

Seventh Amendment to the Contract

This Seventh Amendment to the Contract for Iowa Medicaid Enterprise Services (the “Contract”) between the State of Iowa, Department of Human Services (the “Department” or “DHS”) and Policy Studies Inc. (the “Contractor”) effective as of July 1, 2004 is made pursuant to Section 19.6 of the Contract. This Amendment is effective as of July 1, 2008 (the “Amendment Seven Effective Date”), and will remain coterminous with the Contract. The Amendment modifies, to the extent specified below, the terms and conditions of the Contract:

1. Section 6.1 of the contract is hereby amended to read as follows:

Section 6.1.3 Payment for Ongoing Manual Licensure Maintenance Verification, Consumer Directed Attendant Care (CDAC) Provider Background Checks, CCO Background Checks, Expanded Enrollment Functions and payment for additional CSR staff.

Payment shall be made for work performed pursuant to the Seventh Amendment in addition to the fixed rates set forth in 6.1 and prior amendments. The additional fixed rate payable pursuant to this Section 6.1.3 shall be invoiced monthly according to the additional scope of work and payment schedule set forth.

For the scope of work as outlined in Attachment 13, which is attached hereto, the fixed rate is \$55,146 for each month starting on the Seventh Amendment Effective Date. This fixed rate also includes payment for staff approved from the Fifth Amendment that continue in the Seventh Amendment. The ongoing functions described in Attachment 12 of the Fifth Amendment will continue unchanged through the period of time in Amendment Seven.

2. Ratification

Except as expressly amended and supplemented herein, the Contract shall remain in full force and effect, and the parties hereby ratify and confirm the terms and conditions thereof.

3. Authorization

Each party to this Amendment represents and warrants to the other that:

3.1 It has the right, power, and authority to enter into and perform its obligations under this Amendment.

3.2 It has taken all requisite actions (corporate, statutory, or otherwise) to approve execution, delivery and performance of this Amendment and this Amendment constitutes a legal, valid and binding obligation upon itself in accordance with its terms.

4. Execution

IN WITNESS WHEREOF, in consideration of the mutual covenants set forth above and for other good and valuable consideration, the receipt, adequacy and legal sufficiency of which are hereby acknowledged, the parties have entered into the above Amendment and have caused their duly authorized representatives to execute this Amendment.

State of Iowa, acting by and through the Iowa Department of Human Services (Department)

By: _____

Date: _____

Kevin W. Concannon, Director

Policy Studies Inc. (Contractor)

By: _____

Date: _____

Mark Levy, President

Attachment 13

Scope of Work

Ongoing Manual Licensure Maintenance Verification:

Provider Services is under the assumption that CORE can automate the following list of Iowa licensed providers against an appropriate licensing authority and MMIS license end dates will be updated. Currently there are approximately **17,714** Iowa provider files that could be automated by CORE.

There are approximately **16,981** out of state provider files that cannot be automated from the list below, but could be verified manually on-line.

- Physician MD
- Physician DO
- Podiatrist
- Optometrist
- Optician
- Physical Therapist
- Chiropractors
- Audiologist
- Psychologist
- Hearing Aid Dealer
- Certified Nurse Midwife
- CRNA
- Nurse Practitioner

For all other provider types that are not mentioned above and cannot be verified automatically or on-line, MMIS will generate a 60-day letter to inform the provider that their license is going to expire. The request letter will advise the provider to submit a photocopy of their renewed license. A 30-day letter will be sent if MMIS has not been updated. Photocopy renewed license will be worked through the current change process. Currently there are approximately **35,318** enrollment files that fall into this category. Most professional licenses are renewed every two years; therefore approximately 17,659 providers will need to be manually updated each year.

Amendment 5 assumed there would be “no more than 10,000 files that need to be verified through a manual process on an annual basis”. The number is roughly 70% higher and projected to be as many as 17,659. This number assumes Core can automate the files noted in the first two paragraphs.

Performance Measures

- **Online:** If automatic verification not possible, but on-line verification is available: 95% of all licenses will be verified against an appropriate licensing authority (and the MMIS license end date will be updated) within 30 days after an MMIS license expiration date.
- **Manual:** If neither automatic nor on-line verification is available: 95% of all licenses will be solicited by a system generated letter 60 days prior to MMIS expiration date. If provider fails to respond a second letter at 30 days prior to MMIS expiration letter will be sent.

+Note: If and when license info is returned, it is subject to the existing change queue standards (refer to section 6.3.2.2.7, standard 5 on page 379 of the original contract).

Scope of Work

Individual CDAC Provider and CCO Background Checks: As part of the enrollment process, Provider Enrollment will run a criminal background check on all individual CDAC providers prior to completion of their enrollment. CCO background checks will be completed upon request from Veridian.

- Obtain a signed release with each individual CDAC application. (Request & Acknowledgement to conduct registry and record check)
- CCO Request & Acknowledgement to conduct registry and record check forms are sent via fax from Veridian.
- The CDAC applicant or CCO worker is entered in the SING system (Single Contact License & Background check)
- Results from the check are reviewed by the enrollment specialist
- Approved background checks (no hits) will result in an individual CDAC provider being successfully enrolled and able to provide services. CCO workers are approved to provide services.
- If a hit or a possible hit is returned from the background check additional steps are required before completing the enrollment process. One or all the following may apply:
- For Child or Adult abuse we will contact the DHS abuse registry using the appropriate request form faxed to the abuse registry. Results are faxed back to our unit.
- If a match or possible match is returned from the criminal history check or the sex offenders registry a fax will automatically be sent to DCI on our behalf with the results returned to our unit via fax within 4-10 days.
- If the results come back from Child, Adult, Criminal or Sex Offender registry as a match or founded a request form is sent to the applicant to complete and return for further review. (Form 2310)
- Once form 2310 is received back in our office we will forward this form and all record check results to the Record Check Evaluation department via fax.
- The Record check Evaluation department will send via fax approval or denial of enrollment into the Medicaid program.
- The record check process must be completed within 30 days from being entered into SING or the process must start over from that point.

- Additional call volume

Amendment 5 assumed PSI would make referrals for criminal background checks on all individual CDAC providers. The process is now defined that PSI will conduct the criminal background checks on all individual CDAC providers. In addition, Consumer Choice Option (CCO) workers were added after amendment 5 was approved to expand the scope prior to completion of their enrollment.

Amendment 5 specified there would be 161 new CDAC providers per month requiring a referral for a background check. The amount of time to complete background checks was not estimated in Amendment 5 as this was not originally part of the scope of work. In addition, CCO workers were not included in the original scope of work and have increased the volume by approximately 50 per month.

The staffing allocation in Amendment 5 was 1 FTE to complete both CDAC Provider Background Checks and Manual Licensure Maintenance Verification. Due to a fundamental change in the scope of work required for this project, the increase in background check volumes which now include CCO PSI will adjust the current level of resources dedicated to these functions.

Performance Measures

- 95% of provider enrollment CDAC applications must be verified for completeness or returned to the provider for additional information within 5 days of receipt of the application. Complete applications will have a background check ran and will be completed within 30 days as approved or denied.

Scope of Work:

Expanded Enrollment Function:

CDAC Union Dues-If a CDAC provider wants to become a member of the American Federation of State, County and Municipal Employees (AFSCME) they can authorize AFSCME to deduct dues.

- Forms- IME form “Electronic Funds Transfer (EFT) Authorization Form For Payment to Business Agent” and AFSCME EFT form
- Enrollment Specialist will review IME form for completeness, if not complete will send missing information request letter to the provider.
- If the IME EFT form is complete both forms will be email to AFSCME and BMGI for approval.
- Approval will be faxed to IME from BMGI and attached to EFT request
- CDAC union indicator will be set to “Y” in the Provider Enrollment file on MMIS and bank information will be populated.
- EFT request to cancel/change will be worked through current change process.
- Additional call volume

Performance Measures

When EFT request is received, it is subject to existing online updates to provider data queue standard.

(Refer to section 6.3.2.2.7, standards on page 379 of the original contract)

HCBS Quality Assurance and Quality Improvement

Provider Enrollment will monitor providers to assure they continue to meet eligibility criteria needed to remain certified or enrolled in the HCBS program.

- At the time of enrollment the MMIS will be updated with the most current certification end date to match ISIS.
- Certifications that do not contain an end date will be verified every 4 years.
- 90 days prior to license end date on MMIS a report will be worked to verify eligibility criteria is met.
- MMIS will be updated with the new certification end date or next certification date to be reviewed.
- One time task will be performed to update MMIS and ISIS for existing HCBS providers. Each HCBS enrollment file will be updated to match certification on file.

Performance Measures

- All existing performance standards apply (refer to section 6.3.2.2.7 of the original contract).
- 95% of all HCBS services approved are added to ISIS within 2 business days after approval.

New Business Process for Provider Enrollment Compliance

This expanded enrollment function outlines new processes as precipitated by review for the Medicaid Integrity Group (MIG) audit. This process will be implemented upon the State's approval.

- For those provider applications where required information is noted and complete, request that a random sample of providers submit proof of ownership as they have reported it in Attachment A. We will begin sampling of 200 cases per year, around 17 per month. The steps to be followed are:
 - A. Identify the sample
 - B. Send a letter to the provider
 - C. Process the returned information
 - D. If information is not returned within 30 days, consult with the policy staff on whether to terminate the provider number
- Conduct a random sample of criminal background checks on applicant providers, which would include asking providers to supply proof that they have checked that their owners and managing employees have not been convicted of a criminal offense. We will begin sampling 200 cases per year, around 17 per month. The steps are as followed are:
 - A. Identify the sample
 - B. Send a letter to the provider
 - C. Process the returned information

D. If information is not returned within 30 days, consult with the policy staff on whether to terminate the provider number

- We will develop a process to notify OIG
- We also have added an additional check to all new enrollments to check the EPLS Database prior to enrollment.

Performance Measures

- All existing performance standards apply (refer to section 6.3.2.2.7 of the original contract).
- A monthly report will be given to the Provider Services Unit Manager and the Medicaid Program Integrity Specialist.

Monthly TIN Match Error Report

Provider Services will work a monthly report to identify providers whose 1099 name and address on MMIS do not match the IRS.

- Provider services will work a monthly report
- Provider services will notify providers of errors that will result in one of the following three actions:
 1. The provider will send a new W-9 to IME that matches what they have sent to the IRS and MMIS will be updated accordingly.
 2. The provider will be re-enrolled for any TAX ID changes.
 3. The provider will update the information they have provided to us to the IRS.

Performance Measures

- 95% of all TIN mismatches are contacted within 1 month and follow-up is done within 2 months where the file is either corrected (now matches) or terminated

Call Center CSRs

The call center for provider services was originally staffed by 20 FTE, PSI expanded allocation to 24 FTE at our expense to achieve and maintain performance standards. PSI is committed to maintaining high standards in relation to customer service and would like to retain 4 CSRs that were allocated under the NPI contract. Our assumption is the current call volume and complexity of the call content will continue after the NPI contract ends on June 30, 2008. This is attributable to

- 340B reporting requirements,
- CDAC union dues and related issues
- NDC reporting requirements
- Implementation of Tamper-Resistant Prescription Drug Pads
- Annual Routine Physical Examinations expansion
- Annual Medicaid Cards
- Habilitation Services Implementation

- Remedial Services Implementation

CALLS ANSWERED

	SY06 2005-2006	SY07 2006-2007	SY08 2007-2008
July	17815	25548	29585
August	20694	31358	33114
September	21348	29204	28608
October	20123	30595	34020
November	20389	25607	28982
December	21999	24224	25724
January	20726	28996	31127
February	20956	26561	29498
March	26676	26212	30750
April	23267	29897	30500
May	27504	31333	30500
June	27478	30471	30500
Total	268975	340006	368908

SFY06 to SFY07 26% increase in calls answered

SFY06 to SFY08 37% increase in calls answered

Monthly cost for Ongoing Manual Licensure Maintenance Verification, Consumer Directed Attendant Care (CDAC) Provider Background Checks, Expanded Enrollment Functions and payment for additional CSR staff.

	Manual Licensure Verification		CDAC Provider Background checks		Expanded Enrollment Functions		Additional CSRs for Call center		Total Fixed cost per month
	FTE	\$	FTE	\$	FTE	\$	FTE	\$	
July 1, 2008- June 30, 2009	1.5 FTE	\$7,280	1.5 FTE	\$7,280 4853	5 FTE	\$24,265	4 FTE	\$16,321 estimate (\$23.54 hour)	\$55,146
Option year 2	1.5 FTE	\$7,280	1.5 FTE	\$7,280	5 FTE	\$24,265	4 FTE	\$16,321	\$55,146