our extensive experience with program operations and call center management 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 Member 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	Coordination of Member Services enrollment, inquiry, education and outreach. Medicare Par A and B buy-in, lock-in, disease management, and EPCM activities: Manage and coordinate communications with Department staff and IME vendors for call center programs, lock-in, disease management, and EPCM review activities and staff, manage resources; maintain communications with IFMC corporate staff and community partners. Ensure contractual obligations are met and coordinate quality assurance activities.
Medical Director	15%	1	Medical services program review: Review operations and protocols and provide medical guidance for lock-in, disease management EPCM and member education; maintain and supervise medical consultants; work under the guidance of the IME chief medical director. Reports to account manager.



Key Personnel	Level of Effort	Number of Staff	Responsibilities
Operations Managers	100%	2	Program management: Manage operations, conduct IQC, ensure compliance with performance standards, manage and supervise staff. The managers will be cross-trained and provide back up for one another. One manager will be responsible for management of lock-in, disease management, and EPCM. The other will be responsible for call center activities, MHC enrollment, member inquiry, member outreach and education, and Medicare Part A and B buy-in. Operations managers report to account manager.

Position: Director, Program (Account Manager)
 See Director, Program job description under Transition Phase.

Position: Medical Director
 See Medical Director job description under Transition Phase.

Position: Manager, Quality and Accountability (Operations Manager)
 See Manager, Quality and Accountability job description under Transition Phase.

Position: Programmer
 See Programmer job description under Transition Phase.

Position: LISW Health Coach (Team Lead, Call Center)
 See Team Lead, Call Center job description under Transition Phase.

Position: Health Coach

Position Summary:

Essential Functions:



Requirements:

Physical and Mental Demands



Position: Assistant Health Coach/Customer Service Specialist

Position Summary:

Essential Functions:

Requirements:



Physical and Mental Demands:

Position: **Review Coordinator**

Position Summary:

Essential Functions:



Requirements:

Physical and Mental Demands:



Position: Assistant, Project

See Assistant, Project job description under Transition Phase.

Position: Billing Specialist

Position Summary:

Essential Functions:

Requirements:



Physical and Mental Demands:



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 Member 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 Member 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 Member Services contract. The charts also show the lines of authority and inter-relationship of the various operating units that will be involved in Member Service activities.



The first organization chart provides a high-level overview of our Executive Team and its connection to the Member Services contract:



The following chart provides a listing of the key personnel involved in the Member Services contract during the Transition Phase:



The following chart provides a listing of the key personnel involved in the Member Services contract at an operational level:

As noted in the organizational charts, all key positions for the Member Services contract are filled by individuals with prior experience supporting IME. This will ensure a successful transition and 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)

We have an established track record of securing staff who have the requisite skills to meet all contractual requirements and who have enabled us to meet or exceed all performance standards during the past five years of IME operations. We understand staff positions are effective for the duration of the project.

The account manager and two operations managers proposed for the Member Services contract have experience in IME implementation and operations based on their prior work on the Medical Services contract. They understand the complexities of a multi-vendor enterprise and the need for quality service for Medicaid members.

We will transition our current trained care management teams to Member Services and will increase the number of FTEs for each program. Our disease management and EPCM staff are certified health coaches and have established relationships with members and providers. They are proficient in the use IME data systems (IMERS, ISIS and MMIS) used to gather necessary information, to educate members, and secure full member participation in self management.

Lock-in review coordinators have established relationships with members and providers and are fully versed in IME systems. Our MHEP and lock-in Team has expertise in chemical dependency assessment, treatment, and health coaching. This will enable our staff to more effectively educate members and elicit behaviors that promote positive health outcomes and wise use of Medicaid services.

The Member Services call center staff will be composed of assistant health coaches and customer service specialists. Staff qualifications will include experience in customer service and knowledge of IME programs. We will make a concerted effort to recruit and retain call center and member inquiry staff from the previous Member Services vendor. Adding these personnel to the IFMC team will simplify the transition process and help insure continuity and consistency in program operations. All call center personnel supporting Member Services will be dedicated exclusively to this contract. All call center policies, procedures, and reference materials will be available to staff online for rapid access.

We have a history of success with rapid start up and recruiting associated staff. For example, during our 2005 implementation of the IME Medical Services contract, we were able to hire 100 staff within three months. 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.

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)

, MS, CPHQ, will serve as the account and transition manager for Member Services. She served as the implementation manager for IFMC Medical Services in 2004-2005. She has directed IME programs and supervised IFMC staff responsible for EPCM, disease management, MHEP and lock-in.

DO, will serve as the medical director for Member Services. As the current medical director for IME, has vast experience with IME operations and establishing medical protocols for care management programs.

, RN, will be the operations manager for EPCM, disease management, MHEP, and lock-in programs. was an operations manager for Medical Services during the successful implementation of IME. She has managed all three care management programs.

, LBSW, will be the operations manager for the Member Services call center and activities of MHC enrollment, member inquiry and relations, member education and outreach, member quality assurance, and Medicare Part A and Part B buy-in. She has successfully implemented new IME programs and managed the MHEP and lock-in program.

Resumes and references for all key personnel are provided in Tab 6. All key personnel are current IFMC employees.

Subcontractors (7.2.8.4)

We have chosen as subcontractors for Member Services. We have proven existing relationships with all three organizations and all have been previously approved by the Department.

As part of the disease management program, we plan to subcontract with to provide a remote tele-health monitoring program to members with congestive heart failure. In addition, we will extend our partnership with to provide to members with diabetes, funded by a grant from Health Resources and Services Administration (HRSA).

was created in , a practicing cardiologist, who saw a need for a new, innovative complex chronic condition management model that supported dramatic clinical and financial performance improvement. He envisioned a model that enabled and facilitated provider engagement in care coordination; improved the physician and/or patient



relationship and shifted the paradigm from episodic, reactive and human resource-based interventions to a daily, proactive and technology-based solution.

is the recipient of the prestigious American Heart Association National Outcomes Award. It was also selected for the first ever National Institutes of Health (NIH) sponsored evaluation of remote monitoring interventions. Today, national health plans, Medicaid, Medicare, and Veterans Administration programs are using programs to:

- Reduce health care costs and increase quality
- Increase treatment plan and medication compliance and improve clinical and financial outcomes
- Expand the reach and improve the efficiency and effectiveness of health management programs

has been a partner in the IME disease management program since 2008. Its program has provided IME with improved health outcomes and reduced costs for members with CHF.

will also be our partner in a grant award from HRSA. The grant is for a demonstration project for a diabetes program. The grant also includes training for care coordinators and project partners on all aspects of project deployment, data management, outcomes measurement and timely reporting. We will work collaboratively with to successfully achieve stated objectives of the demonstration project.

The estimated percentage of total Member Services contract dollars for is

We will subcontract with

to complete the Member Services satisfaction survey. survey methodology has previously been approved by the Department for the Provider Services survey we have conducted. They will work with IFMC and the Department to design and implement a survey measuring member awareness and satisfaction with Member Services functions.

is a full-service marketing research company located in . They have demonstrated their ability to meet Department needs by completion of the annual Provider Services survey since 2005. The staff has extensive experience across all industries, including health care, financial services, education, manufacturing, legal, retail, economic development and food/nutrition/agriculture-related industries, as well as government and not-for-profit organizations. They have served more than 400 organizations since its founding in 1981 and have provided clients with user-friendly and useful research results.



will design the survey based on Department goals and objectives. They will provide the necessary statistical data to accurately measure member attitudes and awareness. They have demonstrated ability to obtain the data and analyze the research results to meet and exceed customer goals and expectations.

The estimated percentage of total Member Services contract dollars for _____ is _____



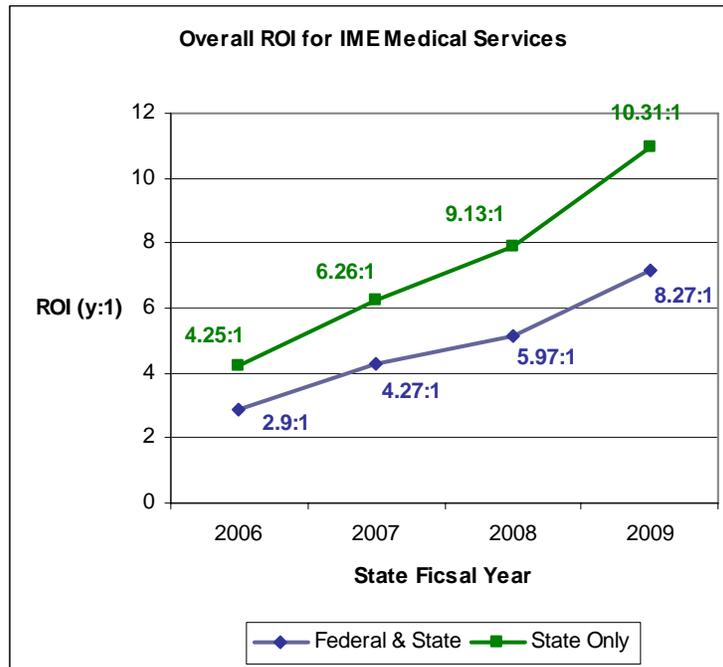
TAB 9 - CORPORATE QUALIFICATIONS (7.2.9)

Corporate Organization (7.2.9.1)

HISTORY (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 awarded 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 disease and care management services. 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 25, 2009

Our extensive knowledge and experience with state Medicaid programs and our direct operational experience with the IME model will ensure the successful implementation of the Member Services Program. As is our standard with all clients, IFMC will work cooperatively



and expediently with the Department and current contractor to ensure an efficient implementation and 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 contractor and launching new programs. In all cases, we have succeeded in meeting client expectations and initiating new programs on time and within budget.

IFMC's corporate organizational chart follows:



IFMC's Member Service organizational chart follows:



STAFF ASSIGNED TO PROJECT OVERSIGHT (7.2.9.1.B)

_____ 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 includes the IME Member Services staff, are committed to providing the clinical and technical expertise necessary to ensure a successful implementation of the Member 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 TruCare™ system. _____ 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 three 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 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

, MS, CPHQ, will serve as the Account Manager and Transition Manager for IME Member Services. reports directly to , Senior Director. 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. is a Certified Professional of Healthcare Quality and has over 11 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. was the IME Implementation Manager for Medical Services in 2005. She has also overseen the lock-in, disease management and EPCM programs.

As a certified professional in healthcare quality, is committed to continuous quality improvement and demonstrates the ability to operationalize these principles into workflow processes.

, DO, has committed to remain with IFMC as the medical director for Member Services. will provide medical leadership for Member Services. As the current medical director for IME, brings his experience of IME and his membership in the state Medicaid Medical Directors Association to his role as medical director of Member Services. will collaborate with the IME chief medical director.

RN, will be the Operations Manager for EPCM, disease management, MHEP, and lock-in programs. was an Operations Manager for Medical Services during the successful implementation of IME. She has managed all three care management programs.

, LBSW, will be the Operations Manager for the Member Services call center and activities of MHC enrollment, member inquiry and relations, member education and outreach,



member quality assurance, and Medicare Part A and Part B buy-in. She has successfully implemented new IME programs and managed the MHEP and lock-in program.

Technical Staff Assigned to IME

, Programmer, will provide support and maintenance to all Member Services system interfaces. will coordinate communication between IME Member Services, DW/DS, Core, as well as IFMC Information Management. He has five years experience with IME systems and has established a collaborative and cooperative relationship with IME IT vendors.

developed the application (MQUIDS) that is currently used by Medical Services. He also provided oversight for the implementation of CareAnalyzer and has collaborated with Core and Data Warehouse staff on numerous projects.

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 Member 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

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 212).

ESTABLISHED COMMUNITY PARTNERSHIP RELATIONSHIPS (7.2.9.1.E)

IFMC is an Iowa-based company with long-standing relationships with local stakeholder organizations including: 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, 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. DHS and DIA (through its survey process) suggested clinical topics, which we incorporated into educational programs.





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 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, IFMC formed the Iowa Immunization Coalition, which included representatives from 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 partner 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 Member Services program.

OTHER SIMILAR PROJECTS (7.2.9.1.F)

We are committed to providing quality services to our clients. Routinely meeting performance requirements is deeply ingrained in all of our efforts. We have never had a contract terminated prematurely for poor technical performance or for reasons related to financial performance. All projects discussed in this section were completed timely and within budget.

Iowa Medicaid Enterprise Medical Services and Pharmacy Medical Services

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	July 1, 2004 – June 30, 2010
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 and lock-in ➤ Disease management ➤ Enhanced Primary Care Management ➤ EPSDT ➤ PACE
Relevance to Member Services	Member Health Education Program/Lock-In, Disease management and Enhanced Primary Care Management are now part of the Member Services contract.
Contact	

Iowa Medicaid Utilization and Quality Review

From 1979 until implementation of IME, the Department contracted with IFMC to conduct utilization management and quality review services in the following settings:

- Nursing Facilities (including Pre-admission Screening and Resident Review)
- Intermediate Care Facilities for the Mentally Retarded
- Mental Health Institutes
- Psychiatric Medical Institutes for Children
- Hospitals (Acute & Outpatient)



- Rehabilitative Treatment Services (1998-2006)
- Adult Rehabilitation Options (2004-2007)

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.

Since 2004 this work has been included in our IME Medical Services contract.

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	



CURRENT CONTRACTS OR PROJECTS (7.2.9.1.G)

MDS and OASIS Automation

IFMC maintains the

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, TCM, 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.

The Department awarded IFMC the contract for Recipient Health Education and lock-in in 1991 and transferred the work to IME in 2006. In 2003 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.



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,
IFMC is prime contractor	

We provide the following services for _____ :

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 _____ 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) and quality improvement activities in physician offices. We provide the following services for the HMP:

- Member enrollment and disenrollment
- Health risk assessment
- Nurse care management
- Client outreach and education
- Practice facilitation for quality improvement
- Provider education
- Data support
- Clinical call center



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 preparing and distributing quarterly newsletters, preparing and presenting seminars. education
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

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:	Providing Medical Management and Case Management
IFMC is prime contractor	

Through our wholly owned subsidiary, ENCOMPASS Health Management Services we provide utilization review and catastrophic case management for the employees of the . 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:	\$190,408
Average staff hours in FTEs during operations:	1
Workload Statistics:	Utilize the approved protocol and tools to determine if the national effectively apply and enforce the Programs. This includes across the country to ensure their performance meets these requirements.
IFMC is prime contractor	

We audit a meets the 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 percent 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 – June30, 2009
Total Contract Value:	
Average staff hours in FTEs during operations:	
Workload Statistics:	Through this project IFMC handles
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:	08/01/2009 to 07/31/2011
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 Member Services RFP and in this proposal.

Oklahoma Health Care Authority

Carolyn Reconnu, Manager, SoonerCare Health Management Program
405-522-7630

Polk County Health Services

Lynn D. Ferrell, Executive Director
515-243-6339

City of Chicago

Nancy L. Currier, Benefits Manager
312-744-6725



Member 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)



Member 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



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



November 10, 2009

Mr. Don Lovasz, CEO
Iowa Foundation for Medical Care
6000 Westown Parkway, Suite 350E
West Des Moines, IA 50266-7771

RE: IFMC Services for Polk County

Dear Mr. Lovasz:

Polk County has contracted with the Iowa Foundation for Medical Care (IFMC) since the mid-1980's to conduct reviews of medical necessity for our clients accessing inpatient mental health and substance abuse treatment and for our more intensive levels of residential care for person with mental illness. In addition, IFMC has done quarterly quality reviews of several programs.

During that lengthy relationship, we have never had dissatisfaction with the responsiveness or quality of IFMC's work. They have conducted themselves professionally and non-obtrusively when doing utilization reviews, they have worked collegially with us and our providers on the quality reviews, and they have been more than willing to go the extra mile with requests we've had for special projects. They continue to perform in this fashion.

If you need any additional information, please contact me at 515.243.6339.

Sincerely,

Lynn D. Ferrell
Executive Director

218 6th Avenue #1000
Des Moines, IA 50309
ph. 515.243.4545
fax. 515.243.8447
www.polk.ia.networkofcare.org
polkpc@pchs.co.polk.ia.us





Member 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





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 H: Certification Regarding Lobbying

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

- a. No federal appropriated funds have been paid or will be paid on behalf of the Sub-Grantee to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of the Congress, an officer or employee of the Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan or cooperative agreement.
- b. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of the Congress, or an employee of a Member of Congress in connection with this Contract, grant, loan, or cooperative agreement, the applicant shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
- c. The Contractor shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C.A. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Denise Sturm 12/2/2009
Name 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

