State of Iowa
Department of Human Services

TECHNICAL PROPOSAL – SANITIZED COPY

Systems and Professional Services for the
Iowa Medicaid Enterprise

Provider Cost Audits and Rate Setting Component

RFP# MED-04-015

Submission Date and Time:
March 26, 2004 (3:00 pm)

FEDERAL TAX IDENTIFICATION NUMBER
48-1164042

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Myers and Stauffer LC
Certified Public Accountants

March 24, 2004

Mary Tavegia, Issuing Officer
Iowa Department of Human Services
1st Floor, Hoover State Office Building
1305 East Walnut Street
Des Moines, Iowa 50319-0114

Re: Transmittal Letter (Tab 2)

To the Evaluation Committee:

Myers and Stauffer is pleased to present our response to RFP #: MED-04-015 issued December 9, 2003. As requested in Section 7.2.2 of the RFP, we present the following information.

1.) The bidder's mailing address:

Myers and Stauffer LC
8555 N. River Road, Suite 360
Indianapolis, Indiana 46240

2.) Electronic mail address, fax number and telephone number for both the authorized signer and the point of contact:

Kristopher J. Knerr (authorized signer and point of contact)
kknerr@mslc.com
Fax number: (317) 571-8481
Telephone number: (800) 877-6927

3.) Myers and Stauffer is a limited liability company organized in the state of Kansas and licensed to do business in the state of Iowa. No subcontractors will be used for completion of this contract. Myers and Stauffer will perform 100% of the work required to complete the contract.

4.) Myers and Stauffer is registered to do business in the state of Iowa. Our corporate charter number is 240079. No subcontractors will be used.

8555 N. River Road, Suite 360 ▪ Indianapolis, Indiana 46240-4305
(317) 846-9521 ▪ (800) 877-6927 ▪ FAX (317) 571-8481

5.) Myers and Stauffer's Federal Tax Identification Number is 48-1164042.

6.) Myers and Stauffer will comply with all Contract Terms and Conditions as indicated in Section 9 of the RFP.

7.) No attempt has been made or will be made by Myers and Stauffer to induce any other person or firm to submit or not to submit a proposal.

8.) Myers and Stauffer is an equal opportunity employer and does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap.

9.) No cost or pricing information has been included in this letter or the Technical Proposal.

10.) We acknowledge receipt of Amendment 1 dated February 4, 2004; Amendment 2 dated February 4, 2004; Responses to Bidder Questions – Set 1 dated February 23, 2004; Amendment 3 dated February 20, 2004; Amendment 4 dated February 24, 2004; Responses to Bidders Questions – Set 2 issued February 25, 2004; Amendment 5 dated March 10, 2004; Amendment 6 dated March 9, 2004; Responses to Bidders Questions – Set 3 issued March 10, 2004; Responses to Bidders Questions – Set 4 issued March 10, 2004, and Amendment 7 dated March 10, 2004; and Responses to Bidders Questions – Set 5 issued March 15, 2004.

11.) Myers and Stauffer certifies:

a.) The prices proposed have been arrived at independently, without consultation, communication, or agreement, as to any matter relating to such prices with any other bidder or with any competitor for the purposes of restricting competition; and

b.) Unless otherwise required by law, the prices quoted have not been knowingly disclosed by Myers and Stauffer prior to award, directly or indirectly, to any other bidder or to any competitor.

12) This is to certify that I, Kristopher J. Knerr, member, am an officer within our organization who is authorized to contractually obligate the firm and negotiate a contract on behalf of Myers and Stauffer LC. I am responsible for, or authorized to make, decisions regarding the prices quoted and I have not participated and will not participate, in any action contrary to item 11 above.

13.) No subcontractors will be used for this contract.

14.) Our proposal consists of one original and eight copies, individually bound. Also enclosed is one additional copy from which confidential information has been excised. This copy has been labeled as "Sanitized Copy".

The following proposal materials are considered proprietary; therefore, we request that they be treated as confidential in accordance with Iowa Code Chapter 22.7, Confidential records. These materials contain trade secrets, privileged information, and proprietary commercial information that, if released, would give an advantage to competitors. We have marked these as confidential:

Company Financial Content	Separately Sealed
Desk Review Program	Appendix A
Auditor's Report	Appendix B
FQHC Cost Settlement Program	Appendix C
Field Audit Program	Appendix D
Facility Questionnaire	Appendix E
Project Summary Sheets	Pages 333-337

I, Kristopher J. Knerr, am the authorized person within our organization to respond to any inquires by DHS concerning the confidential status of the listed material.

Kristopher J. Knerr, Member
Myers and Stauffer LC
8555 N. River Road, Suite 360
Indianapolis, IN 46240
(800) 877-6927

As required in Amendment 7, Myers and Stauffer acknowledges compliance with the listed statements.

Myers and Stauffer warrants that it has no interest and agrees that it shall not acquire any interest in a provider subject to Medicaid rate setting, cost settlements and cost audits that would conflict, or appear to conflict, in any manner or degree with our obligations and performance of services under this Contract. Activities that are prohibited under this section include, but are not limited to the following:

1. Myers and Stauffer shall not conduct and shall not subcontract with another firm to conduct any desk or on-site audits of a provider if the provider is a client of Myers and Stauffer and the provider also provides services for the Department.

2. Myers and Stauffer shall not use any information obtained by virtue of its performance of this Contract and its relationship to the Department to provide what would be "inside information to our clients who are providers of medical,

social or rehabilitative treatment and support services on behalf of the Department or to the organizations that represent such providers.

3. Myers and Stauffer shall disclose its membership on any and all Boards. Myers and Stauffer shall not use any information obtained by virtue of its contractual relationship with the Department to its advantage by voting, or attempting to influence fellow Board members of said Board(s) in the performance of services by that Board's organization. No members, principals or employees are members of any Boards that have involvement with the Iowa Medicaid program.

4. Myers and Stauffer shall not have ownership in any provider or provider organization that contracts with the Department or is approved by the Department for the provision of medical, social or rehabilitative treatment and supportive services on behalf of the Department.

5. Myers and Stauffer shall not pursue, directly or indirectly, using its position as a contractor with the Department or any information obtained from performance of this Contract, legislation or rules which are intended to provide a competitive advantage to us by limiting fair and open competition in the award of this contract upon it expiration.

We look forward to working with the Iowa Department of Human Services on this important project. I am available to make an oral presentation of the bid proposal upon request of the evaluation committee. If you have any questions or need any clarification, please contact me at (800) 877-6927.

Sincerely,

Kristopher J. Knerr
Member

3. Requirements Checklists and Cross-References

3.1 Bid Proposal Mandatory Requirements Checklist

(RFP Section 7.2.3.1)

Bidder Name: Myers and Stauffer LC			
Mandatory Reqt #	Requirement	Bidder Check	DHS Check
1	Did the Bidder submit a Letter of Intent to Bid by 3:00 p.m., Central Time, on January 15, 2004?		
2	Are all Bid Proposal materials being submitted to the Issuing Officer on or before specified submission deadline of March 26, 2004 at 3:00pm, Central Time?		
3	Does each Bid Proposal consist of three distinct parts (i.e., *Technical Proposal, Cost Proposal, and Company Financial Information)*?		
4	Is each Bid Proposal sealed in a box (or boxes), with the *Cost Proposal* and the *Company Financial Information* portions sealed in separate, labeled envelopes inside the same box(es)?		
5	Are packing boxes numbered in the following fashion: 1 of 4, 2 of 4, etc., for each Bid Proposal that consists of multiple boxes?		
6	Are all boxes containing bids labeled with the following information?: Bidder's Name and Address Issuing Officer and Department's Address (Identified by Section 2.1) RFP Title (Iowa Medicaid Enterprise Procurement) and RFP Reference Number (MED-04-015)		

Bidder Name: Myers and Stauffer LC			
Mandatory Reqt #	Requirement	Bidder Check	DHS Check
	RFP Component for which the Bid Proposal is being submitted for consideration (e.g., Core MMIS Contract, Medical Services Contract, et al)		
7	Are separate boxes utilized for each Bid Proposal if submitting Bid Proposals for more than one of the nine separate contract awards?		
8	Are all Bid Proposal materials printed on 8.5" x 11" paper (two-sided)?		
9	Are materials for each *Technical Proposal* presented in a spiral binder, comb binder, or similar binder separate from the sealed *Cost Proposal* materials? *(Note: Technical Proposals in 3-ring binders will not be accepted.)*		
10	Are materials for each *Cost Proposal* presented in a small 3-ring binder, spiral or comb binders, "sliding bar" report cover, or similar binding that allows for easy removal of documents? *(NOTE: This will be determined when Cost Proposals are opened after Technical Proposals have been evaluated.)*		
11	Are materials for each *Company Financial Information* presented in small 3-ring binder, spiral or comb binders, "sliding bar" report cover, or similar binding that allows for easy removal of documents? *(NOTE: This will be determined when Company Financial Information volumes are opened for the financial viability screening.)*		
12	Is one (1) "sanitized" copy of Bid Proposal materials being submitted if any Bid Proposal information is designated as confidential? *(Note: Bidders cannot designate their entire proposal as confidential or proprietary.)*		
13	Does each Bid Proposal package include one (1) original, eight (8) copies, and one (1) sanitized copy (if applicable) of the		

Bidder Name: Myers and Stauffer LC			
Mandatory Reqt #	Requirement	Bidder Check	DHS Check
	Technical Proposal in a separate binder (or set of binders)? Are the original, copies, and sanitized copy correctly marked?		
14	Does each Cost Proposal package contain 1 original, 8 Copies, and 1 Sanitized Copy of Cost Proposal (in Separate, Sealed Envelopes)? Are the original, copies, and sanitized copy correctly marked? *(NOTE: This will be determined when Cost Proposals are opened after Technical Proposals have been evaluated.)*		
15	Does each Company Financial Information package contain 1 original of Company Financial Information (in a Separate Sealed Envelope)? *(NOTE: This will be determined when Company Financial Information volumes are opened for the financial viability screening.)*		
16	Are all Bid Proposals also being submitted on CD Rom (2 CD-Rom copies per Bid Proposal).		
17	Does each submitted CD-Rom contain one full version of each Bid Proposal part and one "sanitized" version of each bid proposal part?		
18	Are all electronic files in PDF format or Microsoft Word 2000 format?		
19	Are all electronic files individually identified by Component Name, Bid Proposal part, and version?		
	TECHNICAL PROPOSAL CONTENTS		
20	Does each *Technical Proposal* consist of the following sections separated by tabs with associated documents and responses presented in the following order?: ▪ Table of Contents (Tab 1) ▪ Transmittal Letter (Tab 2) ▪ Requirements Checklists and Cross-References (Tab 3) ▪ Executive Summary / Introduction		

Bidder Name: Myers and Stauffer LC			
Mandatory Reqt #	Requirement	Bidder Check	DHS Check
	(Tab 4) ▪ Understanding of the Iowa Medicaid Enterprise Procurement Project (Tab 5) ▪ Services Overview (Tab 6) ▪ General Requirements (Tab 7) ▪ Start-Up Activities (Tab 8) ▪ Operational Requirements (Tab 9) ▪ Project Management Planning (Tab 10) ▪ Corporate Organization, Experience, and Qualifications (Tab 11) ▪ Certifications and Guarantees by the Bidder (Tab 12)		
21	Does the *Table of Contents* in Tab 1 of the *Technical Proposal* identify all Sections, Subsection(s), and corresponding page numbers?		
22	Does the *Transmittal Letter* in Tab 2 include the following:		
	▪ A signature by an person authorized to legally bind the bidder		
	▪ Print on official business letterhead		
	▪ The bidder's mailing address		
	▪ Electronic mail address, fax number, and telephone number for both the authorized signer and the point of contact designated by the bidder		
	▪ A statement indicating that the bidder is a corporation or other legal entity. ▪ Identification of all subcontractors ▪ A statement indicating the exact amount of work to be done by the prime contractor [not less than sixty		

Bidder Name: Myers and Stauffer LC			
Mandatory Reqt #	Requirement	Bidder Check	DHS Check
	percent (60%)] and each subcontractor, as measured by percentage of total contract price.		
	▪ A statement confirming that the bidder is registered to do business in Iowa ▪ The corporate charter number of the prime contractor ▪ Assurances that any subcontractor proposed is also licensed to work in Iowa		
	▪ A statement identifying the bidder's Federal Tax Identification Number		
	▪ A statement that the bidder will comply with all *Contract Terms and Conditions* as indicated by *Section 9* of this RFP		
	▪ 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		
	▪ 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		
	▪ A statement that no cost or pricing information has been included in the transmittal letter or the *Technical Proposal*		
	▪ A statement identifying all amendments to this RFP issued by the state and have been received by the bidder. (If no amendments have been received, a statement to that effect		

Bidder Name: Myers and Stauffer LC			
Mandatory Reqt #	Requirement	Bidder Check	DHS Check
	shall be included)		
	▪ A statement that the bidder certifies in connection with this procurement that: ▪ a) The prices proposed have been arrived at independently, without consultation, communication, or agreement, as to any matter relating to such prices with any other bidder or with any competitor for the purpose of restricting competition; and ▪ b) Unless otherwise required by law, the prices quoted have not been knowingly disclosed by the bidder prior to award, directly or indirectly, to any other bidder or to any competitor		
	▪ 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 item 11 above		
	▪ Is a statement from each proposed subcontractor appended to the transmittal letter signed by an individual authorized to legally bind the subcontractor stating: ▪ The general scope of work to be performed by the subcontractor ▪ The subcontractor's willingness to perform the work indicated ▪ The subcontractor's assertion that it does not discriminate in employment practices with regard to race, color,		

Bidder Name: Myers and Stauffer LC			
Mandatory Reqt #	Requirement	Bidder Check	DHS Check
	religion, age (except as provided by law), sex marital status, political affiliation, national origin, or handicap		
	▪ Identification of any request for confidential treatment of information, 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.		
	▪ The name, address and telephone number of the individual authorized to respond to the Department about the confidential nature of the information (if applicable)		
23	Is a completed copy of the *Mandatory Requirements Checklist* included in Tab 3?		
24	Is a *General Requirements Cross Reference* in Tab 3 included for each *Technical Proposal* under consideration, based upon the sample provided by Attachment E as specified in RFP Section 7.2.3.2?		
25	Is an *Operational Requirements Cross Reference* in Tab 3 included for each *Technical Proposal* under consideration, based upon the sample provided by Attachment E as specified in RFP Section 7.2.3.3?		
26	Are requirements numbers listed above the paragraph or set of paragraphs for all addressed requirements in?		
27	Does information in Tab 12 include the following?:		
	▪ A signed copy *Attachment F* which authorizes the release of information to the Department		
	▪ A signed copy *Attachment G*, which certifies that the bidder is not		

Bidder Name: Myers and Stauffer LC			
Mandatory Reqt #	Requirement	Bidder Check	DHS Check
	presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal, department or agency		
	▪ A signed copy of *Attachment H*, which certifies that the Bid Proposal was developed independently, and also certifies that no relationship exists or will exist during the contract period between the bidder and the Department that interferes with fair competition or is a conflict of interest.		
	▪ A signed copy of *Attachment I*, which certifies that the contents of the Bid Proposal are true and accurate		
	▪ A signed copy of *Attachment J*, which certifies that the bidder has sufficient available resources to provide the services proposed in the Bid Proposal.		
	▪ A statement that stipulates that, with the submitted Bid Proposal, the bidder acknowledges the acceptance of all terms and conditions stated in the RFP. (*If the bidder objects to any term or condition, a specific reference to the RFP page, section, paragraph, and line number(s) must be made. Objections or responses that materially alter the RFP shall be deemed non-responsive and disqualify the bidder.)*		
	▪ A written guarantee regarding the availability of the services offered and that all Bid Proposal terms, including price, will remain firm for at least 120 days after the date set for completion of contract negotiations and execution of the contract.		

Bidder Name: Myers and Stauffer LC			
Mandatory Reqt #	Requirement	Bidder Check	DHS Check
	COST PROPOSAL CONTENTS		
28	Does the Cost Proposal include the following sections?: ▪ Table of Contents ▪ Bid Proposal Security ▪ Pricing Schedules		
29	Does Tab 1 include a *Table of Contents* of the *Cost Proposal*?		
30	Does the *Table of Contents* identify all Sections, Subsections, and corresponding page numbers?		
31	Is a Proposal Bid Bond or proposal guarantee in the form of a cashier's check, certified check, bank draft, treasurer's check, or bond payable to DHS in an amount equal to 5% of the total implementation and operations costs identified by *Pricing Schedule A* of the *Cost Proposal* included in Tab 2?		
32	Are photocopies of the Proposal Bid Bond included in Tab 2 in all other copies of the *Cost Proposal* submitted by the bidder?		
33	If a bond is used, is it issued by a surety licensed to do business in Iowa?		
34	Are pricing schedules as specified in the RFP included in Tab 3?		
	COMPANY FINANCIAL INFORMATION		
35	Does the *Company Financial Information* include audited financial statements (annual reports) for the last 3 years?		
36	Does the *Company Financial Information* include at least three (3) financial references (e.g., letters from creditors, letters from banking institutions, Dun & Bradstreet supplier reports, etc.)?		
37	Does the *Company Financial Information* include a description of other contracts or projects currently undertaken by the bidder?		

Bidder Name: Myers and Stauffer LC			
Mandatory Reqt #	Requirement	Bidder Check	DHS Check
38	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?		
39	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. 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?		
40	Does the *Company Financial Information* include a disclosure of any contracts during the preceding three (3) -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.?		
41	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?		

3.2 General Requirements Cross Reference

(RFP Section 7.2.3.2)

RFP Section and Requirement #	Location of Response in Bid Proposal
Section 6.1.1	7.1.A – pg. 47-50
Section 6.1.2	7.1.B – pg. 50-54
Section 6.1.3	7.1.C – pg. 54-55
Section 6.1.4	8.1 – pg. 68-75
Section 6.1.5	7.1.D – pg. 55-56
Section 6.1.6	7.1.E – pg. 57
Section 6.1.7	7.1.F – pg. 57-60
Section 6.1.8	7.1.G – pg. 60-61
Section 6.1.9	7.1.H – pg. 61
Section 6.1.10	7.1.I – pg. 61-63
Section 6.1.11	7.1.J – pg. 63-64
Section 6.1.12	7.1.K – pg. 64
Section 6.1.13	7.1.L – pg. 65
Section 6.7.1	8.2 – pg. 76-80
Section 6.7.2.1	7.2 – pg. 66
Section 6.7.2.1.1	7.2 – pg. 67

3.3 Operational Requirements Cross Reference

(RFP Section 7.2.3.3)

RFP Section and Requirement#	Location of Response in Bid Proposal
Section 6.7.2.2	9.1 – pg. 81
Section 6.7.2.2.1	9.1.A – pg. 81-82
Section 6.7.2.2.2	9.1.B - pg. 82
Section 6.7.2.2.3	9.1.B – 9.1.C – pg. 82
Section 6.7.2.2.4	9.1.C – pg. 82
Section 6.7.2.2.4 Requirement 1	9.1.C – pg. 83-89
Section 6.7.2.2.4 Requirement 2	9.1.C pg. 89
Section 6.7.2.2.4 Requirement 3	9.1.C – pg. 89-90
Section 6.7.2.2.4 Requirement 4	9.1.C – pg. 90
Section 6.7.2.2.4 Requirement 5	9.1.C – pg. 91
Section 6.7.2.2.4 Requirement 6	9.1.C – pg. 91
Section 6.7.2.2.4 Requirement 7	9.1.C – pg. 92-99
Section 6.7.2.2.4 Requirement 8	9.1.C – pg. 99-105
Section 6.7.2.2.4 Requirement 9	9.1.C – pg. 106-116
Section 6.7.2.2.4 Requirement 10	9.1.C – pg. 117
Section 6.7.2.2.4 Requirement 11	9.1.C – pg. 117-118
Section 6.7.2.2.4 Requirement 12	9.1.C – pg. 119
Section 6.7.2.2.4 Requirement 13	9.1.C – pg. 120
Section 6.7.2.2.4 Requirement 14	9.1.C – pg. 120-121
Section 6.7.2.2.4 Requirement 15	9.1.C – pg. 121
Section 6.7.2.2.4 Requirement 16	9.1.C – pg. 121
Section 6.7.2.2.4 Requirement 17	9.1.C – pg. 121-122
Section 6.7.2.2.4 Requirement 18	9.1.C – pg. 122
Section 6.7.2.2.4 Requirement 19	9.1.C – pg. 122
Section 6.7.2.2.4 Requirement 20	9.1.C – pg. 123
Section 6.7.2.2.4 Requirement 21	9.1.C – pg. 123-124
Section 6.7.2.2.4 Requirement 22	9.1.C – pg. 124
Section 6.7.2.2.4 Requirement 23	9.1.C – pg. 124-126
Section 6.7.2.2.4 Requirement 24	9.1.C – pg. 126-127
Section 6.7.2.2.4 Requirement 25	9.1.C – pg. 127
Section 6.7.2.2.4 Requirement 26	9.1.C – pg. 127
Section 6.7.2.2.4 Requirement 27	9.1.C – pg. 128
Section 6.7.2.2.4 Requirement 28	9.1.C – pg. 128
Section 6.7.2.2.4 Requirement 29	9.1.C – pg. 129
Section 6.7.2.2.4 Requirement 30	9.1.C – pg. 129-130

RFP Section and Requirement#	Location of Response in Bid Proposal
Section 6.7.2.2.4 Requirement 31	9.1.C – pg. 130
Section 6.7.2.2.4 Requirement 32	9.1.C – pg. 130-131
Section 6.7.2.2.4 Requirement 33	9.1.C – pg. 131-132
Section 6.7.2.2.5	9.1.D – pg. 132
Section 6.7.2.2.6	9.1.E – pg. 132
Section 6.7.2.2.7	9.1.F – pg. 132
Section 6.7.2.3	9.2 – pg. 133
Section 6.7.2.3.1	9.2.A – pg. 133-134
Section 6.7.2.3.2	9.2.B – pg. 134-135
Section 6.7.2.3.3	9.2.B – 9.2.C – pg. 134-135
Section 6.7.2.3.4 Requirement 1	9.2.C – pg. 135-140
Section 6.7.2.3.4 Requirement 2	9.2.C – pg. 140-143
Section 6.7.2.3.4 Requirement 3	9.2.C – pg. 143-151
Section 6.7.2.3.4 Requirement 4	9.2.C – pg. 152-153
Section 6.7.2.3.4 Requirement 5	9.2.C – pg. 154
Section 6.7.2.3.5	9.2.D – pg. 155
Section 6.7.2.3.6	9.2.E – pg. 155
Section 6.7.2.3.7	9.2.F – pg. 156-157
Section 6.7.2.4	9.3 – pg. 158
Section 6.7.2.4.1	9.3.A – pg. 158
Section 6.7.2.4.2	9.3.B – pg. 158
Section 6.7.2.4.3	9.3.B - 9.3.C – pg. 158-161
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4. Executive Summary/Introduction

We are pleased to submit for your consideration a proposal to the Iowa Department of Human Services (DHS) of the Provider Cost Audits and Rate Setting Component of RFP #MED-04-015 (Section 6.7). Over the last four years, we have developed a strong relationship with the Department. We have assisted in many different areas and through many changes. The Iowa Medicaid Enterprise may be the most important change ever for the Department. We believe our experience and expertise with projects of similar size, scope, and complexity, lends itself well as a component of the IME. Our proposal offers the opportunity for uninterrupted delivery of services we currently provide DHS, including reimbursement technical assistance and system monitoring, maximum allowable cost rate setting for pharmaceuticals, and several revenue maximization strategies. We also look forward to assisting DHS under this project with rate setting and auditing services for all non-fee based providers, as outlined in the RFP.

Summary of Proposal

Our proposal responds to all RFP requirements for this service component and is outlined in the manner specified by RFP, Tab 7 – Format and Content of Bid Proposals. Following the Table of Contents, Transmittal Letter, Requirements Checklists and Cross-References, and Executive Summary, our Technical Proposal contains a description of our understanding of the Iowa Medicaid Enterprise (IME), general project requirements, start-up activities, operational requirements, project management planning and staffing, corporate organization, experience and qualifications, applicable certifications and guarantees, and appendices. The Cost Proposal and Company Financial Information are contained in separate sealed packages as required by the RFP. Each of these sections is logically organized, and easy to follow.

Understanding of Iowa Medicaid Enterprise

We appreciate the challenges and complexity that DHS and IME contractors will face to successfully integrate multiple organizations into a single, cohesive enterprise. By serving on numerous working groups with state Medicaid agency clients, and having provided co-located management and other staff support services through a subcontract arrangement with another state Medicaid agency fiscal agent contractor, we have developed an appreciation of the issues that can occur in this setting. We are prepared to adapt to changing circumstances as directed by DHS and the Implementation and Support Services (I&SS) contractor. Above all, strong and effective communication will be a key ingredient for a successful IME integration. We

have worked closely with DHS for several years and we look forward to an extensive on-site presence as an integral component of the IME.

Services Overview

The RFP requires the contractor to possess extensive expertise in numerous reimbursement and technical areas. We currently have the expertise to meet all of the service requirements of the RFP, without the need to subcontract any services. We also either have in place, or can easily adapt, all tools and systems that will quickly and accurately produce the products and services required by the RFP. These include rate setting systems, status tracking and reporting tools, system monitoring tools, and a wide array of analytic tools that can support all technical assistance RFP requirements. We will provide proposed desk review, field audit and settlement programs and procedures to DHS for review and approval before implementation. We will offer DHS a continuation of many of the services required, including SMAC rate setting, technical assistance and monitoring, and revenue maximization strategies. Since we are currently providing these services, we offer a seamless transition to the IME project without interruption in services. We will begin collecting data and performing analysis to prepare for the upcoming DRG/APG recalibration and rebasing effective October 1, 2005.

General Requirements

Quality work products and services are extremely important. As such, we have allocated management staff who have worked with the Department, are familiar with the health care environment in Iowa, and will ensure we meet our rigorous quality standards. These management staff and others will be available throughout all contract phases. Staff proposed for this project possesses unmatched experience and technical knowledge. We will operate from our temporary office location in downtown Des Moines beginning July 1, 2004, and will be prepared to relocate to the IME facility upon the direction of DHS beginning in 2005. We have designed a proposed technology solution that will accommodate the project needs. Subject to design evaluation, review and approval by DHS. We agree to all general requirements as stated in the RFP, including such items as record keeping, audits, confidentiality, HIPAA compliance, and quality assurance. It is important to note that we have no conflicts of interest, as our firm has not and will not accept health care providers as clients, nor do we have any other potentially conflicting relationships.

Start-Up Activities

There are numerous tasks and activities associated with the start-up phase of this project. It will be imperative for all contractors to communicate and work closely with DHS and the I&SS contractor through this period. We recognize time is a limited resource, and will use it wisely to achieve maximum productivity. We will remain flexible to accommodate changing circumstances and priorities. Following initial meetings with DHS and others, we will prepare proposed work plans for DHS approval. Upon DHS approval of our proposed technology approach, we will initiate development and refinement of our software tools for all rate setting, audit and analysis activities. We will also work closely with DHS through the takeover tasks. Having worked through similar takeover tasks before, we understand the potential challenges and the need to handle this process appropriately with close direction from DHS. Once DHS has approved our work plans, deliverables, and procedures, we will begin the implementation process. Testing of all systems and interfaces will be completed to ensure that the transition to the operations phase presents no significant surprises. We will work closely with DHS throughout this process.

Operational Requirements

There are numerous operational requirements associated with the rate setting, cost settlements and cost audits, and other consulting activities of the RFP. We are familiar with all aspects of the scope of work required based on our previous experience with DHS and other state Medicaid agencies. We will perform all desk audits and field audits in a timely manner, using DHS approved review programs and system interfaces. We will also provide all necessary DRG/APG recalibration services. We understand these services begin July 1, 2004, and we will work with DHS, the core MMIS and Data Warehouse/Decision Support (DW/DS) contractors to obtain the necessary reference materials for the next recalibration initiative to be effective October 1, 2005. We are also prepared to continue providing DHS with revenue maximization strategy consultations and analysis. As there are several key revenue maximization initiatives currently underway that involve on-going negotiations with CMS, we are prepared to continue with this support function.

Strengths of Myers and Stauffer LC

As the Provider Cost Audits and Rate Setting Contractor, Myers and Stauffer presents several important advantages to DHS. These include:

- Many years of extensive experience with *all* RFP service requirements in numerous states.

- A dedicated, knowledgeable project team.
- A proven commitment to complete client satisfaction from all levels within the firm.

Myers and Stauffer was founded more than 27 years ago with the mission of serving the needs of state Medicaid and other health care related government agencies. With government health care and reimbursement as our only major business line, we are committed to staying current on all pertinent health care reimbursement issues, and providing options, recommendations and solutions needed by our clients to address the myriad of challenges they face. Our project team has developed unmatched knowledge and expertise through many years of assisting DHS and other state Medicaid agencies on Medicaid rate setting, auditing, and reimbursement consulting for virtually every Medicaid provider category, development of sophisticated computer systems providing essential tools for effective program monitoring and reporting, and all aspects of revenue maximization strategy development and defense.

We propose a project team of members, principals, managers and other senior staff for the IME project that are dedicated to its success, have extensive experience working with state Medicaid programs, and are very knowledgeable about all relevant issues and potential obstacles likely to be faced during the IME transition. Our project management team has more than 75 years of combined experience delivering rate setting, auditing and related consulting services in the majority of state Medicaid programs. All members of our management team have dedicated virtually their entire careers to serving the needs of state Medicaid agencies. Our management team and staff are committed to the success of the IME initiative.

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

minimum expected and regularly go beyond that level of service. Our goal is to become a trusted partner with our clients to assist them in achieving their objectives. We will continue to provide this high level of service to DHS as the Provider Cost Audits and Rate Setting Contractor.

Key Features of Proposed Approach

The key features of our proposed approach builds on many of our strengths enumerated above. Successfully meeting or exceeding DHS goals and objectives for the IME will require a competent and strong management team, as well as senior and staff resources with considerable subject matter expertise. Our proposed approach involves an experienced and proven management team, and sufficient levels of trained and dedicated staff. Our team will approach this project by developing a collaborative partnership relationship with DHS and other IME contractors to achieve common objectives. We will utilize technology to its highest potential to deliver accurate products and services in the most efficient manner possible.

Myers and Stauffer LC is "the Best of Breed"

By selecting contractors with specialized skill sets to assist with the management, operations and oversight of the Iowa Medicaid program, DHS has determined to bring substantial change to the current concept of Medicaid fiscal agent services. We applaud this innovative approach to Medicaid program administration and fully support these goals. This approach seeks to identify and engage multiple contractors who are best qualified to address interrelated yet different requirements. A firm that has developed high competencies with claims processing, may not have developed similar competencies performing audits of financial statements or conducting utilization review functions. In recognition of this marketplace reality, and instead of accepting a single firm who performs some functions more effectively than others, DHS has determined to seek the "best of breed" contractor for *all* RFP service functions, and will likely engage multiple firms through this procurement. Over the long run, this innovative approach to fiscal agent service delivery should provide substantial benefits to the Iowa Medicaid program beneficiaries, taxpayers, and other stakeholders.

Based on our experience, our understanding of the RFP requirements and our appreciation of the IME concept, we believe we are the "Best of Breed" for the provider cost audits and rate setting component. Our sole mission is to meet the needs of state health care and related government agency clients. We are dedicated to state Medicaid agency needs and have performed all RFP service requirements in the financial reimbursement and rate setting area for

years. Our professional staff time are devoted to pursuing this mission, and we look forward to continuing to provide DHS with these services.

Experienced and Proven Management Team

Our management plan for the Provider Cost Audits and Rate Setting project includes designating Kris Knerr and Jared Duzan as Project Directors, and Amy Perry as the Account and Implementation Manager. They have years of experience successfully meeting DHS needs on many of the same service requirements as contained in the RFP. We are pleased to be able to provide a continuation of strong, experienced leadership to this project. Mr. Knerr and Mr. Duzan have many years of experience working closely with all levels of DHS staff and other stakeholders of the Iowa Medicaid program, and will continue to provide overall leadership and direction to this project. Ms. Perry has worked closely with DHS staff on complex reimbursement projects and issues for several years, as well as working with multiple state Medicaid agencies performing auditing, rate setting and consulting services virtually identical to those required by the RFP. Ms. Perry will relocate to the Des Moines area following notice of contract award, and Mr. Knerr and Mr. Duzan will be available in Des Moines as needed throughout the implementation and operations periods of the project.

Sufficient Levels of Qualified Staff Dedicated to the IME

The RFP requires the successful contractor to provide a significant volume of auditing and rate setting activity. In addition to our strong management team, we will provide sufficient senior and other support staff to meet all service delivery requirements. We are proposing approximately 10 full time equivalent (FTE) staff positions during the implementation period of the project, increasing to approximately 23 FTE during the operation phase. Which, based on our experience performing the RFP functions for Iowa DHS and other state Medicaid agencies, should be appropriate to meet the needs of DHS for the IME implementation and operation.

Develop a Collaborative Partnership Relationship

As has been our practice with DHS for many years, we will continue to build our partnership relationship. We anticipate working closely with DHS and other IME contractors throughout the implementation and operation phases to achieve the common IME goals, and find solutions to the many issues we face.

Provide Technology-Driven Solutions

Our proposed approach relies heavily on computer technology tools to help us deliver timely and accurate products and solutions. These tools are extremely effective at freeing up time for professional and other staff that can be more productively devoted to analysis and problem resolution, rather than merely "crunching numbers." A key element of our staff training protocol includes a focus on bigger picture issues. We strive to minimize the time devoted to immaterial or potentially irrelevant items. The Provider Cost Audits and Rate Setting Contractor must promptly identify, and remain focused on the relevant and material issues throughout this project, in order to avoid overlooking key risk areas within each program category. By designing and developing technology solutions, we are fully prepared to meet the demands of this project.

Summary of Project Management Plans

We have successfully established and staffed other office operations following award of a new engagement and will use a similar approach in Iowa. Our plan utilizes multiple strategies to providing management and staff who are qualified to serve DHS on this project that include onsite management, owner management, other staff relocations to Des Moines, subject matter experts (SME) from other Myers and Stauffer offices, and recruitment of new staff in the Des Moines area. Detailed resumes for all project staff proposed are presented in Tab 10 of the proposal.

Onsite Management

As mentioned above, Ms. Amy Perry will relocate to the Des Moines area following notification of contract award. Ms. Perry has several years of experience managing complex Medicaid agency projects, including recent engagements in Louisiana and North Carolina. She has demonstrated leadership abilities, successfully working with client agencies and provider associations through complex reimbursement system negotiations, development and implementation projects. Her management and leadership abilities are bolstered by previous experience with the firm performing audits, rate setting and complex analytical assignments and projects. Tom Donahue, a manager and Long Term Care Specialist with the firm will also relocate to the Des Moines area to work exclusively on this project. Mr. Donahue has extensive experience working with DHS and other state Medicaid agency clients providing Medicaid long term care rate setting, auditing, litigation support and testimony, and consulting services. He has extensive knowledge of all aspects of Medicaid reimbursement of long term care services.

Owner Management

Our project directors, Mr. Knerr and Mr. Duzan are owners of the firm, and therefore have ultimate authority and overall responsibility for this project. They have worked closely with DHS on current projects for several years, and will continue to dedicate substantial portions of their time to ensure the successful implementation and operations of the IME. We expect that Mr. Knerr and Mr. Duzan will each dedicate 50% of their time to the IME project, and will spend sufficient time on site in Des Moines to ensure DHS' complete satisfaction with all our services.

Other Myers and Stauffer Staff Relocations

During the implementation phase of this project, management will identify 3-5 experienced and qualified staff from other Myers and Stauffer offices and offer these staff positions within the IME project. These staff will have expertise in one or more of the RFP technical areas, and will bring strong support to our management team throughout this process.

Subject Matter Experts (SME)

During the implementation phase, subject matter experts from our other offices will assist the project team. These staff have extensive experience and knowledge of particular subject areas, such as DRG/APG rate setting and rebasing, long term care facility rate setting, SMAC rate setting, and revenue maximization strategies. During the implementation phase, we anticipate that up to 10 staff will contribute to this project as SME, or approximately three FTE. Many of the operational tasks are specialized in nature, and service delivery is less frequent. For example, while there are on-going data collection and review tasks, the most labor intensive activities associated with the DRG/APG rebasing projects occur only every three years. Having sufficient onsite staff available to meet an intermittent need is not efficient. Subject to DHS review and approval of proposed work plans, we propose to supplement these types of work activities with SME from our other offices. These staff will be under the direct supervision of Ms. Perry, our proposed Account and Implementation Manager.

Recruitment

During the implementation phase, we will begin recruitment activities to hire and train qualified staff. Candidates with experience in health care auditing, accounting, financial analysis and programming will be hired. We expect to hire between 10-12 staff from the Des Moines area beginning in the first quarter of 2005.

Project Management Plans for Design, Development and Implementation (DDI) Phase

The period July 1, 2004 through June 30, 2005 represents the DDI phase applicable to rate setting and cost settlements for specified provider types, desk reviews and on-site audits. The Gantt chart contained in Tab 10 outlines proposed workflow and milestones for the DDI contract phase. Our management team will be on-site in our temporary Des Moines office throughout this phase to ensure all tasks remain on schedule and all client needs are identified and met. In addition to thorough planning, this phase will require considerable communication and coordination between DHS, the I&SS contractor, other IME contractors, and the incumbent rate setting, audit and fiscal consultant contractors.

The DDI phase for DRG/APG recalibration, revenue maximization and UPL strategies for hospitals and nursing facilities, physicians and other medical professionals, and reimbursement technical assistance, monitoring and support services begins immediately upon notice of contract award. As we are currently providing DHS with these services under existing contracts, there is no need for a prolonged implementation or transition period with our proposal. We will continue to provide these services in an uninterrupted manner on July 1, 2004, with experienced project staff resources and tools providing a seamless transition to the IME. Upon notice of contract award, and following initial meetings with DHS, we will provide proposed work plans for the DRG/APG rebasing and recalibration services. We will begin transition activities such as establishing data links and communication protocols with the incumbent contractor, to prepare us to assume operational responsibilities on July 1, 2004. As detailed in our proposed DRG/APG Gantt chart, we will begin data collection and analyses to provide newly updated DRG/APG rates for implementation October 1, 2005. Based on our experience with DRG/APG recalibration services, we do not anticipate any significant obstacles to a smooth transition of these services.

Planning

Planning is critical to the success of complex projects such as the IME. Inadequate planning and coordination may lead to surprises and undesirable outcomes. Our management team will meet with DHS and other contractors as needed throughout this process. We will prepare, review and revise work plans for DHS approval before implementing; and will utilize DHS-approved project management systems for tracking purposes. Following the planning activities, we will begin the process of developing any new systems and interfaces that are needed. Similar efforts have been completed through current work for DHS and other state Medicaid agencies. We will tailor

current systems and programs to meet Iowa needs. Complete new developments should be minimal.

Takeover

Following sufficient planning and coordination with DHS, we will begin the process of acquiring applicable data files, reference data, documents, procedure manuals and any useable systems from the current fiscal agent and fiscal consultant contractors. We will provide a proposed schedule of events for a smooth takeover process. We have performed similar activities with other new projects and realize this process can present challenges. We are sensitive to the need to remain professional and work closely with all parties to arrive at solutions for takeover tasks that are reasonable and minimize burdens.

Acceptance and Implementation

As part of the acceptance testing process, we will provide DHS with testing data, procedures, and interface documentation to facilitate final approval of our systems. This will include checklists for verification of operations and procedures. In the event issues are noted during the testing process, these will be addressed in a timely and professional manner. We will provide DHS with draft procedure manuals fully documenting the process and data flows associated with contractor functions. These manuals will be revised and updated to reflect any changes that occur. We will coordinate and lead all walk-through activities as desired by DHS. Following completion of these activities, we will provide DHS with complete documentation and obtain final DHS sign-off of the testing process.

Once DHS has approved and accepted all systems and procedures documentation and testing results, we will begin the implementation process. This will entail moving staff, equipment, and other resources from our temporary office location into the IME facility. We will remain flexible on timing and approach to this transition, as we appreciate that many as yet unforeseen developments may occur. Our information technology support staff will be available as necessary to ensure a smooth transition process.

Throughout the transition process, we will maintain on-going operations of the Medicaid program. We will work closely and proactively to identify any operational issues and assist DHS whenever possible.

Project Management Plans for Operations Phase

Following the transition of all contractor functions to the operations phase, our project management team will be dedicated to continued success. Through our

staffing plans explained above, we will dedicate sufficient management and owner resources to the IME provider cost audits and rate setting project to ensure on-going successful operations. Our account and implementation manager will be onsite at the IME to provide day-to-day direction and coordination for all contractor functions. Our project directors will also be on-site at the IME as needed in order to provide overall leadership on the project and ensure DHS is satisfied with our services.

Project Management Plans for Turnover Phase

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

Our detailed responses to the RFP requirements are presented on the following pages. We are truly committed to the Department and to being an essential component of the IME. We are the best of breed in this area and will provide the relationship within the IME envisioned by the Department.

5. Understanding of Iowa Medicaid Enterprise Procurement Project

We understand the Iowa Medicaid Enterprise concept to be a vision that includes up to nine contractors working together in a cohesive manner to accomplish DHS Medicaid program goals. All IME contractors will be co-located with state staff at a common state facility and to operate certain systems on state hardware. We appreciate the DHS goal in transitioning to this integrated environment, which if designed and managed effectively, may become a trend-setting model for Medicaid agencies.

Medicaid agencies generally have limited resources available to address the vast number of projects and decisions they face. For decades, Medicaid agencies have turned to contractors as part of the solution. History has shown that often a single contractor cannot efficiently and effectively be the one size fits all solution. For example, a contractor may be effective at claims processing, but that same contractor may be less effective at utilization review and policy development.

For over two decades, Myers and Stauffer has met its Medicaid client's needs with skill sets that are unmatched in a multitude of areas. In addition to Medicaid rate setting and auditing, Myers and Stauffer has developed skills in state plan amendments, data analysis, reimbursement systems and methodologies, and policy development. Our understanding of Medicaid agencies has evolved over time, but our goal is not to develop expertise in all Medicaid areas, such as traditional fiscal agent functions. We have heard concerns from our state clients regarding other contractors' difficulty with performing in multiple program areas. The "best of breed" vision is not only innovative, but we believe could be a viable solution to challenges faced by other Medicaid agencies with similar issues.

Because of the nature of our practice, we have, on occasion, subcontracted with other companies on similar engagements. In 1998, Myers and Stauffer submitted a joint proposal with Electronic Data Systems (EDS) to the Indiana Medicaid Agency to perform certain management functions for the drug rebate program. As a result of this successful proposal, Myers and Stauffer management and staff were co-located at EDS office premises and managed the drug rebate program. Our responsibilities on this project included managing EDS personnel relative to daily routine tasks such as invoicing manufacturers and negotiating drug rebate disputes. Myers and Stauffer staff

oversaw the collections and lockbox process and reporting. In addition, we provided monthly drug rebate financial reports in a manner that provided meaningful self-explanatory data. Furthermore, this project required management personnel to integrate into EDS management meetings and leadership initiatives. This integrated solution provided the state of Indiana with two contractors working together to meet established goals and objectives in the drug rebate program. This experience demonstrates our ability to work in an integrated environment with another Medicaid contractor. We have worked with other contractors in similar ways by teaming on work groups and participation in a multitude of meetings. Our experience with EDS provides a unique insight into the challenges that DHS may face in coordinating multiple contractors within a common location.

In order to succeed, the IME will have to address several key areas in the overall design and transition stages. We believe the following areas are critical to the transition and implementation stages:

- Vision sharing and communication during transition.
- Training and integration of systems.
- Cohesive solution-oriented corporate identities.
- Adequate staffing and resources.
- On going communication and coordination.

Vision Sharing and Communication During Transition

Once all IME contracts are awarded, we recommend key staff from each contract serve on a transition work group team. We understand that DHS plans to utilize an Implementation and Support Services (I&SS) contractor to lead the coordination activities of the successful bidders. This contractor's role is crucial to the success of this initiative. We suggest that the transition work group team be led by key personnel from the I&SS contractor.

During transition, we suggest the work group meet on a weekly basis to discuss obstacles contractors may be experiencing with the coordination efforts. Contractors should submit agenda topics in advance of the meeting, with the agenda circulated prior to the meeting. Each contractor should assist in finding solutions. In order for this initiative to be successful, everyone must understand and share DHS goals. I&SS will coordinate efforts to ensure the DHS vision is maintained.

Training and Integration of Systems

One of the challenges of maintaining such a vast computer system as those typically utilized by state Medicaid agencies is the administration of user

logons, security, rights and authority. Sharing the state's systems with potentially nine contractors will be significant. This will require reasonable and effective protocols in addition to routine on-going communication.

Initially, we recommend a sub-work group. This group will include at least one contact from each contractor. This group will establish standard system protocols and will be charged with establishing procedures within security boundaries that also meet all HIPAA requirements. The primary goal of this group is to provide each contractor with the tools and ability to accomplish its goals within the confines of the shared state system.

Communication will be key to the integrated systems. Policies on security, rights, and authority need to be established and communicated to all effected parties. This includes not only the process to establish a new user logon, but also issues such as saving key deliverables, access to key deliverables, allocated space for each contractor, and required archiving procedures. These issues could present obstacles to a contractor if not addressed at the outset. All contractors must abide by the established policies without feeling a lack of control over their systems or ability to meet required deliverables.

Training will be dependent upon the policies established, and will be an important consideration with the integration of systems. Myers and Stauffer has extensive experience utilizing Decision Support Software (DSS) in conjunction with existing state agency clients. Therefore, we are accustomed to having online capability to obtain information and data from state Medicaid systems. In addition, we are skilled in SQL programming and query language. Therefore, the necessary training we require is primarily security and system protocols. However, as the MMIS and/or Data Warehouse contractor(s) implements changes to the system, on-going communication and training will be necessary to ensure all contractors maintain optimal functionality relative to the shared systems.

Cohesive Solution-Oriented Corporate Identities

We understand the importance of high levels of customer service throughout all phases of the IME initiative and incorporate such principles in all our contracts and business relationships. Quality and customer service are the foundation of Myers and Stauffer. This initiative will require that all contractors maintain a "solution-oriented" mindset that is reasonable, objective and effective. Contractors will also have to be flexible in their operations. Each contractor will need to adopt a teamwork attitude that maintains focus on serving and meeting DHS goals and objectives.

We have participated in many work groups that have included multiple contractors. The best results come when all participants provide contributions and the group as a whole responsible for finding solutions. We have been very successful with this type of work group approach. Projects include the implementation of case mix systems for state agencies, service to medical policy committees, and the teaming of agencies to develop audit processes and procedures.

Adequate Staffing and Resources

Effective teaming on projects requires equitable contributions and involvement by all team members. In order for the IME initiative to be successful, certain coordination activities are essential such as periodic leadership and project work group meetings. Each contractor is an integral part of the overall delivery system of services. Without contractor participation, project initiatives will be unproductive and untimely. Each contractor should be required to maintain adequate staffing and resources to ensure attendance at meetings and accomplish team goals. Flexibility will be necessary for many issues such as the scheduling of routine or work group meetings. Myers and Stauffer has an outstanding reputation for building staff resources and consistently providing all necessary resources to meet client needs.

On-Going Communication and Coordination

The above issues are certainly important to the transition stage of this initiative. However, a communication and coordination system must be implemented and required by each contractor on an on-going basis. Issues such as changes in system policies or protocols should occur without interruption by any of the contractors. Advance notice and instruction of these issues will be key to successful revisions and on-going productive operations.

In addition, contractor involvement and participation in work groups will ensure that decisions made in one area will coincide with decisions made in another area. For instance, medical policy recommendations made by the Medical Services contractor will need to be communicated to the Provider Audits and Rate Setting contractor to ensure that DRG and APG re-basing activities meet DHS objectives. Myers and Stauffer has worked with numerous state agencies regarding medical policies that impact reimbursement and we understand the importance of coordinating issue resolution across multi-disciplinary teams. We believe strong coordination efforts will improve DHS' ability to have meaningful data to accompany medical policy decisions. We have also found that with a work group of subject matter experts the resulting solution is often far better than any singular idea initially presented.

We are excited by the possibility of our firm serving DHS in such an important initiative. Our experience with similar initiatives will assist in making the transition process as efficient and effective as possible. We understand this integrated approach is a cost-effective way to achieve DHS goals. The “best of the breed” brings tried and true contractors together to perform services in their area of expertise. This will avoid duplication of effort, possible rework, and certainly will improve the overall service to DHS and Medicaid program stakeholders. We believe our experience is unique in that it includes extensive partnership and work group relationships, as well as experience with co-locating project staff in another corporation’s environment to meet common goals.

6. Services Overview

Myers and Stauffer is pleased to present the following proposal to provide the services requested of the Provider Cost Audits and Rate Setting Contractor to the Iowa Department of Human Services (DHS). Myers and Stauffer first began consulting with DHS in 2000. Since July 2000 we have assisted in the development, implementation, and monitoring of the case mix system, cost report and Minimum Data Set tracking and database development, reimbursement technical assistance support, revenue maximization and state maximum allowable cost (SMAC) program rate setting services. During that time, we successfully assisted DHS through many important benefit changes, political situations and significant procedural and process changes. We are now proposing to serve DHS as the Provider Cost Audits and Rate Setting Contractor.

Our firm is unmatched in its ability to provide a comprehensive array of services to state Medicaid agency clients. We offer access to knowledgeable and experienced professionals. Issues that may arise in Iowa likely have occurred in another state. Our multi-state approach means that DHS will not only receive the staffing resources and knowledgebase from the local office, but also the professional backing of our entire firm. All our offices work as a team to provide the highest level of service to our clients. The service we provide allows our clients to concentrate on the increasing challenges of managing other aspects of the Medicaid program. We are committed to serving Iowa Medicaid with the utmost professionalism, dedication and quality.

6.1 Rate Setting, Cost Settlements, and Cost Audits for Designated Providers

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

While performing these duties, the contractor will need to apply a variety of cost report auditing/settlement techniques to the reimbursement

methodologies specific to each provider type. Also this complexity must be managed within an environment in which errors can have serious financial consequences and/or result in decreased confidence in the program. Our proposal offers DHS the following:

- A team that is expert across the entire spectrum of audit, desk review, cost settlement, data management and consulting issues addressed in the RFP.
- A demonstrated multi-state performance in the management and execution of the duties required of the audit, desk review and cost settlement contractor.
- An innovative risk-based cost report audit methodology that is designed to yield maximum information for DHS, while minimizing the burdens placed upon Medicaid providers during the audit and desk review processes.
- A rate setting and cost settlement approach that incorporates computerized rate/cost settlement templates into the development of our project deliverables.
- A unique mix of qualifications in institutional and non-institutional provider reimbursement, analysis of health care costs and utilization, and investigation of fraud and abuse in cost-reimbursed programs.

6.2 State Maximum Allowable Cost Program Rate Setting

Myers and Stauffer began its Medicaid pharmacy consulting practice in 1973 with a dispensing cost study for the state of Kansas. Since then we have performed numerous pharmacy dispensing and drug acquisition cost studies in 17 states, as well as, several other pharmaceutical consulting engagements for state agencies and CMS. Currently, Myers and Stauffer sets SMAC rates for the states of Indiana, Idaho and Iowa.

Myers and Stauffer offers DHS a work plan that is based on a proven methodology yet preserves the flexibility for DHS to customize the SMAC program to suit its objectives. Our work plan is tailored to the Iowa pharmaceutical marketplace and will result in SMAC rates that are defensible but also meet required budget targets.

One of the most significant challenges Medicaid agencies is to establish reasonable pharmacy reimbursement levels while considering cost and pricing

of pharmaceuticals. Published prices for prescription drugs are unreliable in predicting the amount that pharmacies actually pay to acquire products. In fact, the published Average Wholesale Price (AWP) for multi-source drugs can easily be 10 to 20 times the actual acquisition cost of these products. Basing reimbursement on the AWP can inadvertently result in pharmacies realizing significant margins on products. Additionally, incentives to dispense less costly generic drugs can be corrupted. Similarly, attempts to set SMAC rates using mathematical algorithms based on the AWP can lead to reimbursement that is out of proportion to actual product acquisition cost.

Myers and Stauffer offers an innovative approach to establishing reimbursement proportionate to actual pharmacy cost. Rather than depending on unreliable published pricing for drugs, actual acquisition costs for multi-source products will be determined by surveying invoices from pharmacies participating in the Iowa Medicaid program. SMAC rates are derived from this basic cost data by using a "SMAC multiplier," a customized factor designed to ensure that pharmacies' costs are covered, in addition to providing a reasonable profit margin. The use of this customized SMAC multiplier will allow DHS to retain significant control over cost savings realized by the SMAC program. Myers and Stauffer will use an experienced team of pharmacists, consultants and analysts to recommend policies to govern the selection of multi-source drugs to be subject to SMAC pricing.

Myers and Stauffer will provide timely updates to the SMAC rate schedule based on constant monitoring of the pharmaceutical marketplace. This includes monitoring published prices, product availability, and current best practices in pharmaceutical benefit management. An integral component of on-going SMAC rate maintenance will be to provide mechanisms for Iowa pharmacists to communicate concerns regarding product pricing and availability. Myers and Stauffer will handle provider communication through telephone, e-mail and a web-based reporting tool.

There are a number of on-going reporting and analytical activities that Myers and Stauffer has included in this proposal to provide accountability to DHS and to monitor savings realized by the program. Myers and Stauffer has proposed mechanisms to assure proper claims adjudication for prescriptions subject to SMAC rates and to detect improper dispensing patterns designed to circumvent the SMAC program. Additionally, Myers and Stauffer will provide integral assistance to DHS in presenting and defending SMAC rates to interested stakeholders.

6.3 Rebasing and DRG and APG Recalibration

Since 1992, Myers and Stauffer has provided DRG rate setting and related consulting services to seven states: Alaska, Colorado, North Carolina, Kansas, Indiana, New Mexico and Oregon. The DRG system in North Carolina was designed by Myers and Stauffer and replaced the state's former per-diem reimbursement system. The firm has provided each state with reimbursement system options to address issues related to neonatal, psychiatric, and rehabilitation services. In servicing these DRG rate setting engagements, the firm has developed and refined specialized computer software tools that allow us to conduct the routine portions of the rate setting and modeling processes with superior efficiency. As a result, project team members are able to spend more time on analyses. Myers and Stauffer provides reimbursement system recommendations and assists with implementation and on-going operational issues. Our services include:

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

Myers and Stauffer has the expertise needed to properly perform the DRG/APG project activities. We not only understand the mechanics involved with DRG/APG classification software products, but we also understand hospital cost reporting and cost apportionment issues. These skills plus our ability to work with Medicaid paid claims data makes us uniquely qualified to perform the DRG/APG services under this procurement.

Shortcomings in any of these three areas: grouper software; utilization of paid claims data; and linking payment systems to cost data can severely limit the Medicaid program's ability to pursue sound public policy goals. With Myers and Stauffer as your contractor, these limitations do not exist.

6.4 Revenue Maximization

The services required by this RFP include developing creative approaches or methodologies that maximize Medicaid resources. The successful contractor will be required to develop and accurately perform upper payment limit methodologies for inpatient and outpatient hospital and nursing facility services. Myers and Stauffer is aware of the high public visibility given to the upper payment limits and federal leveraging opportunities available to Iowa. We will assist the state throughout this engagement without the need for substantial administrative support.

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

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

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

CMS scrutiny of state UPL/IGT funding arrangements has increased dramatically over the last several months. Iowa's plans have not been exempted from this scrutiny. While it is clear that CMS desires states to remove these long-standing funding plans from their Medicaid program operations, it remains unclear the extent to which this can occur in the short run and under existing federal authority. We are fully attuned to these developments through established networks of other practitioners and

government officials. Our knowledge, experience and understanding of Medicaid and Medicare reimbursement issues (both technical and political) enable us to meet DHS needs in these turbulent areas.

6.5 Reimbursement Technical Assistance and Support

The Medicaid program has many diverse and potentially competing objectives. Successfully managing such a complex program requires accurate and reliable information. It also requires a team able to respond rapidly to a changing environment and provide assistance and support to meet the objectives of the program. Myers and Stauffer is committed to providing DHS with value added service.

While rate setting and cost audits of various provider types is a major element of this engagement, understanding the environment and the ability to provide competent advice on many complex issues are also vital. The successful contractor must quickly interpret vast amounts of data generated by different participants in health care reimbursement arena, and navigate an uncertain future and a myriad of obstacles to assist DHS achieve its goals. The following is a summary of services that we propose:

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

The complexity of the health care system in general, and the Medicaid program in particular, has increased dramatically over the last several years. This is due to increased federal mandates, state fiscal issues, provider litigation, and increasing competition for limited resources. We maintain staff in a wide variety of disciplines necessary for providing consulting services including accounting, financial analyses, clinical expertise, computer application and forecast model design. Staff are available for participation in meetings and discussions with DHS and other state government agencies involving Medicaid policy formulation.

Conduct studies and analyses of provider information

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

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

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

The LTCIS provides for quick, efficient compilation and summarization of financial and statistical data to develop fiscal estimates. Reports from LTCIS will be generated quarterly and forwarded to DHS and other parties upon request.

We will analyze information from the LTCIS and MDS system for common applications such as assessing compliance with legislative requirements, evaluating case mix increases, assessing profitability, providing fiscal estimates of anticipated or proposed regulation changes, and responding to legislative inquiries.

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

7. General Requirements

7.1 General Requirements for all Professional Service Components

(RFP Section 6.1)

The objective of this procurement is to develop a contract environment where the Iowa Medicaid program is supported by a cohesive enterprise of the best contractors co-located with state staff in a single facility. By establishing the IME, DHS will work with all contractors in a coordinated and efficient manner, which will enable the state to provide a higher level of service to both beneficiaries and providers.

This new structure will consolidate all major functions and services under a single entity and therefore, place a premium on the coordination of efforts. Our firm has a long history of working collaboratively and cooperatively with state personnel and other contractors to solve complex problems and issues. As part of our current contracting responsibilities to DHS, we regularly interact with the Department's other contractors including Ryun Givens Wenthe, and Co., the Iowa Foundation for Medical Care (IFMC) and ACS to ensure that policy goals and program objectives for the nursing facility rate setting are being met.

In July 2001, DHS implemented a new reimbursement system for nursing facilities that, in part, bases the amount of reimbursement on the acuity level of Medicaid residents served by a provider. This type of reimbursement system presented considerable challenge to the state's existing contractors. As part of Myers and Stauffer's contract with DHS, we assisted in educating and training these contractors on the new system and were successful in bringing about a smooth implementation. Our activities included coordinating and leading meetings, identifying issues and workable solutions to complex problems, and working collaboratively with all contractors and DHS staff.

Ongoing, we coordinate the nursing facility rate setting efforts with Ryun Givens Wenthe, and Co., ACS and IFMC to establish quarterly case mix reimbursement rates for more than 440 nursing facility providers. We work closely with Ryun Givens staff to ensure that rate calculations are accurate and timely, with IFMC staff to ensure that residents are classified correctly using the RUG-III system and that the overall facility case mix is calculated

accurately, and with ACS to ensure that provider rate files are received timely and meet established file layout and format standards.

We appreciate the need for all component contractors to exhibit good communication skills and work cooperatively within IME. As the Provider Cost Audits and Rate Setting Contractor, we will continue our proven ability to work cooperatively with other contractors to access the MMIS, POS and data warehouse for the purpose of updating provider rate files, reviewing claims history to settle cost reports and identifying, evaluating and reporting on trends and other provider reimbursement activities. As part of our current nursing facility and hospital UPL/IGT contracting activities with DHS, we collect large volumes of electronic claims data for the purpose of ascertaining what the Medicare program would have paid to deliver Medicaid services. These efforts require the collection, storage and manipulation of millions of claims records.

A. Staffing Requirements

(RFP Section 6.1.1)

Myers and Stauffer acknowledges the need for experienced and dedicated leadership for this project. Our approach to project staffing is straightforward. By dedicating experienced and proven management talent along with qualified and competent professional and support personnel, we can ensure success. Each of the management personnel proposed for this contract have been employed by the firm for more than a decade, managed major healthcare contracts, and have committed to managing this project for no less than the 18-month minimum required by the RFP.

Amy Perry, our proposed account and implementation manager, has been employed with the firm since 1991 and has held numerous positions of increasing responsibility. Ms. Perry's career with the firm began as a staff accountant in our Topeka, Kansas office. She was promoted to manager in 1999 and relocated to our Kansas City, Missouri office in 2001. Recently, Ms. Perry has managed and supervised several of the firm's large Medicaid engagements in the states of Louisiana and North Carolina.

Ms. Perry was also part of the management team that assisted Iowa DHS with the design, development and implementation of the case mix reimbursement system for nursing facilities. She was instrumental in modeling various reimbursement alternatives, communicating findings at meetings with department staff, provider and consumer advocate representatives. Ms. Perry directed and coordinated the implementation efforts for the transition from the

state's cost based nursing facility reimbursement system in 2001 to the modified price based case mix reimbursement system.

Tom Donahue, manager and long term care specialist, has been employed with the firm since 1989 and most recently has managed the firm's home health agency and long-term care rate setting project for the Indiana Medicaid program. Mr. Donahue has more than 14 years of health care experience. He currently provides on-going consulting and support services to DHS staff regarding the case mix technical assistance and ICF/MR provider assessment contracts.

Both Ms. Perry and Mr. Donahue will be 100% dedicated to the Iowa Medicaid Enterprise (IME) project. Neither will be reassigned or replaced, except as allowed for in the RFP, during the first 18 months of the project.

Key Personnel to be Named
(RFP Section 6.1.1.1)

Contained in Tab 10 – Project Management Planning is our proposed account and implementation manager's resume. Ms. Perry's resume includes relevant employment history for more than ten years, along with three professional client references. For each client reference, we have provided the client's full name, street address, telephone number and e-mail address of the client's project administrator.

Early in the fourth quarter of 2004, we will present to the DHS Project Director a candidate to fill the Operations Manager position that is required by January 1, 2005. This candidate will meet all education, experience and other qualification required by the RFP and be 100% dedicated to the IME project.

A project team of experienced professional staff will support Ms. Perry and the operations manager. This professional team will include our most senior management, accountants, financial analysts, programmers, registered nurse consultants, pharmacy consultants and general support personnel. A complete job description for each of these positions is included in Tab 10.

Special Staffing Needs
(RFP Section 6.1.1.2)

Professional Staff Requirements

(RFP Section 6.1.1.2.1)

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

Both Ms. Plake and Ms. Nicholson are registered or licensed to practice medicine and are in good standing with their respective examining boards. Ms. Plake is a registered pharmacist, and is a former assistant pharmacy professor at Drake University and a current assistant pharmacy professor at Purdue University. Ms. Nicholson is a registered nurse, and holds a multi-state license that permits her to practice in the state of Iowa. Professional medical staff will carry malpractice insurance as necessary.

Bonding

(RFP Section 6.1.1.2.2)

The RFP requirement for bonding for staff that handle or have access to checks applies to the Revenue Collection Contractor, and as such is not applicable to our proposal.

Job Rotation and Coverage During Vacations for Sensitive Positions

(RFP Sections 6.1.1.2.3 and 6.1.1.2.4)

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

DHS Approval of Key Personnel
(RFP Section 6.1.1.3)

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

Changes to Contractor's Key Staff
(RFP Section 6.1.1.4)

The IME project requires the coordination of activities between all IME contractors and DHS staff. The impact of changes made by one contractor may have on the processes of another contractor cannot be overlooked or diminished. Equally important is the continuity of key staff resources assigned to the various responsibilities and activities. We will not replace or alter the number and distribution of proposed key personnel without the written approval of the DHS contract manager. If necessary, we will provide the project director notice 15 days prior to any proposed transfer or replacement of key personnel, including the proposed replacement staff's resumes and references. We will only propose staff that have comparable training, experience and ability. Replacement staff will be available to interview with the project director at his/her convenience. Original key staff will remain on the project and be responsible for the performance of duties under the contract until such time as the replacement staff are approved and successfully performing the key functions of the position.

B. Facility Requirements
(RFP Section 6.1.2)

Temporary Office During Implementation Phase
(RFP Section 6.1.2.1)

During the implementation phase, we will operate a temporary office in the Des Moines downtown area. Key personnel will be on-site to coordinate activities and meet with other contractors or DHS personnel. This office will be equipped and furnished to include; network infrastructure and network connections, personal computers, printers, software and software licenses for commercially available packages, phones and faxes, photocopiers, desks, storage for files, cubicles and standard office supplies. Trained computer staff will provide hardware and software systems support required during the

implementation phase. All costs associated with this temporary office are part of our cost proposal and included in our fixed implementation price.

In order to reduce costs to the state and ensure uninterrupted delivery of service during the transition from the temporary office facilities into the Iowa Medicaid Enterprise (IME), we propose to relocate all file servers and related systems hardware purchased during the implementation phase to IME. Ownership of this equipment and software licenses will be transferred, unencumbered, to IME. We will work closely with DHS systems personnel from the outset to ensure that all equipment acquired for the implementation phase of the project meets IME standards. A preliminary list of computer equipment expected for the implementation phase is as follows:

- HP Proliant ML520 2P Model – Tower
- (2) Nortel Networks Baystack 450-24T
- (2) Nortel Networks Baystack 400-ST1
- (2) Cisco 2620XM
- (2) VWIC-2MFT-T1 Voice Interface Card
- (25) HP Business Desktop d350
- (25) HP S9500 monitors
- (4) HP Business Notebook nx5000
- HP 8150DN Laserjet Printer
- HP 2000-sheet input tray

A preliminary list of computer software expected for the implementation phase is as follows:

- Netware
- SQL server
- PKZip
- Adobe Acrobat Writer
- Novel Groupwise
- HFS
- ArcServe
- MS Office 2000
- MS Visual FoxPro 8.0

- Symantec LiveUpdate

Once the Iowa Medicaid Enterprise facility is available, and at the direction of DHS, we will transition our staff and computer systems to the IME. In the event that the Iowa Medicaid Enterprise facility is not available by July 1, 2005, we will continue to maintain a temporary office.

We propose to perform some system development work at our existing office locations. Work performed outside of our temporary office in Des Moines will not require coordination or interaction with other contractors or DHS personnel. Upon successful award of the contract, we will request approval from DHS to perform these system development tasks off-site.

Permanent Facilities
(RFP Section 6.1.2.2)

On or about July 1, 2005, and at the direction of DHS, we will transition our temporary office staff, work files and computer equipment to the IME facility. The state will provide office space, desks, chairs, cubicles, network infrastructure and connections, personal computers, software licenses for commercially available packages, phones and fax machines, photocopiers, network printers, licenses for other non-Microsoft Office software and office supplies necessary to perform our responsibilities. In addition, the state will provide conference rooms at the IME offices for meetings.

Many of the functions performed by the Provider Cost Audits and Rate Setting Contractor are interrelated or dependent on other functions. For this reason, we request that our staff be located in contiguous space within IME. Additionally, since many of the services required in this component require our staff to access financial and statistical cost reports and accompanying schedules daily, storage of these files should be located in close proximity to our staff to ensure maximum efficiency. We request that this file storage area have controlled access.

We estimate our needs for the following items identified in the RFP:

Approximate square footage	6,000
(includes 600 square feet for file storage)	
Manager offices	3
Cubicles	21

Production Photocopiers	1
Fax Machine	1

We proposed to transfer all servers, computers and other hardware and software acquired during the implementation period to the IME. If DHS agrees with our proposed approach to transfer the hardware and software purchased during implementation, then we do not anticipate needing additional personal computers, laptops or a production printer at the start of the operations phase.

In addition to standard furnishings such as a desk, chair, lockable filing cabinet and bookshelves, each manager's office should have a phone with conference capabilities and a network connection. In addition to standard furnishings such as a desk and chair, each cubicle should have a phone and a network connection.

Personal computers purchased during the implementation phase will have the following capabilities:

- HP Business Desktop d530
- Pentium4 2.8 GHz
- RAM 512 MB
- Hard drive 80GB
- CD-RW / DVD
- Fast Ethernet Lan Card 10/100
- 19-inch HP S9500 1600 x 1200 / 75 Hz monitor

Courier Service
(RFP Section 6.1.2.3)

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

Contractor Responsibilities to Provide Software and Equipment
(RFP Section 6.1.2.3.1)

Iowa DHS is proposing to bring substantial change to the present concept of fiscal agent service delivery for the Iowa Medicaid program. DHS desires to establish greater control by the state over all functions of the fiscal agents by requiring all successful bidders to operate their systems on state owned hardware and software and co-locate their staff with state personnel at a common state office location. This realignment of responsibilities expands the current role of DHS to include many of the functions of the prior fiscal agent, such as owning, maintaining, and updating computer hardware and software systems and owning/leasing and maintain property management functions. Therefore, the Provider Cost Audits and Rate Setting Contractor's responsibilities for providing equipment and software are limited to proprietary or non-commercially available software and personal workstation printers.

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

Contingency Plan
(RFP Section 6.1.2.4)

Continuous operation of the provider cost audits and rate setting activities is imperative for the smooth operation of the Medicaid program. A disruption in service due to the unavailability of office space is unacceptable and therefore a contingency plan has to be developed. As part of our contract with a local commercial landlord, we will negotiate provisions that allow us to extend the lease term in the unlikely event the IME facility is not available by July 1, 2005. Once the contingency plan is activated, all operational activities will continue uninterrupted at the temporary office until the IME facility is available.

C. Onsite and Offsite Expectations
(RFP Section 6.1.3)

Onsite Expectation
(RFP Section 6.1.3.1)

Our staffing plan includes relocating existing, experienced staff from other Myers and Stauffer offices, and recruiting qualified candidates from the metropolitan and surrounding areas of Des Moines. Staff will be directly associated with the provisions of the contract and dedicated 100% to the Iowa

Medicaid project. Amy Perry, our proposed account and implementation manager, along with Tom Donahue, our proposed long term care specialist, will be relocating to Des Moines in 2004.

During the implementation period, other Myers and Stauffer staff from our existing offices will assist with various project assignments and tasks. Such assignments will primarily include system development activities, and will not include projects that are directly associated with the provisions of the contract. Such off-site activities will be limited, and work products will be under the direct control and supervision of our management team in Des Moines. The on-going status of all such assignments will be communicated to the on-site staff, other state contractors and DHS staff as needed.

D. Contract Management

(RFP Section 6.1.5)

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

Contractor Responsibilities

(RFP Section 6.1.5.2)

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

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

We will provide reports to DHS regarding the components of our activities and agree to negotiate with DHS the content and format of these reports. The reports should provide DHS and the components contractors with information for management of the contractor's activities and the Medicaid program. Draft formats will be prepared for consideration during this process.

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

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

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

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

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

We will provide weekly progress reports on component contractor's activity to DHS.

We will meet all security requirements within the contractor's operation as required under HIPAA or in effect under state regulations, whichever is more stringent.

Performance Standards
(RFP Section 6.1.5.3)

We will provide the monthly contract management reports to DHS within three business days of the end of the reporting period. We will provide the monthly performance monitoring report card within ten business days of the end of the reporting period.

We will provide training on operational procedure changes as a result of upgrades or other changes within two weeks of the upgrade.

We will update operational procedure manuals within two weeks of the implementation of a change.

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

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

E. Performance-Based Contracts and Damages For Professional Service Contractors
(RFP Section 6.1.6)

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

F. Internal Quality Assurance

(RFP Section 6.1.7)

Our many years of multi-state Medicaid reimbursement experience has enabled us to anticipate Medicaid agency client needs. We understand that for IME to succeed, the contractor must remain forward-looking in all aspects of its responsibilities, both in its ability to assure high quality of services and deliverables and improving processes. Waiting for a system or process to "break," and then attempting to find a solution is not an acceptable alternative. Many times such a retrospective approach to project management leads to avoidable delays, embarrassment to the program, or unnecessary costs.

It is the policy of Myers and Stauffer that all engagements be properly planned, performed, supervised, reviewed, documented and communicated in accordance with professional standards, regulatory authorities, contractual requirements and firm standards. We continually strive to produce quality deliverables and outcomes. In this regard, we have adopted the following general financial review and audit engagement performance quality control steps. In consultation with DHS staff, we anticipate that these steps will be tailored to the different aspects of the contractor's responsibilities in order to ensure that the objectives of this project are achieved.

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

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

These standard operating procedures are applicable to all engagements and will be monitored during this engagement by Mr. Buoy, a member with Myers and Stauffer, who will oversee the quality control reviews and processes, and provide high-level strategic input to the project team.

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

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

Contractor Responsibilities
(RFP Section 6.1.7.2)

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

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

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

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

We will provide quality control and assurance reports, accessible online by DHS and contractor management staff, including tracking and reporting of quality control activities and tracking of corrective action plans.

For any performance falling below a state-specified level, we will provide an explanation of any problems or issues, and identify the corrective action to improve the rating. If situations arise, we are prepared to work collaboratively with DHS staff and other contractors to seek reasonable and workable solutions, and are committed to meeting and exceeding all DHS expectations.

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

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

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

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

Performance Standards
(RFP Section 6.1.7.3)

Through the course of our project management and quality assurance and oversight, we will identify any deficiencies in a timely manner. Promptly following discovery of an issue, we will communicate this discovery to DHS, and will provide a corrective action plan within 10 business days. We will meet 95% of the corrective action commitments within the agreed upon time frame.

G. Training
(RFP Section 6.1.8)

Staff training is the foundation of high quality work. Our firm policy is for personnel to participate in general and industry-specific continuing professional education and development activities. These activities enable staff to satisfy assigned responsibilities and fulfill applicable continuing professional education requirements. In addition to formal staff training, we utilize structured and supervised training in the performance of specific project tasks. We have implemented firm-wide professional development policies that include:

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

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

The firm sponsors periodic in-house training workshops for professional staff from all office locations. Topics at these workshops generally include Medicaid health care reimbursement and issues from a wide array of provider categories and disciplines. Our training workshops include speakers from state agencies, CMS and other practitioners and professionals in health care and related fields who provide valuable insight into evolving issues in health care. In addition, our professional staff typically make presentations in their resource responsibility areas.

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

H. Documentation

(RFP Section 6.1.9)

The Provider Cost Audits and Rate Setting Contractor will be responsible for establishing Medicaid reimbursement rates for institutional-based and numerous other providers under the Iowa Medicaid program. These reimbursement rates will be determined using methodologies described in Iowa administrative rules and the approved Medicaid State Plan. Many of these payment methodologies rely heavily on financial and statistical data reported by providers. In order to ensure the integrity of the underlying payments, DHS, like most other states, will subject these reported data to various desk review and field audit verification procedures. We are very familiar with and fully appreciate the need for thorough documentation of these processes.

We anticipate preparing documentation manuals for all major service functions of the Provider Cost Audits and Rate Setting Contractor components. These manuals will be presented in draft format for DHS approval during the implementation period. We have prepared desk review, field audit and other similar forms of documentation for similar complex projects. During the implementation period, we will review any documentation that may currently exist either with DHS or current contractors. After reviewing such documentation, we will meet with DHS staff to determine strengths and weaknesses of current systems, which will enable us to propose enhancements to the rate setting and auditing processes consistent with DHS objectives. Following these discussions, we will prepare draft outlines of proposed manual documentation for review and approval by DHS.

I. Security and Confidentiality Requirements

(RFP Section 6.1.10)

As a CPA firm, we have in place standard operating procedures to safeguard the confidentiality of all data. These procedures limit access to confidential

files and data to those individuals assigned to the project, and then only on a "need-to-know" basis. We will take all reasonable steps to secure our physical site and data within our temporary office site as well as the IME. We will comply with the Federal Information Processing Standards (FIPS). We will safeguard all data and records that are entrusted to us and within our control from alteration, loss, theft, destruction, or breach of confidentiality in accordance with both state and federal statutes and regulations. We will need to access confidential MDS data, which is obtained through the federal Data Use Agreement (DUA). As DHS' current nursing facility case mix technical assistance contractor, we have an approved DUA currently on file with DHS.

Compliance with the Health Insurance Portability and Accountability Act (HIPAA)

We have implemented all confidentiality policies and procedures required by law, including without limitation those policies and procedures required under the Administrative Simplification section of HIPAA and the accompanying regulations. HIPAA training and policy manuals have been provided to Myers and Stauffer staff. We will work closely with DHS contract management staff during the implementation phase of the project to ensure that all HIPAA requirements are appropriately incorporated into our procedures during and following the transition to the IME.

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

We will take no action that adversely affects Iowa's compliance with HIPAA. Our policies will ensure compliance with the privacy and security of PHI throughout the life of the contract for all activities required to fulfill the requirements of this contract. Policies and procedures relating to the use and disclosure of PHI are reviewed and updated at least annually, or as the law requires, and available for review upon request.

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

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

State and Federal Statutes

Our firm will maintain a comprehensive library in our Iowa office of published resource materials in multiple disciplines, such as accounting, audit, health care and reimbursement. Our library will contain all necessary federal and state laws and regulations that pertain to the Medicaid program. The firm also monitors state plan activities and relevant court decisions. These resources support our project staff to maintain a thorough understanding of the current rate setting criteria, applicable statutes, rules, regulations, policies and procedures specific to the State of Iowa and the Medicaid program as set forth by DHS.

J. Accounting Requirements

(RFP Section 6.1.11)

We agree to maintain all accounting and financial records (e.g., books, records and documents reflecting costs and expenses) associated with this contract in such detail as will properly reflect all direct and indirect costs and expenses for labor, materials, equipment, supplies, services, etc. for which payment is made under the contract. These accounting records will be maintained in accordance with generally accepted accounting principles (GAAP), and will be maintained separate and independent of other accounting records of the contractor. All financial records will be maintained for seven years following

the end of the federal fiscal year during which the contract is terminated or until final resolution of any pending state or federal audit, whichever is later. Records involving matters of litigation will be maintained for one year following the termination of such litigation if the litigation has not been terminated within the seven-year period.

K. Audit Requirements

(RFP Section 6.1.12)

We agree to contract with a certified public accounting firm, at our expense, for an independent audit of the Iowa Medicaid Enterprise account annually, and provide a copy of the audited financial statements to DHS. We also agree to have a biennial examination that conforms with American Institute of Certified Public Accountants (AICPA) Statements of Auditing Standards No. 70 (SAS-70), performed at our expense by a certified public accounting firm, if required by DHS. The audits will meet the requirements specified in RFP Section 9.19.

We agree to permit authorized representatives or agents of state or federal agencies to have access to our financial records, books, documents, and papers during the contract period and during the seven years following the end of the federal fiscal year during which the contract is terminated or until final resolution of a pending state or federal audit, whichever is later, for purposes of review, analysis, inspection, audit, and/or reproduction. We agree that during the seven-year post-contract period, delivery of and access to the items will be at the contractor's expense. We agree to maintain records involving matters of litigation for one year following the termination of such litigation if the litigation has not been terminated within the seven-year period.

We agree to maintain all records and documents relating to the contractor's area of responsibility for a minimum of seven years. We acknowledge that imaged copies of such documents may be used to satisfy this requirement. At the conclusion of the contract, we agree to turn over to DHS copies of all records maintained throughout the duration of the contract.

L. Transfer of Work Responsibilities

(RFP Section 6.1.13)

We will work closely with DHS to ensure that the transfer of responsibilities from current Provider Cost Audit and Rate Setting contractors proceeds smoothly and is transparent to providers and other Medicaid program stakeholders. Immediately upon notification of contract award, we will begin preparing for the transfer of responsibilities, which will include the preparation of transition documentation and schedules for DHS review and approval. We recognize that during this transition period, the risk of problems and unexpected issues is greater, so we will dedicate additional resources to assist with these efforts. At the direction of DHS, we will coordinate and communicate closely with the incumbent contractors, and will cooperate fully throughout the turnover process. We fully accept responsibility for any unfinished workload inventories from the incumbent contractors, which would be equivalent to no more than would be normal at the end of any workday.

7.2 General Requirements for Provider Cost Audits and Rate Setting Component

(RFP Section 6.7.2.1)

The Provider Cost Audits and Rate Setting contractor will be responsible for determining accurate Medicaid payment rates for providers not reimbursed on a fee basis, as well as performing desk or field audit verification of cost report information submitted by health care providers. In order to maintain the integrity of the Medicaid program and the vast resources that are required for the appropriate delivery of services to beneficiaries, the Medicaid payment rates must be determined in compliance with all applicable state and federal laws and regulations, as well as the approved Medicaid State Plan.

Our project team will have access to sufficient information and technology resources necessary to perform these functions in a timely, accurate and professional manner. We will provide high tech computerized rate setting systems for all provider categories, which will enable our staff to work more efficiently by focusing on the key, high-risk areas of provider cost report reporting and compliance issues, rather than devoting attention to routine processes and mundane or immaterial items that can be better performed electronically.

Our field audit process is designed to be an efficient approach to verifying the provider-submitted data utilized to determine reimbursement amounts in an efficient and effective manner. Staff will be fully trained on our desk and field audit approach, and will fully understand the importance of each review procedure.

In performing final settlements, we will obtain all necessary information from the provider and the MMIS/Core and Data Warehouse/Decision Support Contractors, and utilize that information to accurately compute final settlement amounts due or owed to the provider. Based on the results of these settlements, by using approved standard protocols, we will notify the provider of the result of the settlement or adjustment, and will coordinate our efforts with the Revenue Contractor to ensure that any overpayment is collected and accounted for properly. We have many years of experience addressing and resolving numerous issues surrounding a final settlement process for many of the same provider categories contained in this RFP. Our procedures will take this experience into account, and will allow us to provide accurate settlement outcomes in the most efficient and effective manner.

No Conflict of Interest
(RFP Section 6.7.2.1.1)

Myers and Stauffer warrants that our members, principals and staff have no interest and agree not to acquire any interest in a provider subject to Medicaid rate setting, cost settlements and cost audits that would conflict, or appear to conflict, in any manner or degree with our obligations and performance of services under this contract. We will not utilize any subcontractors on this engagement.

Myers and Stauffer restricts its health care practice to state and federal government agencies. As such, we do not accept engagements that would involve auditing, accounting, management or other services for any general medical/surgical hospitals, critical access hospitals, psychiatric (mental) hospitals, psychiatric medical institutions for children (PMIC), nursing facilities, ICF/MR, residential care facilities (RCF), home health agencies, rural health clinics, rehabilitation agencies, home health agencies and other providers providing services under Home and Community-Based Services (HCBS) waivers, federally qualified health centers (FQHC), case management providers, pharmacies, and adult rehabilitation option providers.

We agree not to use any information obtained by virtue of our performance of this contract and our relationship with the Department to provide what would be “inside information” to any outside party without obtaining DHS’ express permission.

We warrant that our members, principals and staff have no membership on any boards of any health care provider or provider associations.

Neither the firm nor any of its members, principals or staff have or will acquire any ownership interest in any provider organization that contracts with the Department or is approved by the Department for the provision of medical, social or rehabilitative treatment and supportive services on behalf of the Department.

The firm and its members, principals and staff will not directly or indirectly pursue legislation or rules, which are intended to provide a competitive advantage to the contractor by limiting fair and open competition in the award of this contract upon its expiration.

8. Start-Up Activities

8.1 General Project Start-Up Requirements

(RFP Section 6.1.4)

The start-up activities associated with the Provider Cost Audits and Rate Setting Contractor are quite complex, and relate to other components of the Iowa Medicaid Enterprise. These interrelationships must be identified early in the planning process, and be closely managed throughout the implementation phase to ensure a smooth and successful transition to operations.

Many of the services delivered require substantial data inputs from provider cost reports that are subject to review and verification, as well as inputs from the systems component contractors or MMIS. There will, however, be some integration with the systems component contractors during the implementation and operation phases. We will work closely with DHS and other contractors to ensure the integration is successful.

The contractor will provide rate setting, auditing and numerous other consulting, analysis and support services for a wide array of provider types. Our many years of experience assisting state Medicaid agencies, including Iowa DHS, have well prepared us to provide comprehensive solutions to all service needs of this project.

Our proposed start-up activities recognize the need to adapt to the different implementation and operational start dates for contractor functions outlined in the RFP. We will begin implementation activities by July 1, 2004, for the rate setting and audit functions for general medical/surgical hospitals, critical access hospitals, psychiatric (mental) hospitals, psychiatric medical institutions for children (PMIC), nursing facilities (NF), ICF/MR, residential care facilities (RCF), rural health clinics, rehabilitation agencies, home health agencies (HHA) and other providers of services under Home and Community-Based Service (HCBS) waivers, federally qualified health centers (FQHC), case management providers, and adult rehabilitation option providers.

We anticipate no significant problems in meeting the July 1, 2005 schedule to transition from implementation to the operations phase for these services.

We will provide uninterrupted services in rate setting for the Iowa State Maximum Allowable Cost (SMAC) program, the multitude of Medicaid

revenue maximization service requirements, DRG/APG rebasing and recalibration, and reimbursement technical assistance and support services that require an immediate (July 1, 2004) operational start date. We are uniquely qualified to provide this uninterrupted and seamless transition to immediately begin the operations phase as we have successfully provided many of these same services to DHS for the last several years.

A. Planning Tasks

(RFP Section 6.1.4.1)

During the planning phase for services required to be operational by July 1, 2005, we will work closely with the DHS contract management team to ensure all tasks are fully evaluated, documented, communicated and approved before taking action.

The following is an overview of the planning tasks outlined by the RFP, followed by a discussion of our proposed approach.

Planning Task Activities, Contractor Responsibilities, Deliverables

(RFP Sections 6.1.4.1.1, 6.1.4.1.3, 6.1.4.1.4)

Initial kick-off meetings with DHS contract manager – We will schedule a series of meetings to identify all critical milestones and deadlines for the initial project phases. Action items and contractor assignments will follow the meetings, and we will ensure our tasks remain on schedule and meet DHS objectives.

Establish DHS approved project team – We will establish and finalize our project team members, who are subject to DHS approval. As addressed in Tab 10, we intend to relocate several of our management and other staff who have years of relevant experience to the Des Moines area. We will also begin recruiting additional staff in Des Moines. Our proposed reporting structure will be addressed as part of this plan for DHS review and approval.

Establish temporary office location in Des Moines – Immediately following notification of contract award, we will secure sufficient office space, conveniently located to current DHS offices, for use during the implementation year. This will provide quick and easy access to facilitate meetings with the DHS contract manager and others as needed.

Prepare implementation work plan – A discussion of our proposed project plan is included in Tab 10. Following notice of contract award, we will refine and clarify the work plan for all contractor responsibilities and timelines,

taking into account new developments pertinent to this project. This refinement process will involve input from DHS through meetings, other discussions, and exchange of documents as necessary. We will be sensitive during this process to the time constraints of DHS contract management staff, and will consult on an as-needed basis to arrive at a work plan that meets all DHS objectives.

Utilize the DHS-approved project management system – We will utilize the DHS approved project management and control system using Microsoft Project 2002, and submit to DHS for approval. Our project management team is experienced with this management software tool and can offer technical support and assistance as needed. This tool will assist in managing and controlling the development of all contractor systems and tasks. We will work closely with DHS to identify all project management system requirements and provide all information to support this approach. We recognize that with such a complex implementation that complete, timely and relevant project status reports assure DHS that all contractor functions and services remain on schedule and well coordinated with other aspects of the IME.

B. Development Task

(RFP Section 6.1.4.2)

We anticipate few, if any, development tasks for maintaining the SMAC rate setting systems and all revenue maximization RFP requirements. We are currently providing these same services to DHS, and have done so successfully for several years. We will work closely with DHS and the I&SS contractor to ensure that all current systems and procedures are fully documented and can be integrated into the IME. Due to our current performance of these services, we anticipate no problems or delays in transitioning these functions.

All remaining RFP service requirements for the Provider Cost Audits and Rate Setting Contractor are services that our firm has performed for numerous state Medicaid agencies for more than 25 years. We have developed operational system structures that support rate setting, cost audit and associated analyses and consulting support, and all associated status tracking and management reporting systems. We anticipate adapting these structures to meet the contractual needs in a timely manner. We have in place standard operating procedures and user manuals and associated documentation to support the desk review and audit functions for multiple provider categories. These will serve as the foundation on which we can develop similar tools tailored to meet DHS program needs.

System Requirements Activities, Contractor Responsibilities, Deliverables
(RFP Sections 6.1.4.2.1, 6.1.4.2.1.2, 6.1.4.2.1.3)

We will provide DHS with documentation based on our in-depth review outlining the requirements of all rate setting, audit and consulting functions.

System and user requirements will be developed in close coordination with DHS and as necessary other contractors. Interaction with the systems contractors should be limited to periodic updates of claims information from the MMIS and other routine data exchanges. We have successfully developed systems to exchange this data for other state Medicaid agency clients, but will consider specific state environmental needs when selecting the methodology to implement. We do not expect a one-size-fits-all solution for the IME project. Instead, we envision a collaborative process with DHS and other contractors to devise the best, highly automated solution.

We will provide DHS with proposed comprehensive requirements analyses to ensure compliance with all functional and technological requirements. This will include a detailed walk-through process with DHS and others to demonstrate the ability of our proposed solution to meet or exceed the expectations and needs of the IME. Appropriate staff will be available to DHS during this process, and will work closely and harmoniously with DHS, the incumbent and other DHS contractors.

System Design Activity, Contractor Responsibilities, Deliverables
(RFP Sections 6.1.4.2.2, 6.1.4.2.2.2, 6.1.4.2.2.3)

We anticipate providing draft procedure manuals for all key functions for the provider cost audits and rate setting contract. These manuals will be tailored to address all aspects of Iowa's Medicaid program, and will define program objectives, workflows, review procedures, deliverables and outputs. During the design task, we will relocate existing Myers and Stauffer personnel. We will also hire and train additional staff from the Des Moines area. Our project team will develop all necessary interfaces with the IME and the systems component contractors.

We acknowledge our responsibility to keep DHS and others fully informed during all phases of this project. Such communication will be handled through meetings, phone discussions, written reports and updates, or e-mail. We will be mindful of other demands on schedules and will provide advance notice and updates whenever practical.

This open communication process will include providing periodic updates to proposed implementation plan tasks based on feedback and experience with

the implementation, facilitating walkthroughs of our systems and approaches as desired, and preparing acceptance test criteria and data sets to ensure all systems are fully tested and approved by DHS. We will develop Workflow Process Management requirements, provide drafts of all deliverables for advance DHS review and approval, and ensure sufficient staff resources are available for the duration of the development task.

Takeover Task
(RFP Section 4.7.1.2)

For the Provider Cost Audits and Rate Setting Contractor, takeover tasks relate to acquiring data files, documents, procedure manuals and any useable systems from the current fiscal agent and fiscal consultant contractors. This task will be addressed early during initial planning meetings with DHS. At that time, we will need to learn additional details about the current contractor's functions, and the aspects DHS considers most critical to successful implementation of the IME. Based on these early discussions, we will prepare a schedule of events and milestones necessary for a smooth takeover process. This work plan schedule will detail all major takeover steps, assign responsibility and resources for each action item, establish deadlines, identify requirements for support from other contractors, and address contingency plans if milestones are not achieved as expected.

We have performed similar takeover activities in other states and understand there can be challenges and obstacles during the process. We anticipate working closely with all parties to find solutions to any problems or issues presented. We do not anticipate the provider cost audits and rate setting component takeover tasks to be prolonged, and we will do whatever is necessary to minimize any disruptions.

Transfer Task
(RFP Section 4.7.1.3)

We will develop and install all major rate setting, auditing and data analysis and support systems as needed to successfully meet all RFP requirements. If it is determined that DHS objectives for this contract can be best met by transferring existing fiscal agent and fiscal consultant contractor systems to support on-going operations, we will adjust our work plan and schedule with close coordination and communication with DHS. During the takeover task meetings with DHS, we will confirm our understandings in this area, and adjust our work plans to accommodate new developments as necessary.

C. Acceptance Test Task
(RFP Section 6.1.4.3)

As the Provider Cost Audits and Rate Setting Contractor, we will participate in the Operational Readiness/Operability Test and the Pilot Test, to ensure that all applicable procedures are in place and that all interfaces are working correctly. Our project management and staff will provide DHS with all necessary testing data, procedures and interface documentation in a timely manner to facilitate the testing process.

Operational Readiness and Operability Testing Activity, Contractor Responsibilities
(RFP Section 6.1.4.3.1, 6.1.4.3.1.2)

As part of the Operational Readiness and Operability Testing Activity, we will provide DHS with comprehensive checklists to facilitate the verification of all applicable operations and procedures, including the interactions with the Systems Component Contractors and others as applicable. We will prepare and provide draft operational checklists to DHS for review and comment. We will respond promptly to all problem conditions noted during the testing activity, and will prepare corrective action plans as needed.

We will participate fully and respond to all issues and problems relevant to the provider cost audits and rate setting component during and after the testing activity. This includes: developing applicable check-off lists of start-up tasks and activities, testing these activities and reporting results to DHS, assuring DHS that all activities have been satisfactorily completed and approved by DHS, providing walkthroughs for DHS as needed, occupying the IME, conducting all necessary training of staff, and obtaining written sign-off from DHS to begin implementation.

Deliverables
(RFP Section 6.1.4.3.1.3)

In order to document compliance with IME standards, we will provide checklist matrices for: operations, training activities, interface operations, documentation activities, and any outstanding issues or problems (with plans of correction,) and updated operational procedures reflecting revisions and refinements culminating from these checklists. These documents will be used by DHS and the I&SS contractor to document successful acceptance testing, to ensure a smooth and seamless transition to the operations phase.

Pilot Test Activity
(RFP Section 6.1.4.3.2)

We will participate in pilot testing to ensure that all Provider Cost Audits and Rate Setting Contractor functions interface with MMIS. At this time, we anticipate only a small number of interface functions between this service component and MMIS (primarily data exchanges). We will prepare all details of the pilot test plan for review and approval by DHS.

Contractor Responsibilities, Deliverables
(RFP Sections 6.1.4.3.2.2, 6.1.4.3.2.3)

We will provide DHS with all necessary pilot testing plans and schedule for review and approval. These plans will detail all interfaces with MMIS that apply to all service functions within the Provider Cost Audits and Rate Setting Component. In the event that the initial pilot testing activity identifies problems or issues, we will work closely with DHS and other contractors to ensure that these matters are resolved in a timely and professional manner.

D. Implementation Task
(RFP Section 6.1.4.4)

The goal of the tasks leading up to implementation is to prepare all RFP service components for a smooth and seamless transition to operations. The RFP outlines many of the required goals that contractors must achieve to DHS' satisfaction before full implementation of the IME can occur. It is likely that throughout the implementation process, there will be additional goals identified by DHS. We will remain flexible throughout this process and adapt our approach and work plans to accommodate changing needs. We understand the responsibilities associated with meeting these implementation objectives. We will have dedicated staff on-site to ensure DHS' complete satisfaction with our services and deliverables.

Our responsibilities during this process will be documented through the agreed-upon work plans, which will be updated as necessary. We will provide sufficient time for DHS to review our proposed revisions to such plans and provide feedback. DHS will be given sufficient time to review all system, user and security documentation for completeness prior to final sign-off and implementation. Before implementation, the system response time and all user and automated interfaces must be clearly assessed and operational.

Contractor Responsibilities, Deliverables
(RFP Sections 6.1.4.4.2, 6.1.4.4.3)

We agree to repeat portions of the operability test as requested by DHS, prepare and obtain DHS approval of an emergency back-out strategy and

operations schedule, produce and update all operations documentation, establish all necessary interfaces with other IME contractors, develop and implement applicable backup and recovery procedures, complete all training, and obtain DHS approval to start operations. We will provide DHS with the final implementation checklist and full documentation and policy manuals as applicable to the Provider Cost Audits and Rate Setting Component.

E. Operations Task

(RFP Section 6.1.4.5)

For the rate setting and auditing functions, we anticipate no problem in achieving this milestone by the July 1, 2005 target date. We will continue providing reimbursement technical assistance and support services, SMAC rate setting for multi-source prescription drugs, and all revenue maximization functions, and do not foresee any problems achieving the immediate (July 1, 2004) operational target date for these services. For the rebasing and DRG/APG recalibration projects, we are prepared to begin operations of these activities on July 1, 2004 as required by the RFP, Amendment 7. We will begin all data collection efforts at this time to ensure we are fully prepared to initiate the next rebasing and recalibration, which is scheduled to take effect October 1, 2005, under current DHS policies.

Reaching the operations phase will require a high level of communication, coordination and cooperation with DHS, incumbent contractors, other IME contractors as well as numerous other Medicaid program stakeholders.

8.2 Specific Provider Cost Audits and Rate Setting Component Start-up Requirements

(RFP Section 6.7.1)

In addition to the general planning issues addressed above, there will be tasks specific to the Provider Cost Audits and Rate Setting contractor functions that will need to be fully addressed.

A. Planning Task

(RFP Section 6.7.1.1)

Detailed Work Plan – To augment the implementation plan discussed above, and with input and direction from DHS, we will incorporate specific details of our work plan. These details will outline specific tasks, milestones and deadlines for all critical functions associated with integrating the contractor systems and operations into the IME from the temporary facilities. Examples of specific work plan tasks include:

Identification of Interface Partners and Data Descriptions – Throughout the entire planning phase of the IME implementation period, it is crucial that all contractors and DHS coordinate efforts and work harmoniously to achieve common goals. For the Provider Cost Audits and Rate Setting Contractor, this will include considerable interaction and interface with the Core MMIS and Data Warehouse/Decision Support Services Contractor to establish workable and efficient methods of transferring data sets between contractors, in both directions. To ensure there are no surprises during later steps of the transition to the IME, we will outline all routine and ad-hoc data requirements from the other contractors that are necessary to support the Provider Cost Audits and Rate Setting functions. This will also include proposed data transfers to these contractors, such as updated rate updates and reimbursement final settlement amounts. We will provide DHS and other contractors with detailed data descriptions of these proposed data transfer processes, seek input on methods deemed preferable to others, and then revise proposed approaches to meet all parties need for such data in the most efficient and effective means possible.

Staffing and Other Support – Following the initial meetings with the DHS implementation team, we will provide further detail on proposed staffing plans necessary to accomplish all required transition tasks in a timely manner. These staffing levels will fully consider all RFP requirements plus other issues that may be discovered after the implementation process begins.

Transfer of Responsibilities and Data Conversion – The Provider Cost Audits and Rate Setting Contractor must be prepared by July 1, 2004, to begin the transition activities on a number of critical functions, followed by beginning actual operations by July 1, 2005. They must also be prepared to begin actual operations of other functions by July 1, 2004. These split operational effective dates will require the selected contractor to effectively manage multiple tasks associated with the transfer of responsibilities from existing contractors, as well as data conversion issues. We will identify in our implementation and work plan proposed specific areas of responsibility for the incumbent contractors and other parties for DHS review and approval. We have successfully transitioned numerous contract services over the firm's history similar to the transition anticipated by this RFP. We understand that considerable contractor management attention and communication with all parties is essential to resolve issues as soon as possible in the process. There will be a seamless transition of services we are currently providing that are scheduled to begin operations on July 1, 2004. Our information technology and data analyst staff will quickly assess and inventory all data files that require conversion to our systems, and we will work closely with DHS and other contractors to ensure this process remains free of obstacles. We routinely handle similar quantities and types of data from DHS and other clients and do not envision any problems with data conversion.

B. Development Task

(RFP Section 6.7.1.2)

The development tasks will include development, design and testing of all necessary systems and software solutions. Many of these systems already exist as a result of our current engagements with DHS, such as the revenue maximization initiatives including Medicare reimbursement methodology systems, SMAC rate setting systems, the Long Term Care Information System (LTCIS) and MDS data management and reporting systems for nursing facilities.

We have standard software tools developed for similar projects that can be quickly adapted to meet the needs of DHS. These include nursing facility rate setting and monitoring systems, and inpatient DRG and outpatient APG reimbursement systems. With these tools readily available, we do not expect any difficulties in meeting all RFP requirements and timelines for the development tasks.

We will work closely with the core MMIS and DW/DS contractors throughout the implementation phase. By consolidating all contractor functions into a common IME facility, it will be necessary to identify efficient

data exchange interfaces to support contractor functions. We have in place numerous tools and mechanisms to acquire various data that we receive to support our Medicaid agency clients. These tools are available and workable, but may not prove to be the best means to acquire the needed data within the IME environment. As such, we will work collaboratively with DHS and other contractors to develop the most efficient approach.

We fully appreciate the need for our staff to be trained on various systems issues, and throughout this development phase, we will identify all training needs to DHS and other contractors. Our project team will also work closely with the Workflow Process Management team to develop the most automated processing solution possible. The key is identifying the system needs of all stakeholders early during the planning phase. We will be reluctant to proceed into the development phases until DHS and all contractors agree that the system requirements and needs are identified and documented.

C. Acceptance Task

(RFP Section 6.7.1.3)

During the acceptance task, we will prepare draft procedure manuals that document in an organized manner the process and data flows associated with all Provider Cost Audits and Rate Setting functions. These newly designed procedures need to be documented to provide a basis upon which DHS and the contractors can measure compliance with established policies. The procedure manuals will be evolutionary output from the planning and development phases, developed through many discussions and exchanges of ideas. These manuals will be presented to DHS for final approval before full implementation.

We understand the importance of initial and on-going staff training to ensure that all contractor staff have current knowledge of established policies and procedures. We will provide DHS with a proposed staff training plan to identify staff positions, training needs (topics, etc.) to adequately perform responsibilities, a proposed timeline for such training, and frequency of update schedule. We will work closely with DHS and the I&SS contractor to implement the training schedule in conjunction with the other contractors. All staff training will be completed before the implementation task.

D. Implementation Task

(RFP Section 6.7.1.4)

Following the successful completion of all planning, development, and acceptance testing activities including staff training, the contractors will begin the implementation tasks. During this phase, all aspects of the IME will begin moving towards the operations phase.

At DHS direction, we will begin moving staff, equipment and other resources from our temporary office location into the IME facility. This process presents numerous logistical challenges, most of which should be identified during the planning phase and transition plan. Some transition issues may not be foreseen. Therefore, all parties will need to remain flexible throughout this process for a smooth transition to occur.

We will link the Provider Cost Audits and Rate Setting computer systems to the core MMIS and Data Warehouse/Decision Support Systems as appropriate. It is likely this process will require additional technical coordination by all parties. We will provide technical and information systems support staff who are very familiar with our system needs. These staff will be on-site at the IME as needed to ensure a smooth transition.

Once all systems are in place and fully tested and approved, then any remaining data transfers or updates will need to occur to ensure all rate setting and audit databases are current. We will employ sufficient testing protocols to ensure all data transfers occur successfully.

We will then begin integrating actual contractor functions and work flows into our operations within the IME. We will initiate provider rate setting and audit activities that are not already operational into production mode.

We appreciate the pressure felt by DHS for the IME initiative to succeed and recognize the unacceptable consequences of any significant break down in Medicaid service delivery during this process. For this reason, we plan on having additional senior and support staff on-site in Des Moines during the several months leading up to the implementation phase. Having sufficient knowledgeable staff on-site is critical to the success of this initiative. Our staff are very experienced in understanding state Medicaid agency needs in general, and DHS program needs in particular. They have many years of experience working on complex issues, are able to address operational issues and respond quickly to questions. Staff will be under the direction of Ms. Perry, Mr. Knerr and Mr. Duzan.

Based on our past experience with all service requirements contained in the RFP Section 6.7, we do not expect any significant difficulty with successfully transitioning through the implementation phase. For all RFP service requirements, we have all necessary backup processes in place for contingency purposes. We are prepared to ensure that the Provider Cost Audits and Rate Setting service functions are successfully transitioned to the IME operations.

E. Operations Task

(RFP Section 6.7.1.5)

Following a successful implementation, we will assume full operational responsibilities for the Provider Cost Audits and Rate Setting functions. The Iowa Medicaid Enterprise is a complex and innovative initiative, and with as many as nine different service contractors involved, the operations cannot be successful without full and complete cooperation and coordination of activities among DHS and all contractors. To ensure appropriate and timely resolution of all issues that arise during operations, it is critical that our project management team, DHS staff and the I&SS contractor remain updated on progress and obstacles associated with all key elements of the work plan. This will require frequent and efficient communications between the parties. Assumptions need to be stated and affirmed before acting on them. Having worked closely with Medicaid program issues for the majority of their professional careers, our project management team truly understands that the IME cannot succeed without on-going communication.

9. Operational Requirements

9.1 Rate Setting, Cost Settlements and Cost Audits

(RFP Section 6.7.2.2)

A. Objectives

(RFP Section 6.7.2.2.1)

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

Audit and rate setting are critical components of this project, however this engagement is about more than just financial and statistical report audit and rate setting. It is also about understanding the environment and providing competent advice. The state needs a rate setting, cost settlements and cost audits contractor that can interpret the vast amount of data generated by the many participants in the health care reimbursement arena. Myers and Stauffer has the experience and knowledge to fulfill this need.

This section of the proposal describes our initial plan for addressing each service requested in the RFP. As required by RFP Section 7.2.9, each service requirement number is highlighted and then followed by our proposed approach. Myers and Stauffer has substantial experience providing the requested services to Medicaid agencies across the nation. We take pride in developing work products designed to meet the specific needs of our clients.

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

and statistical reports adhere to Iowa Medicaid policy and that our work products are delivered timely.

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

B. Interfaces

(RFP Section 6.7.2.2.2)

During the course of this contract, Myers and Stauffer will work closely with other IME contractors and external entities exchanging the necessary information to successfully complete all the requirements of this RFP. Data to perform the rate setting, cost settlement and cost audit functions will be obtained from outside sources. Therefore, it will be critical to establish strong working relationships from the onset with all involved parties to ensure the success of the project. During the course of our current contracts with DHS, Myers and Stauffer staff have demonstrated their ability to work with other DHS contractors and providers.

C. Contractor Responsibilities

(RFP Sections 6.7.2.2.4)

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

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

Develop and Maintain Desk Review Program
(RFP Section 6.7.2.2.4 Requirement 1)

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

Our professionals understand the Medicare and Medicaid definitions of allowable cost along with the underlying reimbursement processes. It is essential for our audit and desk review staff to understand not only the cost report and allowable cost definitions, but also how the reports are used to determine provider reimbursement. There can be no substitute for this in-depth knowledge. It allows us to accurately assess the risk of reimbursement misstatements and to focus our audit and desk review efforts where the risk is the greatest. This understanding allows us to protect program funds and minimize disruptions of provider operations.

Nationally, there is a trend toward using more sophisticated cost finding methodologies for institutional health care providers. The Medicaid and Medicare programs recognize that, combined, they represent a significant payer for most health care providers. To assure that costs are not double-counted or go unrecognized by either program, each program should understand and consider how the other is paying for its services.

Medicaid cost report auditing is quite different from more traditional financial statement audits where the client is the auditee. They are paying for the service and want their financial statements completed and are typically eager to cooperate with the auditor.

Medicaid cost report audits, on the other hand, are performed under contract with a state Medicaid agency. The auditees (providers of health care services) are often less willing to cooperate in the audit process since the audit frequently results in reduction of their Medicaid reimbursement. Traditional audit procedures, while effective at verifying that costs were incurred, are less effective at verifying the allowability and proper classification of costs. These audit functions are unique to the health care environment.

In response to this unique environment, Myers and Stauffer has developed a risk-based audit approach. This risk-based technique is designed to provide the most efficient and effective allocation of audit effort by optimizing the use of historical and current collateral evidence. Our risk-based approach also recognizes that, due to the audit environment, it is extremely important to focus our efforts on those situations where material audit findings are more likely to occur. By focusing on these areas, based upon an evaluation of inherent and control risk, the audits provide the greatest probability of detecting material misstatements, while not unnecessarily burdening the provider community. This approach to Medicaid cost report auditing focuses on high-risk areas that might otherwise have only a cursory review. High-risk areas include:

- Related party transactions.
- Home office cost and management fees.
- Multi-tiered capital or ownership structures.
- Joint use of facilities and personnel with other entities.
- Significant reporting changes from the prior period.
- Complex cost allocation issues.

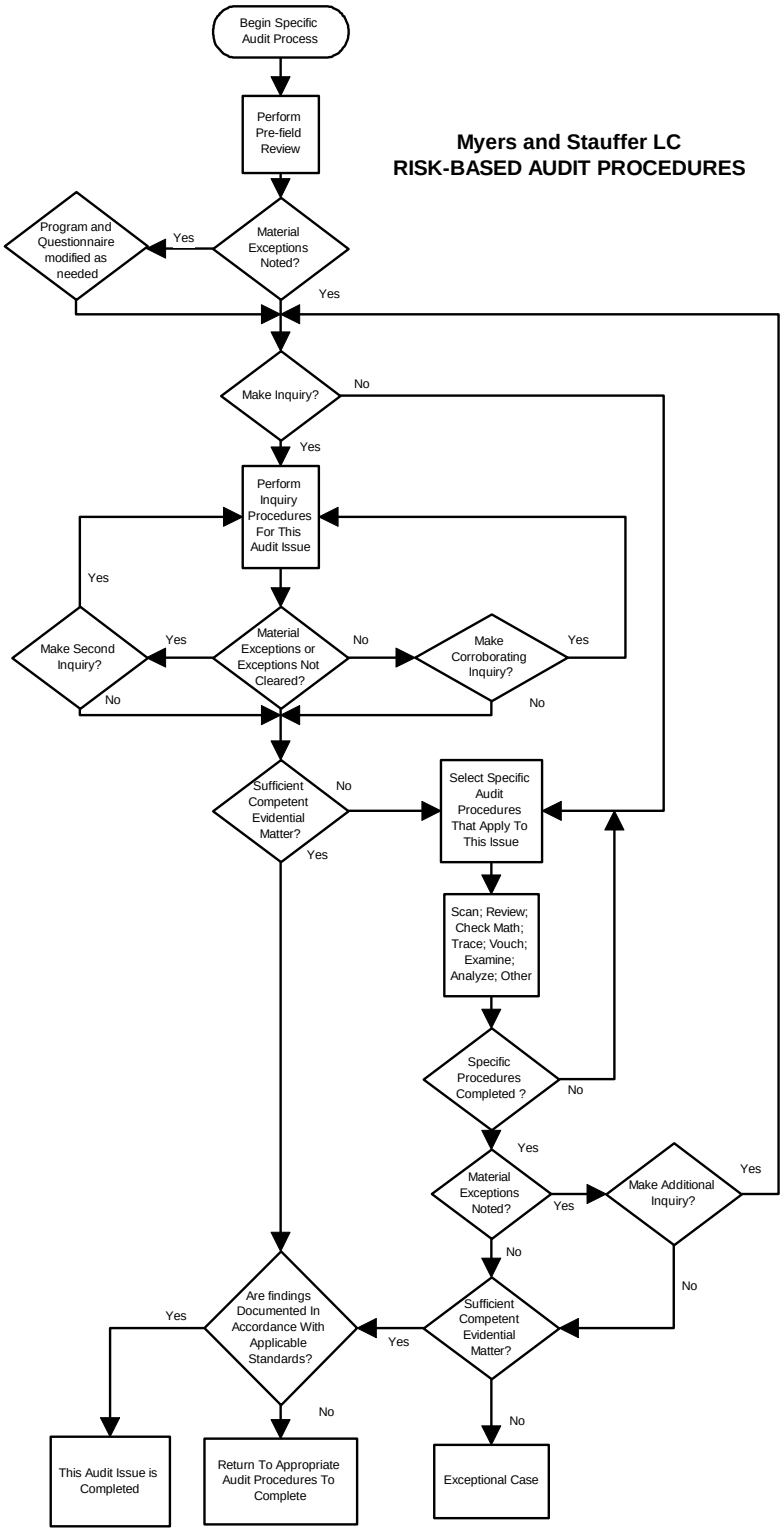
The risk-based approach requires a thorough understanding of the "big picture" of the provider's environment. To develop a complete understanding, we need to know:

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

We consider the impact cost report misstatements have on Medicaid reimbursement. As the reimbursement risk increases, we increase the level of audit resources devoted to examining the issue. By focusing on the big picture and following our risk-based audit approach, we will complete audits in a short period of time, minimize the disruptions within the provider's facility, and obtain results that provide the maximum benefit to the program.

A diagram of our risk-based audit process is included on the following page.

By following this risk-based cost report review process, we will provide the state with a high level of confidence that material cost reporting errors have been detected and corrected. At the same time, we will minimize interruptions and requests for additional information from the providers.



The procedures described in the previous diagram are applied to each audit module (Revenue, Property, Interest, etc.) to ensure an appropriate amount of auditing and corroborating information is obtained. We have performed risk-based auditing on Medicaid cost reports for many years over a wide spectrum of Medicaid providers. This technique is extremely effective in accomplishing our clients' goals for the audit process.

Our proposed desk review program will accomplish four primary objectives:

1. Verify the mathematical accuracy of the cost report.

2. Ensure the cost report adheres to Medicaid and Medicare requirements for the allowance of costs.

3. Verify that Medicaid statistical data (Medicaid days, visits, encounters, Medicaid charges and interim payments, if applicable) are accurate and properly reflected on the cost report.

4. Review by management and issue report.

By incorporating these objectives, we will develop a desk review program for each of the provider types. The desk review programs will be designed to address unique issues identified for each provider type.

Mathematical accuracy of cost report: We verify the mathematical accuracy of the cost reports as part of our data input and reconciliation processes. The first step is to enter cost report information into a database where computer routines verify the cost report foots and cross foots. Mathematical inconsistencies in the as-filled cost report are detected during this data input process. When appropriate, we reconcile the cost report to the facilities working trial balance (WTB). Account balances are traced to amounts reported on cost report lines both on aggregate amounts such as total revenues and expenses and on line item details. These data input checks, reconciliations, and line item tracings result in a thorough check of the mathematical accuracy of the Medicaid cost report. Any exceptions detected are marked for potential adjustment and communicated to the assigned accountant.

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

then use available information or request additional information to investigate each risk area.

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

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

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

Appendix A contains a sample desk review program developed in response to another state Medicaid agency desk review contract. It demonstrates the thoroughness of our desk review procedures. We will develop desk review programs to address the specific requirements of the Iowa cost reports.

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

It is extremely important that the Medicaid program is able to identify the costs providers incur caring for Medicaid clients. This will only happen if Medicaid statistics are accurate and properly stated in the cost reports.

Myers and Stauffer will work with the Medicaid fiscal intermediary (FI) to obtain Medicaid provider statistics and reimbursement reports and ensure that this paid claims data is properly reflected in the cost reports during our desk reviews and audits. The state can then base rates and cost settlements on Medicaid program costs and help ensure the overall integrity of the Medicaid program.

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

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

We use this process to develop and maintain a good professional working relationship with the provider community. We recognize being audited is not enjoyable. As such, we strive to explain our position on desk review findings (adjustments), and provide an opportunity for providers to express their position. These interactions are important in producing accurate, defendable reports, and resolving differences in factual interpretations most efficiently.

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

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

- *A report appendix* that includes a copy of the re-stated (corrected) cost report, any rate setting computations and any additional information requested by the state.

A sample report prepared for another client is included in Appendix B. Due to confidentiality requirements, all identifier information has been removed.

Develop Arrangements to Obtain From CMS 2552
(RFP Section 6.7.2.2.4 Requirement 2)

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

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

During past cost report engagements, we used the ECR file to finalize individual cost settlements. However, the ECR file and Medicare cost report software did not allow us to easily build statewide cost report databases. In response, we have developed computer programs that extract the data elements from the ECR files into statewide databases. We use this information to assist our Medicaid agency clients manage the Medicaid program.

Having all of the hospital, home health agency, etc. cost report data in a single database greatly enhances the value of this information for our Medicaid agency clients. We can quickly and accurately respond to state inquiries and model fiscal impacts from proposed changes to the reimbursement system.

Gather Information to Perform Desk Review
(RFP Section 6.7.2.2.4 Requirement 3)

Upon receipt of a cost report packet from either the Department or Medicare intermediary, project staff will input the cost report into the database and evaluate its mathematical accuracy. Analytical profiles will be generated and

used by the in-charge accountant to make a scope determination. A list of additional data required to perform the desk review procedures will be developed and information requests will be made.

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

While we believe placing reliance on a Medicare intermediary's desk review or audit is appropriate, we have learned through experience that they often do not focus on getting the Medicaid statistical information correct. This includes Medicaid patient days (by level of care), Medicaid charges (particularly ancillary charges) and, where appropriate, Medicaid interim payments. This information must be accurate to ensure that the cost of caring for Medicaid clients is accurately identified from the cost reporting mechanics.

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

Assist Providers in Understanding Medicaid Regulations
(RFP Section 6.7.2.2.4 Requirement 4)

Myers and Stauffer's management and staff are able to provide training to state and provider personnel. Our experienced staff will respond to provider inquiries regarding issues such as rate setting criteria provisions, reimbursement methodologies and cost report filing guidelines. Project staff will monitor for frequently asked questions. These will be evaluated for cause and resolution. Recommendations will be formulated and presented to DHS for review, including additional training or adjustment to the process.

We have provided training sessions on such topics as:

- Cost Report Completion
- Changes in Allowable Cost Definitions
- Case Mix Reimbursement

As training opportunities arise, we will work with the Department to develop materials and programs to meet the needs of the target audience.

Send Blank Cost Reporting Forms to Providers and Ensure Timely Receipt of Cost Reports

(RFP Section 6.7.2.2.4 Requirement 5 and 6)

We will develop a database to track not only the timely submission of cost reports, but also the progress of each cost report through the desk review, audit and settlement process. A report listing all active providers approaching fiscal year-end will be developed and used to generate and distribute the required cost reporting forms and instructions. The database will track extension requests and revised due dates. A report identifying providers who are delinquent filing cost reports will be generated from the database. Providers who are delinquent will be notified and DHS regulations will be enforced. A monthly tracking report will be provided to DHS.

The proposed database will receive cost reports electronically. Myers and Stauffer has developed numerous such cost reporting mechanisms. Any necessary modifications to the current submission process can be implemented in a timely manner.

Myers and Stauffer has also developed a cost reporting tool that allows states to utilize the Medicare cost reporting form for setting Medicaid rates. There are several advantages to this approach including ensuring providers are reporting the same data to the Medicare and Medicaid programs. In addition, it is attractive to the provider community as it reduces the burden of cost-reporting. One difficulty with using the Medicare cost report for Medicaid purposes was that the step-down allocation utilized in the Medicare cost report commingles cost. For instance, the final allocation may include costs that state reimbursement systems want to distribute between direct healthcare and administrative and general.

The step-down process developed by Myers and Stauffer uses the same methodology to allocate costs, however it allocates each cost center individually thereby maintaining its original identity. This allows for the total costs that were stepped down on the Medicare cost report to be identified by cost center and used for Medicaid rate setting purposes. If the Department wants to explore different reimbursement and cost reporting methodologies, we are able to demonstrate in more detail the abilities of this cost-reporting package.

Perform Provider Audit, Annual Cost Settlement, and Rate Determination
(RFP Section 6.7.2.2.4 Requirement 7)

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

The following details our proposed methodology for a few of the provider types to provide DHS with an understanding of our capabilities to successfully perform all rate setting and cost settlement services of this procurement.

Critical Access Hospitals

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

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

Iowa Medicaid reimburses critical access hospitals based on reasonable cost achieved through retrospectively adjusted prospective rates. CAH interim reimbursement is based on the facility specific DRG base rate for inpatient care and the facility specific APG base rate for outpatient care. Retrospective adjustments are made based on the annual cost report submitted by the hospital at the end of the hospital's fiscal year. Once a hospital begins receiving reimbursement as a CAH, the facility specific DRG and APG base rates are adjusted annually during the cost settlement process and are not subject to the statewide rebasing or recalibration processes.

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

Once a cost report or finalized cost report has been received, the paid claims history will be requested from the core MMIS contractor. A work paper

notebook will be assembled and the cost report data will be input into an electronic database.

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

Additional procedures may be part of the cost settlement process to ensure the completeness and mathematical accuracy of the cost report and reconciliation of the cost report to the trial balance and financial statements. Upon contract award, project staff will meet with the Department to review current settlement procedures, discuss the varying levels of verification and analysis that could be performed and develop a settlement program that will meet Department goals. The CAH inpatient and outpatient cost settlement programs will incorporate decisions made during this meeting, as reviewed and approved by the Department.

The following are examples of procedures completed during a combined full-scope desk review and cost settlement.

- Thoroughly review correspondence files, prior year work papers and the CMS-339.
- A materiality worksheet is used to determine factors for calculation of thresholds.
- Annual allowable Medicaid cost, as reported by the provider, is computed.
- Analyze and review of the grouping of the trial balance accounts to ensure proper and reasonable reporting on the cost report.
- Classification of expenses, revenues and statistics are compared to prior year to ensure consistency.
- An analysis is performed to ensure a proper matching of cost to charges.
- Unique cost centers must be reported on corresponding lines on worksheets A, B-1, and C. A review is performed on the cost-to-charge ratios (CCR) and an in-depth analysis is performed on those exceeding established thresholds, based upon materiality, specific to each facility.

- Account descriptions are reviewed in conjunction with review of account balances with exceptions noted for possible non-allowable cost and/or excessive balances. Inquiry is made of the provider for those exceptions having a material impact on reimbursement.
- All variances identified on our current year/prior year comparative reports, which exceed our acceptable threshold based upon the materiality worksheet, are adequately explained and/or adjusted.

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

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

Psychiatric Medical Institutions for Children (PMIC)

Payment to PMIC is based on a monthly prospective rate up to a maximum payment per diem established from cost report data submitted annually within three months of the facility's fiscal year end. Myers and Stauffer will complete the following tasks in regards to PMIC.

- Mail blank cost report forms.
- Develop payment rates annually or when a provider requests a rate review based on an interim cost report.
- Conduct desk review or audit as requested by DHS.

Home Health Agencies

Myers and Stauffer has provided various services pertaining to home health agencies such as cost report verification, rate setting and analysis of alternative reimbursement methodologies on behalf of our state Medicaid agency clients. We recently performed a study to model a reimbursement system following the Medicare PPS methodology. We are familiar with the intricacies of the process of collecting OASIS data from home health agencies to the CMS repository.

It is our understanding that the successful contractor will be required to provide rate setting and cost verification services to DHS. These procedures will mirror those discussed throughout this section of our proposal.

Federally Qualified Health Centers and Rural Health Clinics

Iowa reimburses federally qualified health centers and rural health clinics based on 100% of the costs that are reasonable and related to the cost of furnishing services. Reasonable costs are based on the provider's cost report. Interim payments are made based on a budgeted or projected average cost per visit subject to reconciliation after a cost report has been received. Annually during the settlement calculation process the interim rate for each facility is reviewed and updated if necessary.

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

Both tentative and final settlements are performed. The primary difference between the tentative settlement and the final settlement is the status of the cost report. In performing the tentative settlement the provider's as filed cost report is utilized, whereas the final settlement is calculated based upon the adjusted cost report.

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

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

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

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

As with CAH, draft copies are sent to the provider for review and comment. Once communication with the provider is complete, the working papers and final report are sent to management for final review. Upon management approval, the final settlement documents along with the NPR are forwarded to the Department for approval.

Appendix C contains an FQHC cost settlement program developed in response to another state Medicaid agency contract.

Targeted Case Management Providers

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

Myers and Stauffer will prepare annual rates for each case management provider using the submitted projected cost reports. Cost report data will be entered into the database to test the mathematical accuracy and to evaluate if the cost report was completed and filed in accordance with DHS rules. The monthly rate for each case management provider will be calculated as the average monthly cost per recipient and forwarded to DHS for approval. When approval is received, rate notification letters will be sent to providers and the Core MMIS contractor.

At the end of the fiscal year, Myers and Stauffer will conduct a cost settlement using the final (actual) cost report submitted by the provider. These cost reports will be "as filed" therefore it is possible that additional verification procedures may be required prior to preparing the final cost settlement amount. Cost settlement work papers will be prepared and forwarded to DHS for review and approval. The notice of provider reimbursement will be sent to providers and the revenue collection contractor.

Home and Community Based Waiver Service (HCBS) Providers

The Iowa Medicaid program currently has six HCBS waivers as part of the approved State Plan. These waivers cover service delivery to the following beneficiary categories: HIV/AIDS (AH), Brain Injury (BI), Elderly (E), Ill and Handicapped (IH), Mental Retardation (MR), and Physical Disability (PD). Reimbursement methodologies for these waiver service varies among the different service categories, and are based on either fee schedules, hourly rates or retrospectively limited prospective rates with an upper payment limit.

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

Rehabilitation Agency Providers

The Iowa Medicaid program authorizes rehabilitation agencies that are Medicare-certified to provide physical therapy, occupational therapy and speech therapy to eligible clients. Units of treatment are defined in 15-minute increments and payment is based on Medicare reimbursement principles.

Myers and Stauffer has considerable experience with rate setting for therapy services. For many years, we have partnered with Indiana Medicaid to set therapy rates. We have participated in provider negotiations, performed rate modeling, and assisted in the design and implementation of several rate setting methodologies.

Nursing Facilities

We have provided a detailed discussion of our approach to accomplishing the desk review and rate setting requirements of this RFP in Section 9.1.C Requirement 8. A detailed discussion of our on-site audit procedures is included in Section 9.1.C Requirement 9 of this proposal.

Intermediate Care Facilities for Persons with Mental Retardation

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

- Mail blank cost report forms to providers and track receipt of completed cost reports.
- Perform a desk review of each Financial and Statistical Report submitted.
- Conduct on-site audits annually of approximately 15% of ICF/MR.
- Perform rate determination function.

The following section will describe processes utilized to accomplish the latter three of these requirements. Please see Section 9.1.C Requirements 5 and 6 of this proposal for a discussion on our proposed database that will be used to track cost reports from the mailing of the blank form through the review/audit/settlement process.

Intermediate care facilities for persons with mental retardation are required to submit an annual Financial and Statistical Report, or cost report, with a reporting period of July1 to June 30. For new facilities entering the Medicaid program, either two six-month cost reports or three six-month cost reports are submitted to transition the facility to a reporting period of July 1 to June 30.

Upon contract award, project team members will meet with the Department to gain an understanding of the current desk review process. Discussions of specific issues the Department wants to address in the development of the ICF/MR desk review program will also occur. Project staff will prepare procedures for receiving cost reports from the Department and draft a desk review program for submission to the Department for approval. We have provided a discussion on our approach to completing desk reviews in Section 9.1.C Requirement 1 and 9.1.C Requirement 8 of this proposal.

During the desk review process, project staff will evaluate each cost report based on the historical reliability of the provider's records, the size of the facility, and the length of time since the last field audit to determine if a field audit is warranted. Based on our experience this could occur annually for those facilities that routinely have problems during the desk review process. A list of facilities recommended for field audits will be forwarded to the Department for their review. Project staff will be available to discuss reasons for inclusion and any concerns. Once approval has been received, the audit

activities, as described in Section 9.1.C Requirement 9 will be followed in completing all ICF/MR on-site audit engagements.

Rates will be established annually for each provider based on the most recent desk reviewed cost report. The payment rate will be calculated as the lower of the actual allowable per diem rate, the maximum allowable base rate or the maximum allowable cost ceiling.

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

Perform Desk Reviews, Scope Determination and NF Rate Setting
(RFP Section 6.7.2.2.4 Requirement 8)

Perform Scope Determination and Desk Reviews

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

It is imperative that cost reports are evaluated for risk, and that these risk evaluations determine the amount and nature of testing procedures employed. Factors to be considered in making a scope determination include the facility being reviewed, the historical reliability of the provider's records, the size of the facility, Medicaid utilization, and the professional judgment of the firm's management. The focus is on the potential impact of cost report misstatements on Medicaid reimbursement. As the reimbursement risk increases, increased levels of desk review and audit resources will be devoted to examining each issue.

We believe the goals of all participants (Myers and Stauffer LC, Iowa Department of Human Services, and the provider) in Medicaid cost report desk reviews and audits are similar. All want Medicaid reimbursement rates to be accurate and generated timely with minimal appeals or disruptions. With

these goals in mind, we will evaluate and revise the desk review programs as issues arise.

Upon receipt of cost report, data will be entered into an electronic database and assigned to the appropriate staff level for risk evaluation. The mathematically accuracy of the cost report will be verified. The auditor will make a scope determination that will entail either (as defined in response to question 701) a desk review, full-scope desk review or recommendation to the Department for a field audit. The accountant-in-charge will then discuss his/her findings with the audit supervisor for a final decision. The Department will be consulted if the auditor's conclusion differs from the level of services requested by the Department.

Once the scope has been determined, the auditor will complete the desk review utilizing the procedures outlined in the approved desk review program. A draft and final report will be prepared and issued for each desk review. A discussion of these reports is included in Section 9.1.C Requirement 1 of this proposal. Draft copies will be sent to the provider for review and comment. Once communication with the provider is complete, the working papers and final report will be sent to management for final review. Copies of the final report, including any necessary rate adjustment will be forwarded to the Department for approval. Upon approval, the core MMIS contractor will be notified of any rate changes.

Perform Nursing Facility Desk Reviews

Beginning July 2001, the state began phasing in the newly designed Medicaid case mix reimbursement system for both freestanding and hospital-based nursing facilities.

We worked closely with the Department on the case mix development project and bring that expertise to this proposal. The case mix system was fully implemented on July 1, 2003 and requires the state to rebase on July 1, 2005, and every two years thereafter. The Medicaid case mix rate paid to nursing facilities is based to a large extent on a facility's actual cost experience.

Prior to July 1, 2001, semi-annual submissions of six-month financial reports were required. In order to ease the administrative burden on both the department and providers, one 12-month financial report is filed annually, in conjunction with a revised inflation adjustment methodology to account for cost report timing differences. Freestanding nursing facilities participating in the Iowa Medicaid program are required to complete and file an annual Medicaid financial and statistical report with the Department. The period of

this report corresponds with the facility's fiscal year end for tax reporting purposes.

Hospital-based nursing facilities are not required to complete the Medicaid financial and statistical report but are instead required to submit their completed Medicare cost report form annually. Utilizing the Medicare cost reporting form for hospital-based nursing facilities ensures consistency between its nursing facility cost report and its hospital cost report.

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

We anticipate working closely with the Department to identify any financial reporting incentives that may have arisen under the new system. These issues will be discussed with the Department and incorporated in the desk review and onsite audit programs if deemed appropriate and requested by the Department.

The accountability measure component of the reimbursement system bases a portion of the Medicaid rate on facilities achieving specified measures related to quality of care. Several of these measures are calculated from data on the financial report. These elements will require additional verification procedures, both at the desk review and field audit level. Examples include occupancy levels (both total residents and Medicaid) and employee retention data. Refinements to the financial reporting forms may be required to enhance the validity and integrity of the resulting measures.

A draft of the nursing facility desk review program will be provided to the Department for review and approval. Project staff will meet with the Department to discuss concerns and make the necessary modifications. Project staff will complete an annual desk review of each financial and statistical report or Medicare cost report received from each nursing facility. A detailed discussion of our approach to performing desk reviews is contained in Section 9.1.C Requirement 1.

Calculate Nursing Facility Rates

There are two separate components in the Medicaid rate – direct patient care and non-direct patient care. A facility's costs are subject to several expense limitations that have been part of the Department's prior cost based rate setting system (e.g., non-reimbursable expenses, advertising, owners and management compensation). The reimbursement methodology also provides adjustments for inflation, a utilization incentive and cost normalization. The direct patient care portion of the rate is further adjusted on a quarterly basis by the Medicaid case mix index. Each rate component can be no greater than the established rate ceiling. The rate ceiling for each component is stated as a percent of the median of provider costs. For nursing facilities that costs fall below a predetermined level, additional reimbursement in the form of profit, or cost containment incentive is allowed. Nursing facilities that demonstrate quality care by achieving certain accountability measures may also receive additional reimbursement.

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

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

The nursing facility case mix reimbursement system includes a provision to rebase the Medicaid rates using more current cost data every other year. The next rebase will occur for Medicaid rates effective July 1, 2005 using the latest completed and reviewed cost report with a fiscal year end of December 31, 2004 or earlier.

Medicaid costs will be divided into two components for purposes of determining a facility's rate. The first component is comprised of direct patient care costs that are case mix adjusted: salaries, wages and benefits for nurses. The second component is comprised of all other non-direct patient care costs including administration, support care, environmental and property. A utilization incentive, or standard of 85%, will be applied when determining a facilities allowable administrative, environmental and property cost. The utilization standard does not apply to hospital-based nursing facilities.

The historical costs will then be adjusted for inflation using the Skilled Nursing Facility Market Basket (SNFMB) index published by Global Insight which measures price level changes occurring in Medicare skilled nursing facilities. It is the most widely used measure of nursing facility cost inflation

for Medicaid reimbursement systems. Facility costs will be inflated from the mid-point of the historical cost report period to the first day of the following state fiscal year (i.e., July 1, 2006).

Prior to determining the median costs, each provider's average nursing costs will be restated so that, to the extent possible, cost variations caused by different levels of case mix are removed from the cost comparison. This process is referred to as cost normalization. In this manner, average nursing costs for all providers are determined on a more comparable basis. Cost normalization is accomplished simply by dividing a facility's average allowable direct patient care costs by the facility's average case mix index score. An average case mix index for all residents will be calculated each calendar quarter. The simple average of the four quarters covering the time period of a facility's Medicaid cost report will be used to normalize the direct patient care costs.

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

Separate rate setting ceilings and profit ceilings will be established and applied to each component. These ceilings are stated as a percent of the median costs for each component. Rate ceilings represent the maximum per diem payment a facility can receive. Nursing facilities whose costs are above the rate ceiling will receive reimbursement up to the ceiling. Rate ceilings for direct patient care and non-direct patient care are set at 110% and 100%, respectively.

The profit ceilings for direct patient care and non-direct patient care are set at 100% and 95%, respectively. The case mix system provides an incentive for efficient operations by allowing facilities to retain a percentage of the difference between the profit ceiling and their costs (if their cost is less than the ceiling). For both direct patient care and non-direct patient care, this percentage is equal to 50%. The amount of profit is further limited to no more

than 10% for direct patient care and 15% for non-direct patient care of the median costs.

The opportunity to make a profit encourages nursing facilities to control spending and provides a measure of cost containment to the Medicaid program. The Department has provided for a larger maximum profit payment for the non-direct patient care component. This larger profit potential results in stronger incentives for cost containment on non-direct patient care costs.

An adjustment to the rate and profit ceilings will be applied to nursing facilities located in Metropolitan Statistical Areas (MSA). This adjustment is made to reflect potentially higher salary and benefit costs incurred by these facilities. This adjustment does not apply to hospital-based facilities.

Each facility's Medicaid rate will be calculated as the sum of the direct patient care component and non-direct patient care component. As mentioned earlier facilities have an opportunity to receive additional reimbursement based on achieving certain accountability measures, which more directly links payment to quality of care. This reimbursement is based on available funding, and is calculated as a percent of the combined medians for direct patient care and non-direct patient care, and applied based on the number of measures the facility meets.

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

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

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

The quarterly case mix index calculations will be developed by the Iowa Foundation for Medical Care (IFMC). Project staff will work with IFMC to develop a routine schedule for obtaining the quarterly case mix index calculations and supporting MDS data. We will prepare and send each nursing facility accurate rate sheets each calendar quarter that reflect the adjustment in Medicaid case mix index. For new facility the rate sheet will not reflect the facility's actual Medicaid acuity until the calculation includes a full quarter of assessment data. Under our current contract with DHS, we receive and review the quarterly case mix index calculations.

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

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

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

Perform On-Site Audits
(RFP Section 6.7.2.2.4 Requirement 9)

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

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

1. Examine each identified risk area to ensure that the risk of cost report misstatements is reduced to an acceptable level.

2. Develop sufficient competent evidential matter to provide a basis for expressing an auditor's opinion on the Medicaid cost report in accordance with the Iowa Administrative Code.

We will work closely with DHS to develop the audit program, questionnaire and standard work papers required for the audit. A separate audit program will be developed for each of the provider types to address differences in risk areas and cost reporting requirements. An example of an audit program for nursing facilities developed by Myers and Stauffer for use in a similar engagement is included as Appendix D. The program was developed in accordance with Myers and Stauffer's risk-based approach to auditing. This approach contains "Inquiry and Standard Testing" and "Additional Testing" for each audit area. The inquiry and standard testing steps have been developed to assist the auditor in quickly assessing the reasonableness (material correctness) of the provider's cost report. This testing is generally performed using only the information provided with the cost report or produced as part of a standard accounting package. Yet this testing allows us to assess the risk that the cost report could be materially incorrect in each audit area. If the results of the standard testing indicate that material cost report misstatements may be present, we will perform additional testing to ensure that these risk areas are thoroughly examined. The additional testing steps provide the auditor with guidance for this examination. When necessary, we will request additional information from the providers to resolve material issues. We emphasize our goal is to limit additional information requests to those cases that are truly justified.

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

cost reporting errors have been detected and corrected, while minimizing interruptions and information requests to the health care providers.

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

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

Prefield "Audit Planning" Activities

Upon receipt of an audit assignment, we first contact the provider and establish dates for the site visit. We have a standard scheduling letter that informs the facility of records and personnel that need to be available at the time of our site visit. Concurrently with the audit scheduling, we assign an in-charge auditor and an appropriate number of additional senior and staff auditors, matching audit assignments with staff expertise to properly perform the engagement.

Prior to the field visit, the audit team obtains and familiarizes themselves with relevant documents. These include:

- Medicaid Annual Financial Reports.
- Medicare Cost Report.
- Provider's or Accountant's Cost Report Preparation Work Papers.
- Prior Year Cost Report and Cost Report Audit Reports.
- Provider's Working Trial Balance (WTB) Used to Prepare the Cost Report.

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

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

- Reconciling the cost report to the working trial balance used to prepare the cost report. This reconciliation is performed on total revenues and expenses. We also trace individual expense and revenue amounts appearing on line items on the cost report back to the supporting WTB accounts. These reconciliations and tracings allow our auditors to assess whether the provider has properly reported cost

and revenues on the cost report. It also allows us to identify those costs the provider is claiming as allowable and those costs they have self-disallowed. Our tracings also show which revenues have been used to reduce allowable cost.

- Reviewing analytical profiles to assist our staff in identifying deviations in the cost report from industry norms and past cost report filings for the provider. We typically produce profiles that assist us in identifying deviations in provider reporting for each cost report line item. We also look at the following expense account groupings as part of our analytical review procedures:

  - Salaries and Wages

  - Depreciation and Interest

  - Other Expenses

  - Patient Days and Revenue

  - Allocation Statistics

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

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

An in-depth, expert level of understanding of the reimbursement system and rate development is critical to properly performing audit planning. Our staff development protocols include intensive training on reimbursement systems and properly assessing the risk of cost report misstatements and misclassifications on the reimbursement rates generated from our audited cost data. For example, reported per diem costs must be compared to screens or limits to determine where the provider's costs are being limited. This allows the auditor to assess the potential benefits of misclassifying reported costs to shift them into an area that is not limited by the screen.

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

To thoroughly examine risk areas identified, our audit processes are tailored to each specific audit issue. We frequently add questions to our entrance interview questionnaire to obtain additional representation from facility management. We may also modify our standard audit program to perform additional or expanded testing to examine unique audit risk issues.

Field Audit (Site Visit) Activities

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

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

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

Entrance Interview

At the start of each field visit, we will conduct an entrance interview. This allows our staff to

1. Gain additional familiarity with the provider operation, records and internal control environment.

2. Ensure the availability of records requested in our scheduling letter.

3. Inquire about the issues (risk areas) identified during our prefield procedures.

For other Medicaid cost report audit projects, we have developed Interview Questionnaire forms designed for each provider type. Similar questionnaires will be used on this engagement. Please refer to Appendix E for an example of an audit questionnaire. Additional questions are added to the questionnaire based upon the risk areas identified during the prefield review.

We also typically request a tour of the facility. The tour helps us identify areas of the facility not used for health care activities. For example, we would need to determine if a nursing facility also provides adult day care. If evidence of adult day care is noticed during the tour, we would then verify that this business activity has been properly reflected in the Medicaid cost report. We also look for evidence of new construction, additions/deletions of assets, and when appropriate, if allocation statistics using square footage reasonably agree with the actual facility layout.

The tour also provides an opportunity for our staff to ask additional questions to further our understanding of the facility being audited. For instance, if a nursing facility provider has a distinct room for physical therapy, we could ask if facility staff provide this service or if the facility contracts with a physical therapy company. The knowledge gained from the tour is then used to further refine our subsequent audit steps.

General Ledger/Trial Balance Testing

Once the questionnaire is completed, testing begins. This testing centers on verifying that the prefield information agrees with the facility's general ledger and other subsidiary ledgers. We trace the WTB amounts to supporting general ledger information and determine that records requested in our scheduling letter have been produced. Any exceptions detected during this portion of the audit are discussed with the provider.

Census and Revenue Testing

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

MYERS & STAUFFER		W/P INDEX	600.4
		PREPARED BY	TGM
PROVIDER NUMBER	N/A	REVIEWED BY	
PROVIDER NAME	XYZ, Inc.	W/P DATE	12/19/99
PERIOD ENDED	06/30/99	RUN DATE	01/16/00
SOURCE OR ACCOUNT		NAME OF W/P	RSDY

Resident Days

MM/YY	Census Days	Adj.	Adj. Days	Private Days	Medicaid Days	Other Days	(a) Private Rate	Medicaid Rate	(a) Other Rate	Private Revenue	Medicaid Revenue	Other Revenue	Total Revenue
Jan-98	1,643		1,643	282	1,094	267	102.00	95.14	203.00	28,764	104,083	54,201	187,048
Feb-98	1,548		1,548	268	1,051	229	102.00	95.14	203.00	27,336	99,992	46,487	173,815
Mar-98	1,675		1,675	249	1,250	176	102.00	95.14	203.00	25,398	118,925	35,728	180,051
Apr-98	1,524		1,524	187	1,125	212	115.00	95.14	203.00	21,505	107,033	43,036	171,574
May-98	1,569		1,569	126	1,279	164	115.00	95.14	203.00	14,490	121,684	33,292	169,466
Jun-98	1,641		1,641	100	1,423	118	115.00	95.14	212.00	11,500	135,384	25,016	171,900
Total			9,600	1,212	7,222	1,166				128,993	687,101	237,760	1,053,854
Per Cost Report			9,600	1,170	7,264	1,166							
Difference			0	42	-42	0							
% of Cost Report			0.00%	3.59%	-0.58%	0.00%							

Reconciling Items to Revenue:

	0	0	0	0
	0	0	0	0
	0	0	0	0
	0	0	0	0
	0	0	0	0
Adjusted Routine Revenue	128,993	687,101	237,760	1,053,854
Total Routine Revenue per Cost Report	129,768	688,952	236,956	1,055,676
Difference	(775)	(1,851)	804	(1,822)
% of Cost Report	-0.60%	-0.27%	0.34%	-0.17%

Comments:

(a) See AR Room Rate Master PBP in expandable

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

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

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

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

Allocation Statistic Testing

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

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

Home Office/Related Organization Testing

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

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

It has been our experience that home offices frequently include non-reimbursable cost at the home office level and attempt to allocate this cost to their facilities as allowable facility level cost. There is also concern with expenses such as interest. We need to verify that the provider is not including facility-related mortgage interest expenses in the home office cost and also reporting them as administrative and general home office-related cost on the facility's cost report. Obviously, this reporting scheme would circumvent the Medicaid capital asset reimbursement process.

Payroll (Salary and Wage) Testing

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

MYERS AND STAUFFER		WORKPAPER INDEX	900.2
		PREPARED BY	JMB
PROVIDER NUMBER	N/A	REVIEWED BY	
PROVIDER NAME	XYZ, Inc.	WORKPAPER DATE	2/24/99
PERIOD ENDED	12/31/99	RUN DATE	03/05/99
SOURCE OR ACCOUNT	941's	NAME OF WORKPAPER	RCPR

Payroll Reconciliation

Quarter MM/YY	Gross Payroll	Percent of Period	Current Period Payroll Amount	FICA 7.65% Percent	FUTA 0.80% Percent	SUTA 1.50% Percent	Total Payroll Tax
Mar-99	345,275	100.00%	345,275	26,414	2,762	5,179	34,355
Jun-99	366,050	100.00%	366,050	28,003	2,928	5,491	36,422
Sep-99	362,572	100.00%	362,572	27,737	2,901	5,439	36,076
Dec-99	368,278	100.00%	368,278	28,173	2,946	5,524	36,644
			0	0	0	0	0
			0	0	0	0	0
SUBTOTAL	1,442,175		1,442,175	110,326	11,537	21,633	143,496
RECONCILING ITEMS							
Less Beg. Accruals:			(89,725)	(7,112)	(725)	(1,350)	(9,187)
Plus End. Accruals:			92,674	7,268	760	1,390	9,418
Other: (401K, etc.)							
		Total	1,445,124	110,482	11,572	21,673	143,727
		Per C/R	1,443,694	110,850	11,683	21,234	143,767
		Diff.	1,430	-368	-111	439	-40
		% Diff	0.10%	-0.33%	-0.95%	2.07%	-0.03%

Comments:

Differences appear reasonable. No further testing necessary,

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

- Trace payroll cost for a sample of pay periods from the payroll register to the general ledger, verifying that there has been no cost shifting between payroll departments and that rates of pay and deduction to net pay are reasonable.
- Scan W-2s and the payroll registers looking for owner and owner related party compensation.
- Verify that hours worked per the payroll documents agree with amounts reported on the cost report.

Non-Salary Expenses

During our prefield planning processes and other audit verification procedures, we identify the expense accounts that require additional audit emphasis. Our staff focus their review in this segment of the audit on the examination of these accounts to determine the source of our concerns and then to ultimately determine if the costs are allowable and properly reported within the Medicaid cost report. These focused examinations are typically performed using judgmental sampling techniques.

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

Property, Leased Assets and Other Assets

The following worksheet will be prepared as part of our property, plant and equipment testing. This work paper assists our staff in testing total depreciation expense and verifies that this cost is properly reported on the Medicaid cost report. A similar work sheet for leases is used when the facility is leased from a third party.

MYERS & STAUFFER		WORKPAPER INDEX	400.4
		PREPARED BY	JMB
PROVIDER NUMBER	N/A	REVIEWED BY	
PROVIDER NAME	XYZ, Inc.	WORKPAPER DATE	12/15/99
PERIOD ENDED	6/30/99	RUN DATE	01/23/00
SOURCE OR ACCOUNT		NAME OF WORKPAPER	PPE

Property, Plant, & Equipment

		Verifi-cation Steps	In-Service Date	Land	Buildings, Lease/Impr. and Fixed Equip.	Major Movable Equipment	Motor Vehicles	TOTAL
Beginning Balance at	06/30/98			108,000	1,327,234	313,014	0	1,748,248
Provider Additions/Disposals:								
Medical Equipment		B,C	10/1/98	0	0	2,273	0	2,273
				0	0	0	0	0
				0	0	0	0	0
				0	0	0	0	0
				0	0	0	0	0
				0	0	0	0	0
				0	0	0	0	0
				0	0	0	0	0
C/R balance at	06/30/99			108,000	1,327,234	315,287	0	
Asset Cost Adjustments								
See comment A				0	14,244	13,116	0	27,360
				0	0	0	0	0
				0	0	0	0	0
				0	0	0	0	0
				0	0	0	0	0
				0	0	0	0	0
				0	0	0	0	0
				0	0	0	0	0
Adjusted Balance at	06/30/99			0	1,341,478	328,403	0	1,669,881
Depreciation/Amortization Per C/R:				N/A	19,541	8,957	0	28,498
Depreciation Adjustments:								
				N/A	0	0	0	0
				N/A	0	0	0	0
				N/A	0	0	0	0
Balance Per Depr. Sched.	06/30/99			N/A	19,541	8,957	0	28,498

Verification Steps:

A) Inquiry
B) Evaluate reasonableness
C) Trace to depreciation schedule
D) Examine vendor invoice
E) Trace to provider project worksheet
F) All of the above

Comments:
A - As in prior years, the variances are related to the difference between the Medicaid cost report & the balance per the general ledger.
It appears the provider recorded the G/L costs on the Medicaid cost report, therefore showing an understated asset costs. However, the depreciation expense was reviewed and it appears the correct Medicaid depr. expense is being reported. No further testing necessary.

In addition to testing total capital asset balances and depreciation and lease expense, we also:

- Scan the depreciation schedule to verify that depreciation expense is calculated on the straight line, using American Hospital Association useful lives.
- Determine that the assets in the depreciation schedule are used for patient care activities.
- Determine that other asset accounts (inventories, prepaid expenses, etc.) have been properly maintained in the accounting system.
- Scan repair and maintenance accounts to verify that capital purchases have not been expensed when the proper treatment is to capitalize and depreciate these items.

Exit Conference

Prior to leaving the field, the audit team will conduct a meeting with the provider to discuss the findings and questioned costs identified during the field visit. At this time, the audit team returns the provider's records and a detailed listing of any additional information needed to complete the audit. The results of the meeting will be documented in the work papers.

Post Field/Report Preparation Activities

Upon returning from the field (site) visit, team members meet to discuss any audit issues with the manager or supervisor. The meeting also serves as a planning session for completing the engagement.

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

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

A final review then ensures the initial review was thorough and properly documented in our file. Upon completion of the review procedures, the draft audit report will be issued in accordance with the procedures discussed in our desk review procedures Section 9.1.C Requirement 1 of our proposal.

Recognize and Honor the Agreements for Exchange of Medicare and Medicaid Information

(RFP Section 6.7.2.2.4 Requirement 10)

Myers and Stauffer agrees to recognize and honor the Agreements for Exchange of Medicare and Medicaid Information. We understand the importance of completing a desk review or audit in an efficient and cost effective manner and duplicating tasks is inefficient. Myers and Stauffer has worked closely with Medicare intermediaries on other state Medicaid agency projects. We are confident we will be able to build a productive relationship with Iowa Medicare intermediaries.

It is critical for our audits and desk reviews to ensure that Medicaid statistical information (Medicaid days, Medicaid charges and, where appropriate, Medicaid interim payments) be properly stated in the cost reports. It has been our experience that Medicare audits can be relied upon for total allowable costs, total patient days and other aggregate information, but we frequently are concerned with the accuracy of Medicaid specific information presented in a Medicare intermediaries' audited or desk reviewed cost report.

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

Complete All On-Site Audits in Accordance with Department Guidelines (RFP Section 6.7.2.2.4 Requirement 11)

Inconsistencies in the application of reimbursement rules and/or Department guidelines can generate enormous problems. Yet the consistent application of Medicaid reimbursement policy within an environment that has numerous different ownership structures, various financing and contractual relationships, and disparate cost reporting practices is extremely challenging.

Rather than establishing Medicaid reimbursement rules and policy guidelines, we understand our role as contractor is to apply the state's rules and guidelines consistently during each audit, desk review, cost settlement or other project assignment. The following helps ensure our consistency in this area:

- All work products are subjected to a two-tiered management review for accuracy and consistency in applying Medicaid standards on each engagement. The first review is typically more in-depth and involves a

thorough check of each work paper and a verification of the amount and consistent application of work programs and procedures. The second review also checks for consistency and verifies that the initial review was thorough and documented in the work papers.

- All project staff participate in training to ensure they are knowledgeable of Iowa Medicaid program rules and policies. Staff new to each project must complete standard training activities prior to receiving job assignments. Training is also part of the work review/feedback process and office wide training sessions are scheduled periodically or when changes in Medicaid or Medicare rules and/or policy guidance are revised.
- Project manuals and standardized audit programs and work papers containing Medicaid rule, policy statements and standard audit, desk review and settlement procedures are developed for each project and made available to staff. These manuals, programs and work papers assist in consistent application of their work assignments across providers and over time.
- New and/or unusual situations are discussed with state representatives to prior to finalizing our work assignments. We have found that discussing appeal decisions with our clients avoids the continuation of unsustainable adjustments, and helps develop more specific Medicaid policy position papers to support desired treatment of reimbursement issues.

Using these four processes can minimize inconsistencies in the application of Medicaid rules and policies when performing our project activities. Project staff will work closely with the Department during development of the desk review, audit and cost settlement programs. It is our understanding that the audit shall be sufficiently detailed to enable the contractor to express an opinion on totals costs and statistical data provided by the cost report. Desk review and audit programs will be developed to ensure conformance to the requirements for allowance of costs as state in the Code of Federal Regulations and Iowa Administrative Code.

Verify Cost Report Data, Prepare Adjustment Reports, Prepare Work Papers and Notify Providers

(RFP Section 6.7.2.2.4 Requirement 12)

The Department conducts cost settlements, desk reviews and on-site audits of provider cost report data to ensure that payments are made in accordance with state and federal regulations. Cost report data will be verified utilizing the desk review, cost settlement or on-site audit procedures discussed throughout our proposal. Examples of data that may be used during this process, include the provider's trial balance or general ledger, audited financial statements, CMS-339 (formerly HCFA 339), provider statistical and reimbursement (PS&R) report from the fiscal intermediary and detailed provider records obtained during an on-site audit.

Adjustment reports and audit work papers will be prepared for each desk review, audit or cost settlement. Our work papers will provide an explanation for the adjustment and the supporting regulation citation. Each work paper indicates its purpose and conclusion as well as sufficient detail to support the adjustment and the source of information. To further enhance efficiency and productivity, our work papers are computerized. This enables each auditor to prepare standard work papers, consistent across providers, and to ensure mathematical accuracy. The consistent presentation of audit results has proven to be very useful to users of our work papers. As other users (such as state agency program personnel or state agency attorneys) become familiar with our work paper formats, they are able to quickly comprehend the test we performed and ascertain why we arrived at our conclusions.

To enhance the utility of our audit work papers, we have developed standardized indexing and filing practices. All work papers associated with an audit module are filed together. Each work paper includes a title, index reference number, preparer's initials, preparation date and reviewer's initials. If a particular work paper results in an adjustment, it is noted on the work paper with the applicable regulation citation.

Final procedures of a desk review, audit or cost settlement include preparation of the adjustment report, with draft copies sent to the provider for review and comments. The in-charge auditor will work with the provider to resolve any concerns they may have. Once communication with provider is complete, the work papers and final report are sent to management for final review. Upon management approval, draft of final report, adjustment report, and adjusted cost report is sent to DHS for review and comment. When performing a cost settlement, a settlement reconciliation and notice of program reimbursement will also be sent to DHS for review.

Perform Credit Balance Audits
(RFP Section 6.7.2.2.4 Requirement 13)

Medicaid credit balances exist when the sum of all payments the provider receives for its health care services exceeds the Medicaid allowed amount. In these situations, Medicaid providers need to refund the excess (credit balance) to the Medicaid program, so that their net payment is equal to the Medicaid allowed amount. To ensure this is done, Medicaid agencies typically perform credit balance audits.

Myers and Stauffer will perform these audits as part of our obligations under this procurement. We have developed electronic work papers to assist in the performance of credit balance audits for our other state Medicaid agency clients. These work papers assist Medicaid providers in the identification of credit balances and to calculate the amount owned the Medicaid program.

We understand that approximately 450 credit balance audits will be performed annually. Myers and Stauffer staff will work with Iowa Medicaid providers to identify Medicaid credit balances. We will then coordinate our findings from these audits with the revenue collection contractor to ensure that all amounts due the Medicaid program are collected either through the re-adjudication of the claim or through the receipt of a direct payment.

The current provider audit manual suggests that credit balance audits may be limited to in-state hospitals and their related entities (i.e. hospital-based home health agencies, etc.). If it is the state's desire to limit the credit balance audits to in-state hospitals and their affiliates, we will continue the existing practice. We are however, willing to expand the credit balance audits to entities other than in-state hospitals. This decision should consider the volume of third party payments received in other provider settings, and the Medicaid program's experience receiving credit balance refunds from these providers. We expect expanding the credit balance audits to other provider types would improve the overall efficiency of the Medicaid program and elevate the importance of this issue within other provider settings.

Correct Filed Cost Reports and Notify Core MMIS Contractors
(RFP Section 6.7.2.2.4 Requirement 14)

At the conclusion of each desk review, audit or cost settlement, project staff will prepare an adjusted cost report that will be submitted to DHS with the final report. Depending upon the provider type, the final report may include the final settlement amount, revised interim rates, or revised prospective rates.

The provider and core MMIS contractor will be notified of any rate changes or settlements upon receipt of approval from the Department.

Develop Interim Rates
(RFP Section 6.7.2.2.4 Requirement 15)

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

The accountant-in-charge will review the provider's interim reimbursement rate in relation to the final settlement or cost statements/work papers received by the provider. If the provider's current interim rate appears to be significantly over- or under-stated, the rate will be adjusted to more accurately reflect the provider's current operations, as reflected in the final settlement. Adjustments to interim rates will be forwarded to the Department for their approval. Notification of rate change will be sent to the provider and core MMIS contractor.

Calculate Overpayments/Underpayments
(RFP Section 6.7.2.2.4 Requirement 16)

For those providers that are reimbursed under a cost based methodology with either a retrospective or prospective cost settlement, an overpayment or underpayment will be determined during the cost settlement process. We have provided a detailed discussion by provider type on the procedures we propose to complete in determining the overpayment/underpayment in Section 9.1.C Requirement 8 of this proposal.

Maintain, Update and Load Per Diem Rates for Hospitals with Physical Rehab Units
(RFP Section 6.7.2.2.4 Requirement 17)

Myers and Stauffer will maintain, update and load per diem rates for hospitals with physical rehab units in accordance with the reimbursement guidelines established by DHS. It is our understanding that the prospective per diem rate for each hospital is determined by applying an annual index to a base year per diem rate. Payment to hospitals is based on the lower of the Medicaid cost per diem rate or actual charges.

Rates will be calculated on an annual basis and notification sent to the provider and the core MMIS contractor for upload into the claims system upon approval from DHS. Cost settlement and desk review or audit procedures will be completed at the request of DHS. Any over/under payments will be sent to the core MMIS and revenue contractors for processing.

Provide Notice of Provider Reimbursement to Cost-Based Providers
(RFP Section 6.7.2.2. Requirement 18)

It is our understanding that the Department will approve all reimbursement rates and cost settlements and authorize all collection of overpayments. The final settlement documents along with the NPR will be forwarded to the Department upon completion of each settlement. When approval is received from the Department a copy of the NPR will be sent to providers. The letter sent to providers will include a copy of the adjusted cost report and instructions for remitting overpayments to DHS and their right to request a repayment plan. All overpayments will be processed through the claims payment system as an offset to payments versus a recovery.

A copy of the NPR will also be submitted to the revenue collection contractor who will be responsible for issuing checks to providers for any amounts due or processing overpayments remitted by providers. Project staff will work with the revenue collection contractor in monitoring the collection of overpayments and to ensure that payment on amounts due is made within three months after receipt of the Medicare cost report. A delinquent account report will be generated and provided to the Department quarterly.

Project staff will work with providers to develop a repayment plan and submit to the Department for their approval. Once approval has been received the revenue collection contractor will be notified.

Reopen Cost Report Settlements
(RFP Section 6.7.2.2.4 Requirement 19)

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

Provide Documentation and Participate in Administrative Appeals
(RFP Section 6.7.2.2.4 Requirement 20)

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

Our staff have an expert level of understanding of Medicaid reimbursement processes. Staff having knowledge of reimbursement requirements, and particular knowledge of the issues under dispute, will be available to assist in the resolution of each provider appeal.

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

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

Provide Written Activity Reports Monthly
(RFP Section 6.7.2.2.4 Requirement 21)

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

- Number of cost reports received and in process including status
- Number of desk audits completed

- Number of field audits completed
- Number of cost settlements completed
- Amount of over and under payments

Submit Field Audit Activity Report Monthly
(RFP Section 6.7.2.2.4 Requirement 22)

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

We will work with the Department representatives on the specific format for each report for each provider type. At a minimum the following information will be contained in the monthly reports:

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

Our provider audit and related experience suggests that comprehensive and routine status reporting is essential to properly manage large complex engagements such as this one. It is important for DHS to have current information on the status of each project activity. While many functions and processes remain constant, there will still be the need to continually evaluate the adequacy of routine management reporting. We will work closely with DHS to identify needs and tailor reports to meet those needs.

Conduct Analysis and Provide Data to Support Assurances and Findings
(RFP Section 6.7.2.2.4 Requirement 23)

Unlike many contractors whose cost report audit or rate setting services are just a part of their business, Myers and Stauffer's entire practice is devoted to health care reimbursement issues. We have provided audit, rate setting, and consulting services to numerous states throughout the country. This experience enables us to offer Iowa a unique perspective into the current trends and payment methodologies used by other Medicaid programs

The Department is responsible for developing and maintaining a Medicaid reimbursement system that meets state and federal standards. The repeal of the Boren Amendment in the federal Balanced Budget Act of 1997 (BBA 97) was intended to give states even greater flexibility in designing nursing facility

payment systems. BBA '97 added new requirements concerning federal Medicaid payment oversight by instituting a "public process" through which changes to Medicaid institutional reimbursement rates are to be implemented. The "reasonable and adequate" *payment standard* has now been replaced with a public process *procedural standard.*

The focus of this regulation is a public process requirement, that gives interested parties an opportunity for review and comment on the determination of rates. Proposed and final rates should be published by the state, as well as the underlying methodologies and justifications for these rates.

The rate setting process should document the decision making process, beginning with the accumulation of data through the submission of the State Plan Amendment. We constantly monitor proposed and final federal legislation and regulation relative to the Medicaid program in order to update our clients on the impact any changes may have on the programs they administer. We strive to stay current with the new state plan amendments submitted to CMS as well as the types of information and documentation requested by CMS regional and central offices.

We will assist in drafting state plan revisions as needed. The new state plan amendments will be developed to comply with federal laws and regulations including drafting justifications and publication notices, now required for federal compliance.

We anticipate the Medicaid state plan approval process becoming even more challenging in the near future. It will become increasingly important for states to engage consultants like Myers and Stauffer that are experienced in successfully assisting state Medicaid agencies through the CMS approval process. In addition, the Medicaid rules and regulations of Iowa will be evaluated to determine if and where changes are needed. We realize each state has their own unique regulatory process but our broad experience will provide us with the basic knowledge that can be applied in Iowa.

The Department may also be requested to provide documentation and testimony at administrative and judicial hearings. We have prepared exhibits and provided testimony at legislative meetings and will assist Iowa as needed, including providing necessary research.

Prior to the repeal of the Boren Amendment, we performed detailed findings for several clients each year. An element of these findings was an analysis of the state's compliance with the Medicare upper limit requirement. Since the repeal of Boren, we have worked with many of the same states to develop

appropriate public notice including justifications and Medicare upper payment limit calculations to reflect changes in the Medicare reimbursement methodology.

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

Conduct Analysis and Assist DHS Develop New Reimbursement Methodologies

(RFP Section 6.7.2.2 Requirement 24)

The selected contractor should have a broad understanding of the different methods and standards used across the country in setting reimbursement rates and advise the Department concerning alternative systems. Myers and Stauffer has considerable experience assisting a number of states, which enables us to offer insights into this complex area, and advice on meeting the new standards and completing the justifications process.

Drawing upon the experiences of other states, we can assist the Department in identifying strengths and weaknesses of potential reimbursement systems and developing reimbursement systems that meet the programmatic goals of the state of Iowa.

During this contract period we will participate in meetings, discussions, and training with the Department and other state government agencies involving Medicaid policy formulation and alternative reimbursement methodologies. We will be available to assist in documenting the process of establishing the annual upper payment limits and other components of the rate setting methods and standards.

A key element in developing a new reimbursement methodology is thoroughly modeling the alternatives under consideration. We can create dynamic models that allow for easy modification of reimbursement parameters. Fine tuning the models creates a reimbursement system that meets as many Department goals and objectives as possible.

It is our understanding that DHS anticipates making changes to the home health agency reimbursement system during state fiscal year 2005. Project management scheduled to relocate to Des Moines upon contract award, recently completed a home health agency reimbursement study for the state of

North Carolina. This study included processing of OASIS data, cost report data and claims data to develop a reimbursement model similar to the Medicare PPS.

As decisions are made to modify reimbursement methodologies, project staff will participate in the formulation of Medicaid policy changes. An evaluation will be completed to determine if the changes in the reimbursement system will require modifications to the system component contractors. Meetings will be held with the core MMIS contractor to discuss possible changes to the claims processing and develop a work plan and a timeline for accomplishing changes.

Release Rates Upon Request From Other States
(RFP Section 6.7.2.2.4 Requirement 25)

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

Prepare Annual Compilation Reports
(RFP Section 6.7.2.2.4 Requirement 26)

We will maintain and continue to enhance our Iowa Medicaid cost and statistical databases. The Iowa Medicaid cost and statistical databases will be modified to import and store cost and statistical data for ICF/MR, RCF, and HCBS. Annual reports that summarize cost and statistical data assembled from the provider cost reports will be prepared. Financial and statistical data will be available for quick and efficient compilation and summarization for use in developing fiscal estimates.

We will be available on a regular basis to assist the Department in analyzing cost and statistical information. Common applications for such analyses include providing fiscal estimates of anticipated or proposed changes to regulations affecting reimbursement methodology, or responding to legislative inquiries concerning Medicaid expenditures to NF, hospital-based NF, ICF/MR RCF and HCBS. Reports will be generated upon request and forwarded to the Department and other parties as directed.

Develop Suggestions for Improving provider Accounting Procedures
(RFP Section 6.7.2.2.4 Requirement 27)

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

Attend Training, Meetings or Conferences
(RFP Section 6.7.2.2.4 Requirement 28)

Our account manager and project managers will maintain high levels of communication and coordination of work activities with DHS. Significant amounts of data will need to be exchanged between DHS and Myers and Stauffer during this contract. This includes cost report data, paid claims information, audit/desk review/settlement information, work papers and other data requested by DHS.

Myers and Stauffer personnel will be available to meet with DHS as requested. We anticipate having a monthly meeting with DHS to report progress on each contract activity and discuss issues of concern. We have found the routine monthly meeting process to be very effective in coordinating audits, desk reviews and settlement activities.

As part of Myers and Stauffer's staff development practices, project staff are encouraged to attend outside conferences to keep current on federal and state issues. Insight gained at these conferences is shared with our clients.

We are also available to assist the Department with initiatives or inquiries from other governmental agencies and provider groups to address reimbursement issues, such as developing reimbursement cost ceilings and projecting expenses for Department budgets. We will make available experienced and knowledgeable staff to be responsive to and interact with the Department and providers upon the Department's direction, and offer both phone contact support and written communication as needed. Project staff will respond to questions from Department staff within three working days of the request.

Provider Ongoing Technical Assistance
(RFP Section 6.7.2.2.4 Requirement 29)

Myers and Stauffer will develop a comprehensive understanding of the Iowa Medicaid program through the performance of our contract duties under this procurement. We will provide on-going technical assistance to the Department as it analyzes alternative reimbursement systems. Should changes be desired to reimbursement methodologies, we will assist with the drafting of state plan revisions, developing findings and assisting on other special projects.

We recognize the value state Medicaid agencies can realize from having a rate setting and audit contractor who is available to assist with the plan revisions and special projects.

Provide Assistance with Accountability Measures
(RFP Section 6.7.2.2.4 Requirement 30)

Ongoing monitoring and evaluation of the case mix reimbursement system is essential to ensure that the Senior Living Program and long term care policy objectives are being met. We will provide professional and analytical assistance to the Department on trends in resident acuity and accountability measures for all nursing facilities.

A portion of the Medicaid rates under the new case mix system will be based on each facility achieving certain accountability measures, which will link payment to quality of care. Examples of these measures include standard surveys and complaint investigations from the Department of Inspections and Appeals, customer satisfaction surveys completed by residents, resolution of complaints tracked by the nursing facility's resident advocate committee, professional staffing levels, and employee retention rates.

The contractor is required to collect and compile information received from nursing facilities, and determine the number of measures each nursing facility met. Based on these determinations, the contractor will calculate the rate impact to the provider and adjust the Medicaid rate accordingly. This rate adjustment will occur annually on July 1, and will be based on each facility's performance relative to the accountability measures during the prior year.

A goal of a case mix reimbursement system is to provide an incentive for nursing facilities to accept higher needs patients that might otherwise be cared for in more costly acute care settings. This is accomplished by designing a reimbursement system that recognizes acuity and adjusts payment based on that acuity. Therefore, changes in case mix are expected over time. Another

desired effect of the new system is to encourage higher quality care through the implementation of accountability measures. If these measures are successful in bringing about higher quality of care, we would also expect these measures to change over time. We plan to implement management reports and other analyses necessary to monitor, evaluate and report on trends associated with both these elements.

We agree to prepare the acuity reports and analyses and provider to the Department semiannually by March 1 and August 1 and the accountability measures annually by June 15 of each contract year.

Provide Assistance with Senior Living NF Conversion and LTC Grant Program

(RFP Section 6.7.2.2.4 Requirement 31)

The long term care marketplace is rapidly changing. In order to help nursing facilities adapt to these changes, the Senior Living Program Act established a grant program to provide financial assistance for nursing facilities to convert existing nursing facility beds. These beds must be converted into other uses such as assisted living, adult foster care, and respite care for developmentally disabled citizens.

Facilities are required to meet several criteria before they become eligible for grant funding. They must complete a comprehensive application, submit architectural blueprints, financial feasibility studies and respond to Department inquiries. Our proposal anticipates providing professional staff review for completeness and mathematical accuracy as well as a review of all key elements of each financial feasibility study. We are available to assist the Department in designing standardized review protocols, as well as drafting letters, reports and other necessary documents.

Maintain Sufficient Knowledge on Federal Requirements

(RFP Section 6.7.2.2.4 Requirement 32)

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

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

Myers and Stauffer has assisted several of our state Medicaid agency clients evaluate their health care programs and to restructure payments plans to help maximize federal participation in the Medicaid program. Some of these enhancements are simple to implement and involve relatively small changes to payment plans, while others are complex and require the cooperation from multiply program stakeholders to get the changes implemented.

During our activities under this procurement we will develop an in-depth knowledge of Iowa Medicaid program payment mechanisms, which will assist us in evaluating your payments systems from a state/federal funding perspective. We will inform you of any opportunities identified where the state may increase federal funding. We will them work with the state to evaluate each opportunity and to where appropriate develop implementation strategies.

In the coming months it may also be the case where federal maximization techniques that were allowable in the past will be prohibited from use in the future. Revisions to current federal funding practices will necessitate that Iowa re-evaluate its current provider payment systems to ensure that Medicaid program expenditures continue to be eligible for federal funding participation. It may also require that rate enhancement offered in the past need to be scaled back. We will also be available to assist the state address these contingencies.

Electronically Transmit Data to the Department
(RFP Section 6.7.2.2.4 Requirement 33)

A sophisticated information system is vital for the fiscal consultant to successfully meet all objectives of the RFP. Technology dramatically changed the way everyone works. This change is key in the success of our firm. We are committed to providing the infrastructure necessary to meet the needs of the state's rate setting and analysis requirements outlined in this RFP.

Our proposal presents highly qualified information system professionals, who possess both technical knowledge and Medicaid program expertise to fully understand the needs of the Department. This talented team of computer professionals works to maintain existing systems while developing new applications or enhancements.

We will acquire and maintain hardware necessary to conduct the required rate setting, analyses and reporting activities, and will obtain or develop the software to provide all required services. The systems we develop for this project will be capable of providing either detailed or summary information that could be made available over the Internet. We have developed similar

systems for other states with large Medicaid programs and can provide for the capacity addressed in the RFP.

Our computerized information system will provide the Department with deliverables and reports in either electronic spreadsheets, word processing, or other mutually agreeable formats.

As technologies continue to advance, our computer professionals will review changes and evaluate the potential impact on our rate setting activities. Our goal to provide the highest level of service to the state has a long term perspective so that, as we move into new technology, it has been tested and determined to be reliable and stable.

D. Data Sources

(RFP Section 6.7.2.2.5)

We acknowledge and will utilize the data sources noted in the Request for Proposal.

E. Required Reports

(RFP Section 6.7.2.2.6)

Myers and Stauffer will prepare the following reports:

- Rate sheets
- Cost settlement reports
- Desk review and audit reports
- Compilation reports of costs and statistical data for NF, ICF/MR, RCF and HCBS
- Annual acuity analysis report for accountability measures for NF
- Monthly activity reports

F. Performance Standards

(RFP Section 6.7.2.2.7)

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

9.2 State Maximum Allowable Cost (SMAC) Program Rate Setting

(RFP Section 6.7.2.3)

A. Objectives

(RFP Section 6.7.2.3.1)

We understand the Department's objective to have the SMAC program comprehensively supported, updated and maintained to insure appropriate health outcomes for recipients, prevent barriers to pharmacies' drug purchases, and achieve greater fiscal efficiency in the Medicaid program. Our services to the Department will fully support this objective.

As the incumbent contractor, Myers and Stauffer understands the current SMAC program and the services being requested by the RFP. Furthermore, since we assisted the Department from the beginning of the program, we are knowledgeable of the decisions and factors that led to the current design of the program.

The Iowa SMAC program is based on determining acquisition cost by observing invoice information received directly from pharmacies. We have fostered relationships with the Iowa pharmacy community and achieved a high level of compliance with requests for information necessary to set, maintain, and update SMAC reimbursement rates. In addition, we have extensively studied the fiscal and programmatic outcomes possible for the SMAC program, analyzing each component of the system and how changes to it might impact DHS objectives. We are prepared to seamlessly continue our services to DHS with enhancements and a minimal resource commitment from DHS.

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

quickly respond to stakeholders' questions or concerns about the SMAC program

We propose to provide the following services:

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

B. Interfaces

(RFP Section 6.7.2.3.2)

Communication and planning are essential to the success of a SMAC program. Frequent meetings are recommended with the Department to discuss the SMAC program and any necessary amendments. We will interface with DHS, other Iowa Medicaid Enterprise components and external parties as necessary and directed by DHS.

We have served the Iowa Medicaid program since 2000. We have successful, on-going relationships with each of the other Medicaid contractors. We currently work with several other contractors on pharmacy-related engagements on behalf of DHS. We will pursue our work in a manner that will coordinate with other contractors and agencies, when necessary, at DHS direction and approval.

Myers and Stauffer works cooperatively with stakeholders to address their concerns, provide needed information, and resolve issues, as appropriate and at the direction of the Department. We understand the important role that pharmacies have in the SMAC program and we will be responsive, diplomatic, and prompt in addressing inquiries and conducting meetings or other interactions with providers.

C. Contractor Responsibilities

(RFP Section 6.7.2.3.4)

The Provider Cost Audits and Rate Setting Contractor is responsible for the following tasks.

SMAC Program and Rate Schedule Maintenance

(RFP Section 6.7.2.3.4 Requirement 1)

Assume responsibility for operation, support, and maintenance of Iowa SMAC program and rate schedule.

As the incumbent contractor assisting DHS with the SMAC program, Myers and Stauffer has worked side-by-side with DHS, providing information, practical scenarios, advice, recommendations, empirical research and other services necessary to determine appropriate courses of action for addressing the decisions regarding the SMAC program. We have supported DHS efforts to explain the SMAC program to stakeholders, deflect critics, achieve better health outcomes, reduce expenditures, make amendments to the program, and monitor the progress of the program. We look forward to working with DHS further, overcoming new challenges and making additional enhancements to the program—adding more acclaim to a program that draws inquiries from other Medicaid programs seeking to duplicate its success.

Myers and Stauffer's approach to developing SMAC programs maximizes the cost-effectiveness of pharmacy services by setting reimbursement amounts for therapeutically equivalent drug products at the same price, based on the average price pharmacies pay to obtain the products. The foundation of this approach is acquisition cost information obtained from pharmacies' financial records, with periodic comparisons to published pricing information.

Pharmacies' acquisition costs are determined by obtaining, examining, and utilizing pharmacies' drug purchase records for selected periods of time. SMAC rates are developed from this information. Our experience suggests that successful SMAC programs are built upon seven key elements:

Element 1—Environmental Evaluation

To operate a successful SMAC program, it is critical to understand the regulatory, political, clinical, and fiscal environment facing Iowa Medicaid decision makers.

Element 2—Strategic Planning and Project Communication

Communication and planning are also essential to the success of a SMAC program. Frequent meetings are necessary to discuss the SMAC program and potential policy options. Fiscal goals must be considered and explored. Strategies for addressing external stakeholder concerns must be developed. Amendments to administrative rules, state laws, and program policies necessary for SMAC program implementation must be planned.

Element 3—Robust Data Collection

Since the foundation of our approach to SMAC programs is access to pharmacy cost information, it is important that efforts to collect this information be robust and receive a high level of participation and compliance. Our approach to data collection has been successful wherever we have conducted such activities. Myers and Stauffer has cultivated relationships with the Iowa pharmacy community, including corporate offices of large chains, the owners of local pharmacies, institutional pharmacies, and retail stores in both urban and rural areas. We focus on building a trust that results in a high level of participation from pharmacies and reimbursement rates that are reflective of the marketplace.

Element 4—Proper Drug Selection

Among the more important aspects of a successful SMAC program is the selection of drugs for the SMAC list. Myers and Stauffer works closely with the program managers to establish thresholds for drug selection and continuously evaluates the drug marketplace to determine which drugs should be recommended for the SMAC program. Our approach utilizes a pharmacist as a final step to valid therapeutically equivalent brand and generic drugs and groups and common classifications.

SMAC programs are a tool for Medicaid programs to better align reimbursement with the pharmacies' cost of the drugs, as opposed to a standard discount applied to AWP. However, the ultimate goal for Medicaid

programs is to protect program recipients and ensure the best health outcomes possible. States must incorporate measures to protect Medicaid patient outcomes and ensure that the SMAC rate schedule does not offer perverse incentives in drug selection. We recommend SMAC programs include the identification and removal of controversial or Narrow Therapeutic Index drugs.

Myers and Stauffer utilizes a pharmacist to support its work for SMAC programs. Our pharmacist's primary responsibilities in the operation and support of a SMAC program are:

- Recommend and evaluate drug selection criteria.
- Assist in assessing market sources for drugs.
- Assess and research therapeutic equivalency ratings for drugs.
- Assist in the identification of narrow therapeutic ratio drugs.
- Monitor other drug issues (shortages, recalls, scientific controversy, etc.).
- Provide pharmaco-economic observations.
- Assist with market research and reimbursement rate issues.
- Serve as professional resource for State staff and peers.
- Provide expert testimony or opinion as necessary.
- Review clinical issues and questions.
- Review provider and recipient utilization trends and cases.

Element 5—Stakeholder Relations

Whether pharmacies, legislators, recipients, other Medicaid contractors, the media, trade associations or others, stakeholders take a vested interest in the SMAC program and expect a role, sharing input and staying abreast of events within the program.. Diplomacy is necessary when interacting with stakeholders, as is a thorough understanding of their interests, concerns, and positions. Myers and Stauffer works cooperatively with stakeholders to address their concerns, provide needed information, and resolve issues, as appropriate and at the direction of the Department.

Element 6—Reporting, Utilization Review, Program Evaluation

A final key element is periodic program evaluation, trending, and utilization review. In addition to our pharmaceutical expertise, reputation for assistance on fiscal matters and information management, Myers and Stauffer brings its

considerable knowledge of utilization management and abuse prevention to SMAC programs. Because our firm is multifaceted and understands the Medicaid program from various perspectives, we approach SMAC programs in an unparalleled manner. Our work is not completed once rates are established. Following rate development, it is essential to measure resulting trends and changes in the drug program. Recipient and provider behaviors may change as a result of the SMAC program. We provide our clients with reports, analyses, and other information to assist in determining needed program changes, educational activities or other measures that preserve the integrity of the established SMAC program.

Respond to changing circumstances in the drug marketplace that require SMAC fees to be removed or suspended, or SMAC fees to be developed.

Available pharmaceutical industry data and information provided by Iowa pharmacy providers will be used to monitor the pharmacy marketplace and, as necessary adjust the list of drugs affected by the SMAC and the SMAC rate schedule(s). Internal data will be used to identify manufacturers' price changes, as well as SMAC drug classes that should be added or removed from the SMAC rate schedule. It is anticipated that mechanisms for fulfilling this project task will employ the following types of review activities:

- Adding New Drugs

  New drug products meeting requirements for inclusion in the SMAC rate list will be identified as they are recognized and transmitted by national drug information suppliers. This occurs primarily as the patents of brand name drugs expire and generic equivalents enter the market.

- Removing Drugs

  Drug products no longer meeting requirements for inclusion in the SMAC rate list will be identified as products become obsolete, become unavailable from three sources, or fail to meet FDA therapeutic equivalency standards.

- Assessing Product Availability or Pricing Issues

  Industry information will be consulted to identify issues with product availability. In addition, providers will be encouraged to inform Myers and Stauffer of specific changes in the pharmacy marketplace affecting the availability of drug products and forward specific concerns about the SMAC rate schedule to us. Supporting documentation, such as invoice information may be forwarded to Myers and Stauffer to illustrate specific concerns about SMAC rates, product availability, or other issues.

- Assessing Provider Requests

  Providers who wish DHS to consider adjustments to SMAC rates or other concerns about the SMAC program may make such a request by contacting DHS or Myers and Stauffer in writing, by e-mail or regular mail. When making such a request, providers will be asked to supply as much information as possible to assist DHS and Myers and Stauffer in understanding the specific issue raised and the desired outcome. This information could include drug purchase summaries, invoices, remittance advices, and other such documentation. Provider requests cannot be fully considered without sufficient information. Providers initiating requests for review of SMAC rates or other issues may be contacted to provide supporting documentation or other information.

Complete a comprehensive update of SMAC rate schedule(s) on an annual basis.

Myers and Stauffer will complete a comprehensive update of SMAC rate schedules on an annual basis. This process will require annual surveys and review of pharmacies' drug acquisition costs. Copies of invoices, as well as electronic registers of purchase history, or current acquisition cost information provided by the pharmacies' wholesaler will be requested from a sample of enrolled Iowa Medicaid pharmacy providers annually. Participation will be voluntary.

Complete updates to the SMAC rate schedule(s) every two (2) months or as frequent as required in state law.

In November 2003 changes to the SMAC program for generic drugs were implemented to reflect requirements of the statute resulting from House File 619 (HF619), passed by the 80th General Assembly. Section 4(c) of HF619 requires that the SMAC program be reviewed every two months to identify updates necessary to ensure adequate product availability. Every other month, Myers and Stauffer conducts the required review of the fee schedule and forwards the results and a recommendation to DHS. This determination is made through drug market research based on published drug prices and information obtained from pharmacies participating in the Iowa Medicaid program. We also consider pharmacies' comments and input regarding SMAC prices that may require an update to ensure adequate availability.

While the review required by statute is extremely important, it is not the sole activity we undertake to review the SMAC program. Daily interaction with service providers, monthly reviews of published drug price changes, quarterly

report development and claims review also supplement the statutorily mandated review.

Maintain a website approved by DHS and available to all providers.

As part of its current services to the Department, Myers and Stauffer operates an Internet site at http://www.mslciowa.com/pharmacy to receive and respond to providers' input regarding the SMAC program. Providers requesting adjustments to SMAC rates or submitting other concerns about the SMAC program may contact Myers and Stauffer via forms downloaded, completed and forwarded to us, or simply completed on-line. When making such a request, providers are asked to provide background information such as purchasing invoices to assist the Department and Myers and Stauffer in understanding the issues raised by the provider. The Internet site is also an information repository, featuring Informational Release letters, Myers and Stauffer contact information, information on the Federal Upper Limit, and other helpful information.

Program Monitoring, Product and Rate Review and Adjustments

(RFP Section 6.7.2.3.4 Requirement 2)

Monitor product availability at a national level.

Pharmaceutical prices and product availability change on a regular basis. Accordingly, we maintain multiple published, academic, and electronic resources for monitoring changes in the drug marketplace and determining an appropriate response, consistent with the efficient and successful operation of SMAC programs. We currently utilize these resources to support our work for DHS and will add other resources as necessary to further enhance our services to the State of Iowa.

Employ rigorous data analysis; Identify drugs that lose patent protection, test product availability.

Myers and Stauffer receives monthly updates to reference and other information maintained by the drug claims processing contractor, for purposes of managing the SMAC program. In addition, we maintain subscriptions to national publications that provide information on drug patents, new products, product availability, and drug trends. Our staff includes clinicians and pharmacists who actively assess and interact with the drug marketplace. We anticipate continued use of these mechanisms to detect and respond to changes in the Iowa pharmaceutical market affecting the SMAC program.

Perform programmatically driven data analysis to identify changes in drug volume, utilization patterns and other factors.

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

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

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

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

Perform an acquisition cost study, at least annually.

We will conduct, at a minimum, an annual survey to evaluate and update SMAC pricing to reflect prevailing Iowa pharmaceutical market conditions by soliciting invoices, electronic purchase information, or other current acquisition cost information from a sample of Iowa pharmacies or their drug suppliers. As the incumbent contractor we have built relationships within the Iowa pharmacy community and have implemented a data collection procedure that is cooperative and successful.

Evaluate the SMAC rate schedule, at a minimum every two (2) months.

House File 619 requires that the SMAC program be reviewed every two months to identify updates necessary to ensure adequate product availability. Myers and Stauffer analyzes product availability and other marketplace information and forwards the results and recommendations to DHS for consideration.

Monitor changes in Average Wholesale Price (AWP).

As the incumbent contractor, we conduct drug market research based on published drug prices and information obtained from pharmacies participating in the Iowa Medicaid program. In addition, we considered pharmacies' comments and input regarding SMAC prices that may require an update to ensure adequate availability. Changes in Average Wholesale Prices (AWP) for drugs on the SMAC list are examined based on information obtained from First DataBank and from the most current, available, edition of *The Red Book* and its periodic supplements. We observe published prices for all drug groups included in the SMAC program and measure the degree to which AWP has changed. Circumstances where AWP changes occurred in excess of a predetermined threshold are noted, and additional research, including the collection of invoices from providers, are undertaken to determine the degree to which actual drug acquisition prices may have changed. A recommendation

is then made to DHS regarding any necessary refinements to the SMAC program.

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

Among the more important aspects of a successful SMAC program is the selection of drugs for inclusion in or exclusion from the program and continuous efforts to identify new opportunities to add drugs to the program as the pharmaceutical market evolves. Myers and Stauffer works closely with the Department to establish thresholds for drug selection and evaluates the drug marketplace to determine which drugs should be recommended for the SMAC program. Current parameters for drug selection apply to products available from at least three sources in the pharmaceutical marketplace that have not received a rating of lower than "AB" by the Food and Drug Administration (FDA). A pharmacist identifies therapeutically equivalent brand and generic drugs and groups them into common drug classes. When drugs become eligible for the SMAC program, it is important that they be reviewed and, if appropriate, added in a timely manner, offering opportunities to produce program savings.

Consult pharmaceutical industry information to identify issues with product availability.

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

SMAC Program Administrative Support and Assistance to the Department

(RFP Section 6.7.2.3.4 Requirement 3)

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

Our work on SMAC programs, pharmacy programs in general, and other Medicaid program areas has given us the opportunity to work with and exchange data and other information routinely with many other Medicaid vendors. We are familiar with the types and conventions of the most commonly recognized pharmaceutical information sources and are experts in information technology and claims processing. We presently exchange SMAC rates, updates, and other information with Electronic Data Systems (EDS) and

Affiliated Computer Services (ACS), facilitating claims processing utilizing SMAC rates we developed for other state Medicaid programs. We will receive monthly claims files from the Medicaid POS contractor to support the evaluation and management of the SMAC program.

Provide experienced staff sufficient to work with large sets of Medicaid claims data and identify and analyze trends affecting the SMAC program.

Myers and Stauffer staff are recognized as information and data analysts experts. We invest in the technological resources, staff, equipment, software or other items necessary to successfully support our work. In addition to management who bring their skills to this engagement, we will rely on a well-trained, analytical staff who can use basic data storage and retrieval systems, common desktop software, advanced knowledge of claims processing and reimbursement systems, practical experience, and statistics to identify and act on potential payment errors or inappropriate billing activities. Firm-wide, we have a staff of more than 160 persons who have extensive academic training and specialized experience experienced in performing rate setting, program integrity, payment system consulting services, data management and reporting and a wide array of other health care related services. We have clinical consultants, managed care consultants, health care policy and reimbursement analysts, academic researchers, computer information systems professionals, and support staff who will contribute or be available to contribute to this engagement.

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

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

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

Accurate, up-to-date, clear, and concise information, communication, reports, and reference materials are essential for maintaining Medicaid program integrity. As we perform the primary work objectives under our contracts, we understand the need to communicate with program stakeholders, revise program manuals, and otherwise document work activities, decisions, and other related items. We routinely prepare memorandums, arrange meetings, coordinate with other contractors and state agencies, and perform other tasks in the interest of promoting information-exchange and clear directives in the Medicaid program.

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

Myers and Stauffer is familiar with claims processing systems used by major fiscal agent and POS contractors. Accordingly, we understand the functionality and limitations of most systems. Having worked with several states to establish and maintain SMAC programs, including the present Iowa Medicaid SMAC program, we understand the technical capabilities and system functionality necessary, including features that allow:

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

If opportunities for modifying the POS system are determined, Myers and Stauffer will prepare any required system change requests and assist in their implementation.

Over the past several years, as part of ongoing rate setting and analytical services provided to state Medicaid programs, Myers and Stauffer has identified numerous phenomena in claims data that may have been reflective of payment errors, POS system malfunctions, provider fraud, billing problems, or the need for POS system modifications. Should these phenomena be

identified, we will work with the Department to develop the appropriate strategies to affect the necessary changes.

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

Successful operation and maintenance of the SMAC program may result in the need to periodically revise state administrative rules and employee and provider manuals. Myers and Stauffer will periodically review the regulatory environment in which the requested services are to be provided. . We will assist the Department in determining whether administrative rule changes, State Plan Amendments, or other changes are necessary or what processes may need to be amended to accommodate and comply with all such changes. Our reviews will include a focused examination of:

- Department rules
- Program instructions
- Medicaid State Plan
- Federal regulations
- Employee and provider manuals
- Laws that may impact the activities requested by the RFP

Develop all draft documents, to amend the Medicaid State Plan to support the SMAC program.

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

We monitor CMS websites on a daily basis for revisions, upgrades and publication of new federal requirements relative to the Medicaid and Medicare programs. We update our clients on the impact any changes may have on the programs they administer. We strive to stay abreast of the new state plan requirements as well as the types of information and documentation requested by CMS regional and central offices. Also, members of our staff attend conferences and training seminars to stay current on national, state and local health care issues.

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

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

Once the state plan has been submitted, the state will work with CMS to ensure its approval. We anticipate the Medicaid state plan approval process becoming even more challenging in the near future. Myers and Stauffer will be ready to assist you with analysis and research during this process.

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

An experienced consultant to multiple state Medicaid programs, we have often assisted our clients in preparing information requests, findings and assurances, and in responding to inquiries from CMS. By virtue of our experience and national presence, we often are aware of potential matters, policies, or approaches that CMS may question. As such, we strategize with our clients when formulating state plan amendments and in addressing CMS questions should they occur. We will also prepare all findings and assurances as part of the rate setting process.

Design, develop, and implement protocols to analyze, review, and research utilization and service delivery patterns for brand and generic drugs.

The Department must monitor the fiscal impact of the SMAC rates as well as the utilization behavior of physicians, pharmacies, and beneficiaries. In addition, the POS system and claims processing procedures should be monitored to ensure appropriate claim adjudication, limiting instances where applicable SMAC rates were not applied or where pharmaceutical market trends favorable to the program were not acted upon timely. Factors affecting program savings and largely driven by service provider and patient behaviors are termed, “utilization factors.” Utilization factors are not simply the quantification of units of service provided or dollars reimbursed. Utilization factors also encompass deliberate service provider or patient actions that may promote or produce program inefficiencies, abuse, or fraud. Myers and

Stauffer will develop a series of mechanisms we propose to utilize in assisting DHS in monitoring SMAC program savings on a monthly or quarterly basis.

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

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

1. Expenditures by drug, drug group, or NDC.
2. Quarterly SMAC drug spending.
3. Change in AWP by drug group.
4. Brand medically necessary overrides.
5. Brand medically necessary overrides by drug.
6. Brand medically necessary overrides by pharmacy.
7. Physician prescribing patterns.
8. Brand and generic preferences.
9. Strength and dosage interchange.
10. Drug interchange.

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

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

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

Myers and Stauffer will recommend policy, utilization, or other program changes that might assist the Department in refining the SMAC program to better meet is health outcome and fiscal goals, as well as the overall integrity

of the Medicaid program. A primary tool in determining a need for such changes will be measuring program utilization.

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

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

See Section 10 of our proposal for information regarding the project team.

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

Myers and Stauffer utilizes a pharmacist, licensed in the state of Iowa, to support its work for State Maximum Allowable Cost (SMAC) programs. Kimberly S. Plake, R.Ph, Ph.D. is a graduate of Purdue University, and teaches and performs research in the areas of pharmacoeconomics and geriatrics. She is knowledgeable of pharmacology and pharmacy law, having practiced, taught, or worked in the pharmaceutical industry in multiple states, including Iowa. Dr. Plake previously served as an Assistant Professor at Drake University in Des Moines. Our pharmacist's primary responsibilities in the operation and support of a SMAC program are as follows:

- Recommend and evaluate drug selection criteria.
- Assist in assessing market sources for drugs.
- Assess and research therapeutic equivalency ratings for drugs.
- Assist in the identification of narrow therapeutic ratio drugs.
- Monitor other drug issues (shortages, recalls, scientific controversy, etc.).

- Provide pharmaco-economic observations.
- Assist with market research and reimbursement rate issues.
- Serve as professional resource for state staff and peers.
- Provide expert testimony or opinion as necessary.
- Review clinical issues and questions.
- Review provider and recipient utilization trends and cases.

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

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

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

Whether pharmacies, legislators, recipients, other Medicaid contractors, the media, trade associations or others, stakeholders take a vested interest in the SMAC program and expect a role, sharing input and staying abreast of happenings. As with most matters surrounding the Medicaid program and reimbursement, diplomacy is necessary when interacting with stakeholders, as is a thorough understanding of their interests, concerns, and positions. Myers and Stauffer works cooperatively with stakeholders to address their concerns, provide needed information, and resolve issues, as appropriate and at the direction of the Medicaid office.

Another key to the success of a SMAC program is periodic program evaluation, trending, and utilization review. In addition to our pharmaceutical expertise, reputation for assistance on fiscal matters, and mastery of information management, Myers and Stauffer also brings its considerable knowledge of Medicaid utilization management and abuse prevention to SMAC programs. Because our firm is multifaceted and understands the Medicaid program from various angles, we approach SMAC programs in an unparalleled manner. Major activities are not concluded once rates are established. Following rate development, it is essential that Medicaid programs be positioned to measure resulting trends and changes in the drug program. Recipient behavior will change, as will provider behavior. At this time, we provide our clients with reports, analyses, and other information to assist in determining needed program changes, educational activities or other measures that preserve the integrity of the established SMAC program.

Consult with and review recommendations from the Medical Services contractor regarding changes within the SMAC program.

We have served the Iowa Medicaid program since 2000, and we also have extensive experience working with other states. We have built successful, on-going relationships with each of the other Medicaid contractors with whom it was necessary to coordinate or exchange information. We currently work directly with several other contractors on pharmacy-related engagements on behalf of DHS. We will pursue our work in a manner careful to coordinate with other contractors and agencies, when necessary, at DHS direction and approval.

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

Following rate development, it is essential that Medicaid programs be positioned to measure resulting trends and changes in the drug program. We will prepare and provide monthly reports indicating the savings associated with the SMAC program. We will also provide analyses and other information to assist in determining needed program changes. Where analyses reflect potential changes to the SMAC program, a financial projection will be provided.

Stakeholder Support
(RFP Section 6.7.2.3.4 Requirement 4)

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

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

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

Under our current contract with DHS we developed and use an Internet site (http://www.mslciowa.com) to receive input from providers regarding the SMAC program. This have proven to be an effective tool in responding to service providers' questions and concerns regarding the SMAC program, and we will continue the use of this support mechanism.

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

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

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

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

As a DHS contractor for the current SMAC program and other engagements, we have built successful, on-going relationships with industry groups, DUR boards and other Medicaid contractors with whom it was necessary to coordinate or exchange information. We have often made presentations to DUR boards to assist our clients in implementing programmatic changes such as adding SMAC rates, prior authorization changes, and POS alerts. We have also built many relationships with other state agencies and enjoyed successful working relationships. Presently, we work directly with several other

contractors on pharmacy-related engagements on behalf of DHS. We will pursue our work in a manner careful to coordinate with industry groups and other contractors and agencies, when necessary, at DHS direction and approval.

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

Providers will be encouraged to forward specific concerns about the SMAC rate schedule to Myers and Stauffer via e-mail, telephone, fax, regular mail, the Internet, or otherwise. Where supporting documentation, such as invoice information may be necessary to evaluate specific concerns about SMAC rates, product availability, or other issues, pharmacies will be contacted directly and requested to provide such information.

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

Providers will be notified at least 30 days prior to the effective date of any new drug(s) being added to the SMAC fee schedule. Providers will be notified of any changes in reimbursement rates and any deletion(s) of drug product(s) from the SMAC fee schedule on a regular basis. Changes will be communicated to providers in the most efficient and comprehensive manner, typically through informational releases by DHS.

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

The POS contractor will be notified at least 30 days prior to the effective date of any amendments to the SMAC fee schedule. Changes will be communicated by e-mail, by regular mail, or any other required media and will include the necessary detail in the necessary format to most efficiently interface with the POS system for claims processing.

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

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

Among the more important aspects of a successful SMAC program is the selection of drugs for inclusion in or exclusion from the program and continuous efforts to identify new opportunities to add drugs to the program as the pharmaceutical market evolves. Myers and Stauffer works closely with the Department to establish thresholds for drug selection and evaluates the drug marketplace to determine which drugs should be recommended for the SMAC program. Current parameters for drug selection apply to products available from at least three sources in the pharmaceutical marketplace that have not received a rating of lower than "AB" by the Food and Drug Administration (FDA). A pharmacist identifies therapeutically equivalent brand and generic drugs and groups them into common drug classes. When drugs become eligible for the SMAC program, it is important that they be reviewed and, if appropriate, added in a timely manner, since SMAC reimbursement's equitable application of drug pricing to like products offers opportunities to produce program savings. To monitor compliance to policies, we subscribe to reference materials and other tools to identify drugs of similar chemical composition, package size, dose, and form. As a secondary review, our pharmacist also reviews and approves proposed SMAC list drug changes.

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

SMAC programs allow Medicaid programs to more appropriately align reimbursement for drugs to the price pharmacies pay to purchase those products. However, the ultimate goal for Medicaid programs is to protect program recipients and ensure the best health outcomes possible. When developing SMAC programs, we are mindful to incorporate measures to protect Medicaid patient outcomes and ensure that the SMAC rate schedule does not offer perverse incentives in drug selection. One common measure we recommend be included in SMAC programs is the identification and removal of controversial or Narrow Therapeutic Index drugs.

D. Data Sources
(RFP Section 6.7.2.3.5)

Myers and Stauffer has established a process for routine receipt of claims information for support of the SMAC program.

Since the foundation of our approach to SMAC programs is access to pharmacy cost information, it is important that efforts to collect this information be robust and receive a high level of participation and compliance. As the incumbent contractor operating the SMAC program, Myers and Stauffer has cultivated relationships with the Iowa pharmacy community, including frequent interaction with the corporate offices of large chains, the owners of local pharmacies, institutional pharmacies, and retail stores in both urban and rural areas. We focus on building a trust that allows us to be successful, with a high level of participation from pharmacies and thus, the ability to set reimbursement rates most reflective of the marketplace.

E. Required Reports
(RFP Section 6.7.2.3.6)

Provide a monthly report on the savings associated with the SMAC
Provide a quarterly report on SMAC program operation and utilization trends

Following rate development, it is essential that Medicaid programs be positioned to measure resulting trends and changes in the drug program with a particular focus on savings. We will prepare and provide to DHS reports, analyses, and other information to assist in determining savings associated with SMAC.

Provide recommendations every two months on updates to the SMAC

Myers and Stauffer will provide recommendations on updates to the SMAC list at a minimum of every two months and as necessary to respond to changes in the pharmaceutical marketplace that may need to be addressed in the interim.

Provide an annual acquisition cost study summary

Following data collection, summary statistics describing the sample surveyed and those that provided information will be produced and forwarded to DHS. Such information will include, but not be limited to, the types of pharmacies involved, expenditures and recipients served, geographic designation, corporate structure, and specialty.

F. Performance Standards
(RFP Section 6.7.2.3.7)

Complete required reports accurately and timely

Myers and Stauffer understands the need to provide accurate and timely information. We will pursue our work providing the services requested by the RFP in a manner consistent with the production of accurate and timely information.

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

Myers and Stauffer understands the need to complete all duties requested by the RFP in an accurate, complete, timely, and professional manner. We will pursue our work providing the services requested by the RFP in a manner that is consistent with accurate, complete, timely, and professional outcomes.

Be knowledgeable of and apply all state and federal requirements

Since its inception, Myers and Stauffer has worked on engagements involving drug reimbursement. We are experienced in developing SMAC programs and performing pharmacy acquisition cost studies nationwide. Our staff has obtained an unrivaled expertise in understanding various state and federal regulations affecting drug reimbursement, and we also have an intimate knowledge of pharmaceutical practice and operations from a store-level to the highest levels of insurers and other payers. The project team providing the services requested by the RFP will be knowledgeable of and apply all state and federal requirements affecting the SMAC program.

Demonstrate annual savings in total outlays for prescription drugs associated with the SMAC program

We understand the necessity to evaluate the outcomes of the SMAC program from an aggregate and micro perspective. We will provide DHS with information or reports necessary to accomplish its goals and objectives for the SMAC program. Annual savings will be provided in total outlays for prescription drugs associated with the SMAC program.

Provide notification to the POS contractor a minimum of thirty- (30) days prior to implementation of changes to the SMAC fee schedule

The POS contractor will be notified at least 30 days prior to the effective date of any amendments to the SMAC fee schedule. Changes will be communicated by e-mail or by regular mail and will include detail in the necessary format to interface with the POS system for claims processing.

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

Providers will be notified at least 30 days prior to the effective date of any new drug(s) being added to the SMAC fee schedule. Providers will be notified of any changes in reimbursement rates and any deletion(s) of drug product(s) from the SMAC fee schedule on a regular basis. Changes will be communicated to providers in the most efficient and comprehensive manner, typically through informational releases by the Department of Human Services.

9.3 Rebasing and DRG and APG Recalibration

(RFP Sections 6.7.2.4)

A. Objectives

(RFP Section 6.7.2.4.1)

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

B. Interfaces

(RFP Sections 6.7.2.4.2)

Myers and Stauffer is prepared to provide these services to the Iowa Department of Human Services (DHS). We understand that work will commence effective July 1, 2004. We will work with DHS staff, the core MMIS contractor, and the DW/DS contractor to obtain the necessary reference materials, provider cost information, and claims data including charges. Myers and Stauffer will also work with 3M-HIS to obtain historical information related to their contractual work on the setting of DRG and APG weights. We have a working relationship with 3M-HIS and employ their 3M Core Grouping software for both DRG and APC/APG grouping of claims. As part of this project, we will continue to work with Medicare intermediaries in the State of Iowa to obtain Form CMS 2552 (Hospital and Healthcare Complex Cost Report) and other any information needed to complete the recalibration.

Myers and Stauffer understands that we will follow policies established by the state governing the triennial hospital rebasing and recalibration. Our policy has always been to provide our state clients with the best possible options and the necessary information to make appropriate decisions. State officials are best situated to understand the various ramifications of fiscal changes and we will not implement any changes to the reimbursement systems, including rates, without approval.

C. Contractor Responsibilities
(RFP Section 6.7.2.4.4)

Upon contract award, project team members will meet with the Department to gain an understanding of the current DRG and APG reimbursement methodology. We have vast experience in developing and maintaining DRG reimbursement systems and are currently assisting our state clients with the evaluation and eventual implementation of APC systems. We understand and appreciate that each state has unique requirements that guide us in our approach.

Base Rates and Related Parameters

Our review of the Iowa State Plan indicates that Myers and Stauffer will need to determine both aggregate and facility-specific hospital costs on an inpatient and outpatient basis. Hospital costs will need to be apportioned to Medicaid based on facilities' hospital cost reports (CMS 2552). In the past, we have utilized claims data to apportion costs based on routine per diems and ancillary cost to charge ratios. It is also possible to apportion costs based upon discharges and/or payor days. Ancillary costs will need to be further divided into inpatient and outpatient services.

At this point, capital costs will be isolated. Capital costs are easily identified on the hospital cost report. For purposes of rate setting and following state guidelines, these capital costs will be multiplied by 80% and then divided by the number of discharges and the facility's case-mix index.

Medical education (both direct and indirect) expenses will then need to be identified. Direct medical education expenses are usually identified as a post-step-down adjustment. Indirect medical education expenses are not directly identifiable from a hospital cost report. Instead, indirect medical education expenses are usually determined as a percentage of cost using a formula based upon the number of hospital beds and the number of interns and residents.

Since the PPS reimbursement systems will have additional expenditures for transfers, outliers and physical rehabilitation services, we will need to make allowances for these payments. These allowances will be determined from calculations using historical claims data, fiscal impact models, and following guidelines from the State Plan.

In the next step, case mix indices will be determined in aggregate and on a hospital-specific basis using historical claims data and either APG weights or DRG weights for outpatient and inpatient services, respectively. A case mix index is simply the total aggregate weight divided by the number of claims

and is a relative measure of patient acuity and/or resource utilization. Facilities with more complex cases have a higher case-mix than facilities with less complex cases.

Aggregate and hospital-specific costs will then be divided by their respective Iowa Medicaid discharges and case-mix indices to determine a case-mix adjusted cost per discharge. This amount is then adjusted to reflect inflation to the upcoming rate year to establish a base rate.

Using this methodology produces initial base rates for operations and capital. There are further refinements and "blending" of rates indicated in the Iowa State Plan that Myers and Stauffer will follow to produce the final DRG and APG rates

Medical Education and Disproportionate Share Payments

Hospitals providing medical education programs and/or serving a disproportionate share of low-income patients are eligible for additional payments from Iowa Medicaid. As part of our information gathering task, Myers and Stauffer will determine the eligibility of hospitals in receiving these payments and the appropriate levels of reimbursement under these programs.

Medical education payments fall under two categories, direct and indirect medical education. Indirect medical education payments further break out into two separate categories, payments for all facilities with medical education programs and supplemental indirect medical education payments for facilities that qualify for the first category and have more than 500 beds and/or eight or more specialty or subspecialty programs. Medical education fund distributions are apportioned from a fund established for these programs based on various parameters including: claims data, facility bed size and the number of interns and residents.

Disproportionate share hospital (DSH) payments also break into two separate pools of funding. Hospitals qualify for the first fund by having a low-income utilization rate exceeding 25 percent or their Medicaid utilization rate exceeds one standard deviation from the statewide average Medicaid utilization rate or as a children's hospital meeting certain criteria. Myers and Stauffer will determine the apportionment of this fund based on state guidelines.

A supplemental disproportionate share payment fund, known as the GME and DSH fund, is available for facilities qualifying for both DSH and graduate medical education payments. These facilities must also have more than 500

beds and be owned by the state of Iowa. Myers and Stauffer will determine the apportionment of this fund based on state guidelines.

Recalibrate APG and DRG Weights

The determination of APG and DRG weights are very similar tasks. The chief exception is that for the determination of APG weights only the claims with "singleton" APG are utilized.

Claims are edited to ensure that non-covered and duplicate claims are removed. They are then processed with the latest version of their respective grouper. Any grouping errors are investigated and any systematic coding mistakes are reported to the state for follow-up action with providers (informational provider bulletins, etc.)

Statistical analyses are then run on the data sets to identify potential outlier claims. Outliers will be identified based on criteria established under the state plan. Hospital charges will be capped at the outlier threshold and then these "trimmed claims" will be added to the non-outlier claims to form the database that will be used to determine DRG/APG weights.

From the resulting database, the geometric mean of the charges for the aggregate claim set and for each DRG/APG are determined. To determine the DRG/APG weight, the geometric mean of each DRG/APG is divided by the geometric mean of the data set. This set of weights is normalized so that the average case has a weight of 1.0000.

Once weight sets are generated, Myers and Stauffer will generate fiscal impact models to demonstrate any anticipated changes in reimbursement between the new set of weights and the set of weights currently used for reimbursement.

While this is a simplified explanation of the methodology that Myers and Stauffer will employ in recalibrating DRG and APG weights, the methodology employed will conform to the methodology as described in the Iowa State Plan and we will seek the approval of state officials for our final work plan developed after our initial consultations.

There are several areas of PPS reimbursement that Myers and Stauffer would like to discuss with state officials based on our experiences in other states. The two issues that always seem to be of interest to our clients are the handling of neonatal claims, especially premature newborns, and the systematic determination of weights for low volume cases. Any options that we would present would have significant background analyses and would be at the complete discretion of state officials.

D. Data Sources

(RFP Section 6.7.2.4.5)

Myers and Stauffer understands that the data sources that will be used for the rebasing and recalibration of the DRG and APG functions include Iowa Medicaid paid claims, hospital cost report (CMS 2552) data, along with DRG/APG grouper software.

Myers and Stauffer has extensive experience across the entire data sets needed to complete the recalibration of weights and base rates. We are one of the few firms in the entire country that has extensive experience auditing and cost settling hospital inpatient and outpatient services, that also has extensive experience working with and analyzing Medicaid paid claims data and DRG/APG/APC grouper software products. Few, if any other firms can match our knowledge and experience across this spectrum.

Myers and Stauffer offers the Iowa Medicaid program a DRG/APG recalibration contractor that is expert across the entire spectrum of issues needed to properly perform the recalibration project.

E. Required Reports

(RFP Section 6.7.2.4.6)

In the process of completing updates to the DRG and APG reimbursement systems, Myers and Stauffer will generate various work products including databases, spreadsheets and accompanying memorandum. These will be provided in draft form to state officials on a regular basis during the completion of our tasks.

Upon completion of each task, Myers and Stauffer will generate a comprehensive report that includes the following:

- Hospital-specific and statewide average rate sheets with supporting documentation used to generate base, capital cost, disproportionate share, and indirect and direct medical education rates.
- Revised DRG and APG weight schedules including outlier thresholds and average lengths of stay.
- Hospital-specific and statewide average case-mix indices based on both the updated and previous DRG and APG weights.
- A summary of projected charges to projected payments and estimated cost based on hospital cost report and claims data for both individual hospitals and on a statewide basis.

- Fiscal impact models that project hospital payments for inpatient (outpatient) services using the updated case-mix indices, base rates, capital cost rates, direct and indirect medical education payments, and disproportionate share rates. These models will also include the estimated payments under the previous system parameters.

Only after state officials have approved the new rates, weights, and accompanying report will a final report be issued.

F. Performance Standards

(RFP Section 6.7.2.4.7)

Myers and Stauffer ensures, at minimum, a 95% accuracy rate in our calculations to apportion costs to Medicaid for each hospital submitting Form CMS 2552. We also ensure, at minimum, a 95% accuracy rate in calculating hospital case-mix indices, inpatient base, capital cost, direct and indirect medical education and disproportionate share rates and outpatient base and direct medical education rates. This same level of accuracy will also be obtained in the calculation of DRG/APG weights.

Our quality control for this project is broken down into several redundant levels. Our staff has several years of experience in this area and are accustom to dealing with the differences between state reimbursement systems and identifying potential difficulties. We also employ automation whenever possible to remove human errors from the process. Once work products are generated, staff is trained to seek out and evaluate potential areas of concern.

Complete work product is then presented to our project managers for review and compilation. Extensive experience allows them to identify common areas prone to errors and cross check results. Once they have reviewed and approved the results they are presented to the project director. The project director reviews both the results and the methodology employed to generate the results.

As a final check, Myers and Stauffer utilizes a quality control manager that is outside of the project team. A fresh viewpoint is introduced to question assumptions made by the project team in internal discussions.

9.4 Revenue Maximization

(RFP Section 6.7.2.5)

Myers and Stauffer has assisted the Department with upper payment limits (UPL) and other revenue maximization initiatives for the past four years. We have witnessed numerous changes at the federal level to limit and minimize states' ability to maximize federal funding leveraging opportunities. The state has also been faced with a challenging economic situation. Changes at the federal level that significantly impacted states' ability to meet the costs to care for a growing Medicaid eligible population include separating private and non-state government owned or operated (NSGO) facilities into different UPL categories, the establishment of the 150% limit for NSGO facilities, and the elimination of the 150% limit for NSGO facilities.

CMS's recent attempts to curtail the use of legally permissible intergovernmental transfers (IGT) means that more changes are likely on the horizon. This environment necessitates that states continuously monitor and evaluate changing CMS and Medicare regulations and reimbursement policies. We are aware of this situation and are prepared to assist you throughout this engagement by providing the necessary support and evaluative services. We will assist the Department in analyzing the impact of proposed rules and legislation, as well as changes to the Medicare program that impact the UPL calculations for hospitals and nursing facilities, and the Department's use of IGTs. We believe our relationship with you, our skills, experience, and expertise lend themselves well to this type of working relationship.

Our goal is to assist DHS in the development of sustainable payment systems. This long-term perspective has helped our clients avoid difficult transitions and maintain appropriate provider payment levels. Myers and Stauffer is currently assisting several states with Medicaid program policy issues addressing budgetary concerns. Knowledge gained through these projects enhances the value we bring to Iowa.

A. Objectives

(RFP Section 6.7.2.5.1)

Our objectives in serving the Department with these services include:

- To conduct research to determine the best, most appropriate and defensible UPL for inpatient and outpatient hospital and nursing

facility services up to the maximum permissible under federal regulations.

- To accurately and efficiently compute the UPL tests for all categories of hospital and nursing facilities.
- To assist the Department in maintaining maximum contributions to the Hospital Trust Fund and the Senior Living Trust Fund.
- To conduct research, identify opportunities, and compute payments that maximize federal Medicaid reimbursement for physicians and other ambulatory providers employed by government-owned or operated institutions.
- To conduct research and to assist the Department in identifying opportunities to utilize and convert "state-only" funding for health care services to Medicaid services subject to federal financial participation.
- To assist the Department in interactions with the Centers for Medicare and Medicaid Services, the Iowa General Assembly, Iowa Hospital Association, the Iowa Health Care Association, the National Governor's Association, the Counsel on Human Services, the Legislative Rules Review Committee, and other interested parties or stakeholders.
- To assist the Department in identifying and analyzing non-leveraging opportunities.

B. Interfaces

(RFP Section 6.7.2.5.2)

Myers and Stauffer has significant experience interfacing with the Department of Human Services. We will be available to interface with the Department as needed throughout this engagement.

Over the years, Myers and Stauffer staff has worked with a number of fiscal agent contractors and decision support products. We understand the importance of forming a strong working relationship with other contractors to ensure the smooth operations of the IME. We will be happy to work with other IME contractors as needed throughout this engagement.

Myers and Stauffer often works with providers and industry associations through our cost report and desk review functions. In these relationships, we certainly understand the delicate balance of maintaining the Department's interests without creating negative reactions from providers. As such, we have

good, professional working relationships with the associations. We will continue these relationships as part of the IME.

C. Contractor Responsibilities

(RFP Section 6.7.2.5.4)

The following regulations and policies are major factors in our work plan that impact the outcomes of the revenue maximization initiatives:

Non-State Government Owned and Operated Hospitals

- The final rule published in the January 12, 2001 Federal Register modified the Medicaid upper payment limits for nursing facilities and hospital services provided by non-state government owned and operated (NSGO) hospitals. The modifications permitted NSGO facilities to receive up to 150 percent of the Medicare upper payment limit, or the amount that Medicare would have paid for the same service.
- Before the final rule, the Medicare upper payment limit was applied to State-operated facilities, as one category, and all other facilities as a second category. The final rule established an aggregate upper limit that was applicable to NSGO, and a separate aggregate upper limit on payments made to privately-owned and operated facilities. As a result, payments for NSGO facility services are subject to one of three upper payment limits, depending on the type of facility: State-owned or operated, non-state government-owned or operated, and privately-owned and operated.
- On January 18, 2002, CMS published a final rule to amend 42 CFR 447.272. The amendment reduces the upper payment limit for NSGO facilities from 150 percent of the Medicare Upper Payment Limit to 100 percent. The United States District Court for the Eastern District of Arkansas delayed the implementation of this final rule amendment until May 14, 2002. The UPL for NSGO facilities remains at 100 percent of the amount that Medicare would pay for the same services, using Medicare principles of reimbursement.

Intergovernmental Transfers

- The states have flexibility to use local government funds for the non-federal share of Medicaid expenditures. Under section 1902(a)(2) of the Act, states may fund up to 60 percent of the non-federal share of Medicaid expenditures with local government funds. Section 1903(w)(6) of the Act specifically limits the Secretary's ability to place restrictions on a state's use of certain funds transferred to it from

a local unit of government subject to the requirements in section 1902(a)(2) of the Act.

- Recent actions by CMS attempt to limit States' ability to utilize intergovernmental transfers as an allowable funding mechanism. Although states seemingly have explicit authority to utilize IGTs, CMS can establish regulations or policies to limit federal financial participation for such transactions. Many states, including Iowa, would be severely impacted by decisions to eliminate or reduce the use of IGTs.

Codes of Federal Regulations

- 42 CFR 447.253(b)(2) requires that a state Medicaid agency demonstrate that the estimated average payment rate for inpatient hospital services is reasonably expected to pay no more in the aggregate than the amount that would be paid for the services under the Medicare principles of reimbursement. The regulations permit States discretion in determining if the requirement has been met. Furthermore, the state has flexibility to develop procedures for applying the upper limit test.
- 42 CFR 447.271 requires that payments for Medicaid inpatient hospital services be no more than the provider's customary charges to the public for services. However, the state agency may pay a public provider furnishing services free or at a nominal charge at the same rate that is used if the provider's charges were equal to or greater than its costs.
- 42 CFR 447.272 limits overall aggregate state payments and aggregate payments to inpatient state-operated providers, non-state operated providers, and privately owned and operated facilities. Payments for inpatient hospitals and nursing facility services may not exceed the amount that could reasonably be estimated would have been paid for the services under Medicare payment.
- 42 CFR 447.304 describes that if a provider does not adhere to upper payment limits, no federal financial participation is available. States must provide separate assurances to CMS regarding the UPL. The UPL will be applied as a limit on total costs incurred by all facilities within a specific category.
- 42 CFR 447.321 places an upper payment limit on outpatient hospital services and clinic services furnished by hospitals. The upper payment limit for outpatient services is calculated based on total payments received by all providers, which results from determining the payments made to individual providers during the period.

Centers for Medicare and Medicaid Services (CMS)

- Policy - States are not required to consider and document the impact of the limits for all facilities in the State to support UPL findings. A random sample of facilities may be used to make the determination.
- Policy - States are not precluded from making payments to individual facilities in excess of the amount that Medicare would have been paid for services to that facility. Savings must be shown elsewhere to ensure that the aggregate payout to all facilities does not exceed the UPL.
- Letter to State Medicaid Director (July 26, 2000) – This correspondence addresses the issue that states can gain federal Medicaid matching payments without new state contributions through the flexibility in setting the maximum rates that can be paid under Medicaid. Although it is considered a "loophole" by CMS, States can pay the highest Medicaid rate possible along with additional amounts to create payments to county or municipal facilities. States can claim federal matching dollars and in turn request amounts over facilities costs to be given back to the state for other health and non-health issues. Also, some states circumvent the statutory DSH limits and attain more than the statute was intended to allow. This letter was a precursor to the final rule published on January 12, 2001.
- Letter to State Medicaid Director (March 13, 2001) – This correspondence addressed the confusion associated with the implementation of the January 12, 2001, final rule on the revision to UPL requirements. The final rule became effective on March 13, 2001. Any State plan submitted on or after March 13, 2001 must conform with the new UPL requirements to receive federal participation.
- Letter to State Medicaid Director (November 20, 2001) – This correspondence informed States that CMS would not approve any state plan amendments submitted after the Notice of Proposed Rulemaking publication date that would allow payments in excess of the proposed upper payment level of 100 percent.
- On November 20, 2003, the Congress enacted The Medicare Prescription Drug Improvement and Modernization Act of 2003 (Public Law 108-173). This law included a series of changes to Medicare reimbursement for inpatient and hospital services. Hospital UPL methodologies that utilize the Medicare prospective payment methodology are estimated to increase between 2 and 4 percent as a result of these changes.

- On January 7, 2004, a *Federal Register* notice (69 Federal Register 923) was published that contained a transmittal from CMS to the Office of Management and Budget requesting a change in the state budget forms for Medicaid. If enacted, this policy would require state budgets to be prior approved, based on the types of services eligible for federal financial participation. It is widely believed that this action may be the first of many steps CMS is undertaking to limit the use of permissible intergovernmental transfers and other mechanisms states utilize to leverage federal revenue.

Computing upper payment limits and maximizing federal leveraging opportunities requires a complete understanding of reimbursement systems. Utilizing these systems and understanding the variables within them enables Myers and Stauffer to compute the most defensible and reliable UPL calculations. A brief overview of hospital and nursing facility reimbursement systems and UPL options are briefly described below.

Inpatient Hospital Services

Under retrospective reimbursement, hospitals prepared and submitted cost reports that apportioned the cost they incurred in providing patient services to each of the government programs during the preceding year, and the payers paid that cost. Retrospective cost-based reimbursement is generally believed to have been a primary contributing factor to the massive inflation (exceeding 15% per year) in hospital costs experienced through the 1970s and early 1980s.

In order to control this inflation, the federal government abandoned cost-based reimbursement in favor of prospective systems. In 1982, Medicare instituted the system commonly known as TEFRA as an interim measure that limited the growth in each hospital's cost per discharge to a preset inflation rate. The following year, Medicare implemented its current prospective payment system for acute care services, which is a case rate system using Diagnosis Related Groups (DRGs) for case mix adjustment.

Over the past 18 years, many states have implemented some sort of a DRG or per diem (or the similar per discharge methodology) prospective inpatient payment methodology as its primary method for Medicaid inpatient reimbursement.

The defining characteristic of a prospective payment method is that the payment rate is determined by the payer, in advance, for each type of service. In this case, the maximum payment per discharge is pre-set and thereby presents the provider with an incentive to control the use of its resources. If the provider can treat the patient at a cost less than the prospective rate, a

profit can be realized. If the costs of treatment exceed the payment rate, there will be a loss. As the hospitals develop internal cost savings, these savings are reflected in reduced rates during future rate rebasing. Lengths of stay become less important to the state under such a reimbursement system.

In DRG systems, cases are assigned to a DRG based upon diagnoses and procedures performed. Each DRG receives a relative value based upon resource utilization relative to all other DRGs. A prospective payment rate is then established for each unit of DRG weight for reimbursement purposes. No adjustments in hospital rates are required for categories of service since the intensity of services is included in the DRG relative weight. Facilities that treat patients with the greatest acuity receive higher levels of reimbursement.

In per diem systems, a prospective payment rate is established for each day of hospital care, covering both routine and ancillary services. More advanced (and effective) systems recognize that different levels of costs are incurred in treating different types of patients. Rates that vary by hospital, either on a hospital-specific basis or by peer-grouping, recognize that due to hospital characteristics, case-complexity and costs per day vary even within the levels of care. For example, the average acuity of ICU patients in a tertiary care facility will be higher than the average acuity of ICU patients in a community hospital.

Inpatient Hospital UPL Options

Prospective Payment System (PPS): In the PPS option, Medicaid utilization data and hospital financial data would be used to complete the analysis. Under this methodology Medicaid utilization is classified into Medicare DRGs using the Medicare grouper. The estimated Medicare payment is computed using Medicare PPS payment policies. Beyond the PPS DRG payments, the comparison can also include capital payments, medical education payments, outlier payments, Medicare DSH payments and any other additional reimbursement subject to the UPL determination.

Tax Equity and Fiscal Responsibility Act (TEFRA) Targets: The computation of the Medicare upper payment limit can be based on the Medicare payment methodology known as TEFRA, which specifies the computation of hospital-specific target rates and rates-of-increase. TEFRA was used by Medicare as a reimbursement methodology for all hospitals during the transition from retrospective cost reimbursement to the PPS. Medicare continues to use TEFRA principles to reimburse hospitals and units exempt from the PPS.

Medicare Costs: A third upper limit model option uses total allowable Medicaid costs identified using information contained in facility cost reports.

The estimated upper payment limit will be computed using Medicare cost principles, including capital and medical education costs. The upper payment limit is the lower of the cost of the service or the usual and customary charge. This model may also permit the following costs for tertiary services owned by the hospital: home health/hospice services, nursing facility services, medical school costs, physician costs and transportation costs.

Outpatient Hospital Services

Outpatient prospective payment systems (OPPS) have been developed in response to the imposition of inpatient cost controls and because of significant developments in a broad range of medical technologies. Comparative outpatient costs typically range from 85% to 95% of inpatient costs.

Outpatient prospective payment systems are often described by their level of packaging. Fee schedule-based OPPS are the least "packaged" system with payments for all procedures, services and some supplies. Ambulatory Patient Groups (APG) are the most "packaged" system. A single payment packages pharmacy, routine supplies and facility services, including recovery room and observation, into surgical and medical group payment rates. Even some surgical procedures and ancillary services are included in the payment for the primary APG. APGs fall in the middle of these extremes. Most notably, routine diagnostic procedures are reimbursed separately from their related surgical/medical APGs. In keeping with the less packaged approach, APGs do not include the significant procedure consolidation algorithm.

Medicare's APC OPPS is an offshoot of the APG system originally developed under the direction of CMS. Payment for outpatient services under Medicare's APC OPPS has similarities to the inpatient DRG system and the physician RBRVS system. Cases are assigned to various APCs using HCPCS/CPT codes for procedures performed, ancillary services provided and certain supplies used. Like DRGs, the APC payment includes supplies (in most instances) used for the procedure. Unlike DRG systems, multiple APCs are reimbursed. Like RBRVS systems, the APC has a relative weight that is multiplied by a conversion factor subject to geographic adjustment.

An important element of the OPPS is the discounted reimbursement of multiple APCs. Not all APCs are subject to discounting but the majority of procedures are subject to a reduction of payment for secondary procedures.

Many states have developed outpatient prospective payment systems using a combined bundled system for surgeries and treatment rooms and fee schedules for all other services. Such systems typically rely on a modified version of Medicare's APC groups for surgery services, all-inclusive fees for

emergency and clinic department visits, and fee schedules for laboratory, radiology, durable medical equipment, drugs and blood products. Some states continue to cost settle for outpatient services.

Outpatient Hospital UPL Options

Ambulatory Payment Classification: In the APC option, Medicaid utilization data and hospital financial data supports the underlying calculation. A version of the APC grouper is used to classify Medicaid utilization into Medicare APCs. The estimated Medicare upper payment limit is computed using Medicare APC payment policies similar to the inpatient PPS model. Add-on payments for graduated medical education and bad debt can be added to the base payment amounts.

Outpatient Costs: A second option may be developed using total allowable Medicaid costs. Medicaid costs would be identified using information contained in facility cost reports. The estimated Medicare UPL would be computed using Medicare cost principles. Based on our experiences with these models, however, we believe that a UPL that simulates Medicare APC payments, including pass-through payments and add-on payments, yields the best result.

Nursing Facility Services

Prior to the implementation of the price based reimbursement systems, nursing facility cost reports were used to compute a daily rate or per diem. While some cost limitations were utilized, the per diem rates of the facilities were a function of the facility's cost. There was little to no direct correlation between a facility's cost and the resource needs of its residents. Under this methodology, states experienced significant growth in their reimbursement of nursing facility services and it created incentives for the industry to supply more beds than needed.

To control escalating costs and improve the quality, the Congress enacted the Omnibus Reconciliation Act of 1987 (the "Act"). The Act mandated the use of a standardized, comprehensive, and reproducible assessment process. The assessment document used in this process later became known as the Minimum Data Set (MDS). In December 1997, CMS implemented a Final Rule that required nursing facilities to use the MDS in order to receive Medicare reimbursement. Today, the MDS serves as the cornerstone for price based reimbursement systems in that it permits reimbursement to be directly correlated to the resource needs of the facilities residents.

Computing the Nursing Facility UPL

Medicare's PPS is an acuity-based, pricing system with a specific rate paid for each resident based on the resident assessment classification and the facility's urban/rural designation.

Under the PPS option, MDS assessment data is used to determine the appropriate RUG-III classification and Medicare PPS rate for each Medicaid resident. Individual resident PPS rates are aggregated to determine a facility average estimated Medicare PPS rate. Because the PPS rate is all-inclusive, an analysis to determine coverage differences between Medicare and Iowa Medicaid is required. These services typically include items such as pharmacy, laboratory, and radiology. To account for the differences in coverage, the average per diem Medicaid payment will be adjusted upward to account for services covered and reimbursed by Medicare through the PPS rate, but not within the nursing facility per diem rates.

To perform the upper payment limit and Medicare/Medicaid rate differential calculations, it will be necessary to utilize MDS data. Myers and Stauffer currently maintains an approved Data Use Agreement for this purpose.

Upper Payment Limit Maximization, Performance of Upper Payment Limit Tests and Revenue Maximization for Hospitals and Nursing Facilities

(RFP Section 6.7.2.5.4.1)

Review and analyze hospital and nursing facility Medicaid and Medicare reimbursement data.

(RFP Section 6.7.2.5.4.1 Requirement 1)

Myers and Stauffer has extensive experience auditing Medicaid cost reports, analyzing reimbursement rates, using cost report data to rebase and recalibrate prospective payment systems and developing upper payment limit findings. Medicare principles of reimbursement, cost reporting processes, and administrative guidelines form the foundation upon which many Medicaid systems are built. Myers and Stauffer professionals have developed a detailed understanding of the Medicare program – including cost reporting and allowable cost guidelines, provider reimbursement, rate setting rules and regulations and the specific administrative processes that execute program requirements. We currently process approximately 600 hospital cost reports annually.

As a current contractor to the Department, we maintain hospital and nursing facility cost report information necessary to review and analyze statistical

information used in the computation of UPLs. For hospitals, this includes the following forms of information:

- 2552-96 Cost Report Worksheet S-3
- 2552-96 Cost Report Worksheet D Part V
- 2552-96 Cost Report Worksheet E Part A
- 2552-96 Cost Report Worksheet E Part C
- 2552-96 Cost Report Worksheet E Part D
- 2552-96 Cost Report Worksheet E Part E
- 2552 96 Cost Report Worksheet D-1, Part II
- Consumer Price Index - Urban
- Medicaid Medical Capitation Utilization
- Medicaid FFS Utilization Data
- Medicaid Rebasing Statistical Worksheets and Fiscal Analyses
- Medicare Metropolitan Statistical Area (MSA) Assignments
- Annual Medicare Labor and Non-Labor Amounts
- Annual Medicare DRG and APC Weight Schedules
- Annual Medicare Fee Schedules for Physicians, Clinical Laboratories, and Durable Medical Equipment.
- Annual Medicare Public Use Files and Impact Files for Inpatient and Outpatient Hospital Services
- Other Information from the Annual Federal Register Hospital Updates

For nursing facility services, this includes the following forms of information:

- Medicaid Patient Days and Facility Data
- Medicaid Utilization Data for Outpatient Services, Laboratory Services, Radiology Services, and Prescription Drugs
- Medicare NF Labor and Non-Labor Standardized Amounts
- MDS Assessments
- RUG-III Classification System
- Medicare Metropolitan Statistical Area (MSA) Assignments

Due to the importance of the underlying data, we will perform data quality checks before beginning our analyses and modeling activities. We anticipate

this phase of the project will involve performing analytical procedures to identify data elements or relationships between data points that appear aberrant.

After analyzing information necessary to compute the UPL findings, we will present options for the Department to consider, ranging from maintaining the current methodology to implementing new approaches that maximize leveraging opportunities. Our final recommendation to DHS will rely heavily on the quality of the data used to model Medicare upper limit methodologies.

Develop an approach or methodology that can be used to perform the upper payment limit tests for all hospital and nursing facility services. (RFP Section 6.7.2.5.4.1 Requirement 2)

One of the most important aspects of this engagement is the ability to make good, informed decisions. Myers and Stauffer will prepare models or methodologies for DHS to consider. These models will illustrate the upper payment limit using different variables and/or approaches. Over the years, we have developed numerous models and other computerized tools to support these activities. The development of models and the analysis of relationships between variables and approaches is essential to making good decisions. Our models will provide the highest degree of flexibility possible to achieve these objectives.

Myers and Stauffer will continue to conduct research and analysis to determine the best approach and methodology to maximize reimbursement to NSGO hospitals and nursing facilities. While we believe that Medicare payment simulation offers the best UPL options, our studies will consider other approaches to maximize reimbursement. Although states have traditionally had considerable flexibility in determining the upper limit, that flexibility appears to be changing. CMS continues to alter its policies and define "Medicare principles of reimbursement."

Under the current reimbursement parameters defined by CMS, our methodologies have maximized reimbursement. Although this approach has been successful, we will continue to examine new approaches and innovations to assist the Department in maximizing allowable leveraging opportunities. We will also investigate allowable Medicare costs and payment that have been successfully applied in other state programs to determine their applicability in Iowa. This analysis will enable Myers and Stauffer and DHS to further refine the upper limit methods and identify the recommended approach.

Prepare a report explaining the approaches or methodologies in detail, with supporting documentation, and an assessment of the pros and cons of the approaches or methodologies.

(RFP Section 6.7.2.5.4.1 Requirement 3)

Myers and Stauffer will prepare a detailed report of our findings. The report will include discussion of the research performed, details of the methodology, and the basis for a recommendation. The report will also detail an assessment of the pros and cons, information received from CMS, and the success of the approach, if used by other state Medicaid programs. We will include work papers, reference materials, and other information to document the procedures completed. We will schedule a meeting to discuss our recommendations, and to address any questions or concerns that arise after reviewing the materials. The feedback will be used to further refine the upper limit methodology and to prepare our final recommendations and report.

Make a recommendation on approaches or methodologies to perform the upper payment limit tests for inpatient and outpatient hospital services and nursing facility services.

(RFP Section 6.7.2.5.4.1 Requirement 4)

After analyzing the cost report, utilization data, and Medicare information used to prepare the UPL tests, Myers and Stauffer will prepare recommendations and comparative analyses for the Department to consider that will enable the Department to maximize leveraging opportunities. To accompany the options, we will also include a discussion of any tangential factors the Department should consider, such as applicability in other states, methodological concerns, or underlying assumptions that influence the outcomes of the analysis.

Our recommendation will consider at least the following policy questions (in no particular order of importance):

1. Does the model support/improve quality health care?
2. What is the budgetary impact of the model and what is the marginal impact between models?
3. What is the appropriate level of payment to the provider, if any?
4. Does the model create risk to DHS or the provider community?
5. Will the model be accepted by CMS?

6. Has the model been applied in other states?

7. How will the UPL be administered?

8. What political factors must be considered?

9. What factors will influence provider acceptance and compliance?

10. What regulatory, state plan, process and procedure changes will be required?

As with all project deliverables, we understand and acknowledge that DHS must review and approve the final recommendation.

Accurately perform the upper payment limit tests and for inpatient and outpatient.

(RFP Section 6.7.2.5.4.1 Requirement 5)

After making our recommendation to DHS and making applicable regulatory and State Plan amendments, Myers and Stauffer will perform the UPL tests for all hospitals, both inpatient and outpatient services, as well as nursing facility services. We will also prepare final versions of "findings" that must remain on file with DHS. We acknowledge and agree that UPL tests will be performed on a preliminary basis within 30 days after the beginning of each state fiscal year, applicable (prospectively) for that state fiscal year and that the final fiscal analyses for hospital and nursing facility services will be completed within 30 days after the end of each state fiscal year.

Establish a reimbursement system for all State government-owned or operated, non-State, government-owned or operated, and privately-owned and operated hospitals and nursing facilities.

(RFP Section 6.7.2.5.4.1 Requirement 6)

Myers and Stauffer assisted the Department with the development of an appropriate payment mechanism to maximize federal leveraging opportunities based on the UPL test. Payments made to participating nursing facilities and hospitals are deposited into the Senior Living Trust Fund and Hospital Trust Fund, respectively.

On the hospital side, payments are made to Franklin General Hospital up to the Medicare Upper Payment Limit for hospitals. Payments are made to participating NSGO facilities up to the Medicare Upper Payment Limit for nursing facility services.

Provide documentation and data files supporting the reimbursement system.

(RFP Section 6.7.2.5.4.1 Requirement 7)

Myers and Stauffer will provide documentation and data files to support the reimbursement system. The UPL test and source information will be included in the final reports to the Department. Our plan is to deliver documentation and data files to support the reimbursement systems at two stages. First, preliminary estimates of the additional payments to nursing facilities and hospitals would be provided during the first quarter of the state fiscal year. Once all of the information is available to compute the final UPL (which typically occurs in the third to fourth quarter of the state fiscal year), we will compute the final payment amounts. Preliminary payments made to providers can be adjusted up to the final UPL amount.

Develop draft documents to amend the State Plan.

(RFP Section 6.7.2.5.4.1 Requirement 8)

Based on the approaches that have been developed under the current CMS regulations and policies, we do not anticipate that further significant changes would be required to the Medicaid State Plan or other policy documents. However, we will develop State Plan Amendments should the regulatory environment necessitate such changes, or if new or modified approaches to complete the UPL are identified. In that event, we will prepare and submit these documents to DHS for consideration. Myers and Stauffer is quite familiar with these processes, from public notice to responding to questions from CMS, our staff has assisted many state clients with these responsibilities. Typically, we submit documents to our clients in “strike and add” format to illustrate the changes made. Once the changes have been agreed to, we will prepare the final, “clean” version for CMS.

Develop draft documents to the State administrative rules and the employee and provider manuals.

(RFP Section 6.7.2.5.4.1 Requirement 9)

Based on the changing regulatory environment surrounding the use of UPL tests, it is quite likely that further refinements to the State administrative rules and provider manuals could be required. Additional modifications may also be required as we continue to examine models that could increase the UPL spread. In the event that this occurs, we will prepare and submit these documents to DHS for consideration. Myers and Stauffer is quite familiar with these processes, from the preparation of the public notices to the final Blue Sheet, we will assist the Department with these processes.

Assist the Department with presentations.

(RFP Section 6.7.2.5.4.1 Requirement 10)

Myers and Stauffer will assist DHS with presentations to the Council on Human Services, the Legislative Rules Review Committee, other legislative groups, and industry groups throughout the engagement. We will assist DHS in meetings and presentations. Over the years, we have forged a solid reputation and positive, professional working relationship with industry groups and their consultants. We have served in this capacity for many of our engagements, including those in Iowa. Every member of our management team has participated in such meetings with industry groups. Many have also participated in meetings with rule making committees and legislative groups.

Update or make changes to comply with change in federal or state law.

(RFP Section 6.7.2.5.4.1 Requirement 11)

Given the current climate, we envision that CMS may implement changes to the UPL testing process and/or restrict the utilization of payment strategies that maximize permissible leveraging opportunities. The models that we develop and utilize will have the flexibility to accommodate such changes. If changes occur, we will modify the UPL calculations to comply with federal or state laws, as well as CMS policy changes. Upon completing the changes to the methodology, we will provide the Department with analyses that detail the impact of those modifications and the resulting changes to the Senior Living Trust Fund and Hospital Trust Fund accounts.

Federal Medicaid Maximization for Physicians or Other Medical Professionals
(RFP Section 6.7.2.5.4.2)

We recognize that the Medicaid environment is complex and that policy decisions have far reaching effects. We strive to assist our clients in their development of Medicaid program features that serve their current needs and position the program for success in the future. We believe that issues regarding state/federal funding of the Medicaid program will continue to evolve and that current funding activities in this area could need revision in the near future.

Our approach for assisting the Department on this project will involve an analysis of available federal funding options for physicians and other medical professionals, and also a risk assessment for pursuing each alternative. We will assist the state in avoiding funding and provider payment strategies that could be disruptive to the Medicaid program in the future, should federal policy changes occur. At the same time, we will help the Department fully leverage all available federal funding within the Medicaid program.

We will utilize methodologies developed over years of successful engagements and their logical extensions to meet the needs of the Department. We believe our approach provides the State with its best chance for long-term sustainability for the revenue maximization initiatives. We acknowledge and agree to respond to requests and inquiries from the Department regarding all federal Medicaid maximization work within 24 hours of the request.

Obtain and analyze physician or other medical professional charge and claims data.

(RFP Section 6.7.2.5.4.2 Requirement 1)

As a current contractor for the Department, Myers and Stauffer maintains a complete database of utilization data from January 1, 2000 to present. The database contains claims from all program areas.

Analysis of utilization data suggests that faculty physicians at major teaching facilities such as at the University of Iowa Hospital and Clinics and Broadlawns Medical Center may be the most appropriate candidates for federal maximization initiatives. We have assisted the Department in determining that the faculty physicians at these facilities serve the greatest number of Medicaid recipients and uninsured persons within the State and that their costs are not covered by current Medicaid reimbursement.

Other program areas the Department may wish to consider include home health services, hospital based clinic services, and transportation services.

Determine the best approach or methodology to maximize federal Medicaid reimbursement for physician or other medical professional services.

(RFP Section 6.7.2.5.4.2 Requirement 2)

Myers and Stauffer utilizes a data-driven approach to decision-making and policy formulation. After data are analyzed, we will explore relevant regulations, statutes, policies, and other guidance at both the state and federal level to determine the feasibility of a successful implementation. We will also consider factors such as the costs and benefits of the initiative, and success of other state Medicaid programs in attaining federal approval, as applicable.

Prepare a report detailing recommended methodology.

(RFP Section 6.7.2.5.4.2 Requirement 3)

Myers and Stauffer will prepare a discussion paper identifying revenue maximization opportunities, including the recognized associated benefits and risk for each opportunity. With limited state resources and time, this step is extremely important to ensure that efforts are directed in those areas that provide the highest potential benefit to the state. Our reports and analyses will also include a detailed description of the approach (and calculations), the basis of the recommended methodology, and any supporting documentation. After the Department has the opportunity to consider the report, we would propose a meeting to further discuss the initiatives and to address any questions the Department may have.

Accurately calculate reimbursement rates based on approved methodology.

(RFP Section 6.7.2.5.4.2 Requirement 4)

Once approval is received from the Department, we will compute the reimbursement rates that maximize federal Medicaid payments. Project managers and directors will review rate computations for accuracy and completeness before we submit them to the Department.

We acknowledge and agree to provide preliminary reimbursement rate calculations for services delivered by faculty at academic institutions or physicians or other medical professionals employed by government-owned or operated institutions within 30 days after the beginning of each state fiscal

year, applicable (prospectively) for that state fiscal year and to provide final fiscal analyses for reimbursement rate calculations for services delivered by faculty at academic institutions or physicians or other medical professionals employed by government-owned or operated institutions within 30 days after the end of each state fiscal year.

Develop draft state plan amendments, assist in preparing finalized documents and responding to inquiries by CMS.

(RFP Section 6.7.2.5.4.2 Requirement 5)

The staff assigned to this project have assisted several states in their regulatory process including, the state of Iowa. Our assistance has included the formulation of state plan/rule language, reviewing regulations and drafting responses to questions from legislative and other interested parties. We have worked with states in amending their state plans in response to policy changes, litigation and updates required by state and federal legislation or regulation. When unanticipated changes occur in any of these areas, Myers and Stauffer responds quickly and efficiently to incorporate new state and federal requirements and regulations.

We monitor CMS websites on a daily basis for revisions, updates and publication of new federal requirements relative to the Medicaid and Medicare programs. We update our clients on the impact any changes may have on the programs they administer. We strive to stay abreast of the new state plan requirements as well as the types of information and documentation requested by CMS regional and central offices. Also, many of our staff are members of national associations and are active in association activities and conferences to stay current on national, state and local health care issues.

During the course of this project, various issues pertaining to state and federal laws and regulations may arise. We will assist the state in researching and resolving these issues using our knowledge base and experience.

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

Once the state plan has been submitted, the state will work with CMS to ensure its approval. During our 25 years of experience, Myers and Stauffer personnel have assisted in drafting numerous state plan revisions and responses to questions from CMS and will assist the Department in

responding to any inquiries. We acknowledge and agree to draft all policy changes to the Medicaid State Plan, state administrative rules, and provider or employee manuals according to the timeframe required by the Department.

Develop draft changes to the state administrative rules and provider manuals.

(RFP Section 6.7.2.5.4.2 Requirement 6)

The Medicaid rules and regulations of Iowa will be evaluated to determine if and where changes are needed. Project staff have participated in a number of Iowa regulatory amendments and will prepare additional amendments should they be required. We acknowledge and agree to draft all policy changes to the Medicaid State Plan, state administrative rules, and provider or employee manuals according to the timeframe required by the Department.

Assist the Department with presentations.

(RFP Section 6.7.2.5.4.2 Requirement 7)

Myers and Stauffer will assist DHS with presentations throughout the engagement.

Prepare all necessary reports, communications and correspondence to affected hospital providers, legislators, and other stakeholders as requested by the Department.

(RFP Section 6.7.2.5.4.2 Requirement 8)

Myers and Stauffer will prepare all necessary reports, communication, and correspondence to the affected providers, legislators, stakeholders, and other interested parties as requested by the Department. Members of our management team have met and interacted with many members of the affected providers, as well as Iowa state legislators. This experience and the relationships we have built will be crucial in receiving acceptance from the provider community of proposed initiatives.

Prepare documentation outlining all technical specification changes to the MMIS claims payment system.

(RFP Section 6.7.2.5.4.2 Requirement 9)

Myers and Stauffer will prepare all documentation and technical specifications for the MMIS system, as necessary. Members of our project team have significant experience working with ACS is Iowa, and a multitude of other fiscal agent contractors on similar initiatives. We often write Change System Requests and other technical specifications, and work directly with fiscal agent staff to ensure the specifications are understood and implemented as requested.

Review output from the MMIS claims payment system to evaluate compliance with technical specifications.

(RFP Section 6.7.2.5.4.2 Requirement 10)

Should system enhancements or modifications be required as a result of our revenue maximization initiatives, we will work with the fiscal agent contractor to develop technical specifications for the changes, and to develop a testing plan before moving the changes into the production stage. Once into production, we will monitor output to ensure compliance with approved requirements, policies, and procedures.

Participate in meetings, assist the Department in evaluating and analyzing the unique characteristics of these provider types to identify opportunities to increase provider participation.

(RFP Section 6.7.2.5.4.2 Requirement 11)

As the Department considers revenue maximization initiatives, Myers and Stauffer will assist in meetings with affected providers, legislators, or other stakeholders or interested partners. We are a technical resource to turn to when such meetings occur. We will prepare meeting agenda, support materials, reports, or analyses that will be distributed during the meeting. Although the Department will always define our role, we are ready to serve in any capacity that the Department requires. Members of our project team have interacted with these provider groups over the years, and as such have a good working knowledge of the unique health care environment in Iowa. We will work with the Department to identify and achieve maximum participation throughout the provider community.

D. Data Sources
(RFP Section 6.7.2.5.5)

We acknowledge and will utilize the data sources noted in the Request for Proposal.

E. Required Reports
(RFP Section 6.7.2.5.6)

Myers and Stauffer will prepare annual reports and fiscal analyses to document the approaches or methodologies used and the findings from both the upper payment limit tests and the other revenue maximization initiatives. We will also prepare any other reports, materials, documentation, or reference materials needed throughout the project.

F. Performance Standards
(RFP Section 6.7.2.5.7)

Our objective is to perform at a level that meets and exceeds your expectation throughout the engagement. We acknowledge and agree to the minimum performance standards listed below for the Revenue Maximization function.

1. Provide annual reports of upper payment limit test results and preliminary fiscal analyses for hospital and nursing facility services within 30 days after the beginning of each state fiscal year, applicable (prospectively) for that state fiscal year.

2. Provide final fiscal analyses for hospital and nursing facility services within 30 days after the end of each state fiscal year.

3. Provide preliminary reimbursement rate calculations for services delivered by faculty at academic institutions or physicians or other medical professionals employed by government-owned or operated institutions within 30 days after the beginning of each state fiscal year, applicable (prospectively) for that state fiscal year.

4. Provide final fiscal analyses for reimbursement rate calculations for services delivered by faculty at academic institutions or physicians or other medical professionals employed by government-owned or operated institutions within 30 days after the end of each state fiscal year.

5. Respond to requests and inquiries from the Department regarding all federal Medicaid maximization work within 24 hours of the request.

6. Draft all policy changes to the Medicaid State Plan, state administrative rules, and provider or employee manuals according to the timeframe required by the Department.

9.5 Reimbursement Technical Assistance and Support

(RFP Section 6.7.2.6)

A. Objectives

(RFP Section 6.7.2.6.1)

Myers and Stauffer LC has been providing reimbursement technical assistance and support services to the Iowa Department of Human Services since July 2001. Our relationship with DHS began with the successful development of the case-mix reimbursement methodology for Iowa nursing facilities that was implemented July 1, 2001. Myers and Stauffer LC is the contractor presently providing technical assistance and support services for all of the ongoing projects addressed in Section 6.7.1.1 of the RFP. Our project staff has the technical expertise required for these projects and experience working on these and similar projects for Iowa and other states. We address all of the technical assistance and support services as follows:

B. Interfaces

(RFP Sections 6.7.2.6.2)

In the performance of our duties as the current technical assistance and support contractor, Myers and Stauffer LC routinely communicates and shares data with the MMIS and other contractors.

In the performance of our duties as the current technical assistance and support contractor, Myers and Stauffer LC routinely communicates and shares data with the external entities such as obtaining and reviewing MDS data from the Iowa Foundation for Medical Care (IFMC). We have developed data extraction software that IFMC utilizes to extract MDS data for our review. We instructed IFMC in the preparation of the point in time rosters. Twice a quarter we receive point in time rosters from IFMC containing RUG-III classifications and case-mix indices for over 27,000 nursing facility residents in Iowa. We verify the RUG-III classifications and case-mix indices calculated by IFMC using MDS data elements and RUG-III grouper software.

C. Contractor Responsibilities
(RFP Section 6.7.2.6.4)

Reimbursement Methodologies for Bed-Hold Days
(RFP Section 6.7.2.6.4.1 Requirements 1-6)

Prior to May 1, 2003 reimbursement for bed-hold days was made at 75 percent of the nursing facility's rate. Effective May 1, 2003, DHS revised its reimbursement policy for bed-hold days. Under the amended policy, reimbursement for bed-hold days is made at 42 percent of the nursing facility's rate. The amended policy affects both bed-hold days for visits and hospitalization.

Myers and Stauffer currently provides technical assistance and support services to DHS on the amendments to the bed-hold reimbursement policy. Our services include drafting and amending all documents associated with rule changes, provider manual updates, drafting technical specifications and state plan amendments. During the policy making process we modeled proposed bed-hold reimbursement methodologies and provided fiscal impact analyses of the proposed methodologies. For example, one alternative that was considered by DHS was to only make bed-hold payments to nursing facilities that have occupancy levels greater than 90 percent. We developed models to assess the fiscal impact of this alternative for individual facilities, all facilities, rural versus urban facilities, and free-standing versus hospital based facilities. We currently monitor and review MMIS claims payment data for compliance with bed-hold reimbursement policy. Myers and Stauffer possesses the technical expertise, experience and ability to provide all necessary technical assistance and support services to DHS for the ongoing monitoring and evaluation of the bed-hold reimbursement methodology.

Crossover Claim Reimbursement Methodologies for Hospitals
(RFP Section 6.7.2.6.4.2 Requirements 1-6)

The Medicare fiscal intermediary (FI) processes claims for dually eligible beneficiaries (i.e., eligible for both Medicare and Medicaid benefits). During Medicare's adjudication process, the FI determines any applicable coinsurance and deductible amounts owed by the beneficiary. Because the beneficiary is dually eligible, Medicaid is the financially responsible party for any applicable coinsurance and deductible amounts due for these services. These claims for Medicare coinsurance and deductible amounts are referred to as "crossover claims." After verifying Medicaid eligibility for the provider and recipient, the Medicaid fiscal agent contractor pays the crossover claim amounts as computed in accordance with Medicaid payment policy. Any

reduction in Medicaid reimbursement to providers for the crossover claim is allowable as bad debt expense on their Medicare cost report. Medicare policy for hospital-based Medicare certified facilities allows recovery of only 70% of bad debts.

Currently, Myers and Stauffer is assisting DHS in developing revised reimbursement methodology for crossover claims for hospitals under which reimbursement for crossover claims would be limited by the Medicaid allowable amount. Our services on this project have included drafting and amending all documents associated with rule changes, provider manual updates, technical specifications and state plan amendments. We have modeled proposed reimbursement methodologies for crossover claims and provided fiscal impact analyses of the proposed methodologies. We have also been involved in discussions with CMS and provider associations regarding proposed changes in reimbursement methodology for crossover claims for hospitals. Myers and Stauffer has the technical expertise, experience, and ability to provide all necessary assistance to DHS with ongoing development, monitoring and evaluation of the crossover claim reimbursement methodology for hospitals.

Crossover Claim Reimbursement Methodologies for Nursing Facilities
(RFP Section 6.7.2.6.4.3 Requirements 1-6)

Effective May 1, 2003, DHS amended the Medicaid reimbursement policy for crossover claims for free-standing nursing facilities. Under the new policy DHS will pay up to the Medicaid allowable amount for Medicare Part A nursing facility crossover claims for residents in free-standing nursing facilities. If the prior Medicare payment for free-standing nursing facilities is greater than the Medicaid allowable (computed as the Medicaid per diem multiplied by the number of days), then DHS will pay zero for the crossover claim. If the Medicaid allowable is greater than the prior Medicare payment, DHS will pay the difference, up to the coinsurance and deductible amount of the crossover claim.

Myers and Stauffer currently provides technical assistance and support services to DHS for the change in reimbursement methodology for crossover claims. Our services on this project have included drafting and amending all documents associated with rule changes, provider manual updates, technical specifications and state plan amendments. We have modeled proposed reimbursement methodologies for crossover claims and provided fiscal impact analyses of the proposed methodologies. We currently monitor MMIS claims data for compliance with the reimbursement policy for crossover claims. When it was determined that Part B claims were not being paid correctly, we

met several times with the Medicaid fiscal agent contractor to assist them in identifying the crossover claims that are subject to the reimbursement policy. We spoke with the Medicare FI and reviewed sample claims to identify the claim fields that should be used by the Medicaid fiscal agent contractor to identify the Part A claims subject to the policy. We have developed reports to assist with monitoring the fiscal savings resulting from the amendments made to the Medicaid reimbursement policy for crossover claims. We have also worked with Department staff to assist the county IM workers in revising procedures for applying client participation in accordance with the reimbursement policy for crossover claims. Myers and Stauffer possesses the technical expertise, experience and ability to provide all necessary technical assistance and support services to DHS for the ongoing monitoring and evaluation of the crossover claim reimbursement methodology for nursing facilities.

Reimbursement Methodologies for Dual Eligibles
(RFP Section 6.7.2.6.4.4 Requirements 1-3)

Effective July 1, 2003 nursing facilities that are not Medicare certified are required to certify that they will not request payment from Medicaid for services rendered to a dually eligible recipient who is eligible to receive Part A nursing facility benefits from Medicare.

Myers and Stauffer is currently working with DHS to evaluate reimbursement policy for dually eligible beneficiaries and develop alternative approaches to ensure Medicaid payments for nursing facility services are not made when Medicare is the primary payer. Using MDS data, we have identified nursing facilities with dually eligible beneficiaries and have performed analyses on the data. We have assisted in the review if CSRs for several reimbursement initiatives, and are experienced in the review of claims data. Myers and Stauffer has experience in leading meetings with DHS and other contractors and in problem resolution on the various projects for which we provide technical assistance and support services. Myers and Stauffer possesses the technical expertise, experience and ability to provide all necessary technical assistance and support services to DHS for the ongoing monitoring and evaluation of the reimbursement methodologies for dual eligibles.

Other Technical Assistance and Monitoring
(RFP Section 6.7.2.6.4.5)

Maintain operation and support of nursing facility monitoring and reporting system.

(RFP Section 6.7.2.6.4.5 Requirement A)

Myers and Stauffer has developed and maintains extensive databases containing financial and statistical data from cost reports, rate calculation data, and MDS assessment data for Iowa nursing facilities. These databases are organized to promote rapid retrieval of data and flexibility in data queries and analyses. We have assisted DHS in meeting the monitoring and reporting requirements contained in House File 740 regarding the use of any excess payment allowance to nursing facilities. For the direct care excess payment allowance, providers are required to spend the additional reimbursement to increase direct care staff compensation, or increase direct care staff ratios. For the non-direct care excess payment allowance providers are required to spend the additional reimbursement to fund resident "quality of life improvements". Using cost report and MDS data we performed detailed analyses on nursing facility spending patterns that are required by H.F. 740. Based on our analyses DHS was able to satisfy their monitoring and reporting requirements and conclude that the intent of H.F. 740 had been met.

We currently utilize these databases in modeling proposed changes in reimbursement methodology, performing analysis on provider costs, statistics and case mix indices, cost coverage statistics, financial projections, and monitoring of expenditures. We have developed and currently prepare numerous reports for DHS such as the cumulative rate listing and CMI summary. Myers and Stauffer possesses the technical expertise, experience, infrastructure and ability to provide all necessary technical assistance and monitoring services to DHS.

Technical assistance with case mix system.

(RFP Section 6.7.2.6.4.5 Requirement B)

DHS reimburses nursing facilities through a modified price-based case-mix reimbursement system. The case-mix reimbursement system was implemented effective July 1, 2001, and was phased in over three years. Rates are established on July 1 of each year with quarterly updates for changes in Medicaid CMI. Costs are rebased every other year beginning with July 1, 2001.

Myers and Stauffer provided technical assistance and support services to DHS during the development and implementation of the case-mix reimbursement system and currently provides ongoing technical assistance and support services to DHS on the case-mix reimbursement system. We have developed detailed models to assess the fiscal impact of changes in reimbursement methodology such as the recent change in the minimum occupancy used in the non-direct care component of the rate from 80 to 85 percent. We work with DHS to review case mix rates calculated quarterly by the current rate setting contractor. State regulation requires case mix rates to be updated with new cost report data adjusted for inflation every second year. We assist DHS with ensuring the appropriate cost reports data has been utilized, the correct inflation applied and the case mix indices generated.

We have worked with DHS in the development and monitoring of the accountability measures, which provide additional reimbursement for nursing facilities. As part of the accountability measure monitoring process, we assist DHS and the current rate setting contractor with developing reports for summarizing accountability measure information and review accountability measure summaries for accuracy.

The Iowa Administrative Code allows nursing facilities to request an exception to policy for the geographic wage index. The purpose of the exception is to allow nursing facilities that are classified as rural to request an exception to their classification when they can demonstrate that their costs, wages and location are similar to that experienced by urban facilities. Nursing facilities receiving a geographic wage index exception are allowed greater recognition of incurred nursing wage costs when the facility has high costs that are influenced by urban populations. T he amount of additional reimbursement to be received by nursing facilities classified as urban is determined annually. We assist DHS in calculations the urban wage index amount applied to urban nursing facility rates in accordance with regulations. We worked with DHS to develop criteria for reviewing and approving the requests for geographic wage index exception requests. We drafted an information release providing guidance to providers on the review process and criteria. We also performed reviews and analyses on all exception requests submitted and made recommendations to DHS on whether the requests satisfied the exception criteria. As part of our review process, we assist with monitoring the status of geographic wage exceptions and drafting responses to providers facilitating compliance with time requirements outlined in the regulations.

Another example of technical assistance and support services we have provided to DHS involves changes of ownership. When the case-mix

reimbursement system was implemented cost reporting requirements were changed from six month cost reports to twelve month cost reports. This change impacted the cost reporting and rate setting requirements for new providers and facilities experiencing changes of ownership. We assisted DHS in developing policy for cost reporting and rate setting for new providers and facilities experiencing changes of ownership. We prepared a decision tree flow chart for DHS to use in determining cost reporting requirements and cost reports to use in rate setting based on when the new facility was certified or when the change of ownership occurred. We have also researched and assisted DHS in developing policy for reviewing rates for out of state providers.

We currently monitor and review CMI data, RUG-III calculations, rate calculations, cost report data, and project expenditures. We have participated in meetings with DHS, legislators, workgroups, and other contractors. Myers and Stauffer has the technical expertise, experience, infrastructure and ability to provide all necessary technical assistance services with the case-mix reimbursement system.

D. Data Sources

(RFP Section 6.7.2.6.5)

Myers and Stauffer routinely obtains data from the MMIS claims payment system, state MDS data repository and financial and statistical reports. We obtain data from the appropriate sources and maintain the resulting databases. We maintain strict security and confidentiality of all data.

E. Required Reports

(RFP Section 6.7.2.6.6)

We will provide all of the required reports contained in the RFP. Two times per contract year we will provide reports on monitoring the MMIS claims payment system for compliance with reimbursement policies for bed-hold payments, crossover claims for hospitals and nursing facilities, and dually eligible beneficiaries. Myers and Stauffer currently tracks and monitors program expenditures and recommends adjustments to reimbursement based on our findings. We have experience in compiling and performing detailed analyses of cost report and MDS data for DHS and other states. We will provide any other reports as requested by DHS. Myers and Stauffer has the technical expertise, experience, infrastructure and ability to provide all necessary reports to DHS.

F. Performance Standards

(RFP Section 6.7.2.6.7)

Myers and Stauffer takes pride in providing the highest quality services to DHS. Our project staff are knowledgeable of federal and state rules and regulations. Our project staff committed to this engagement possess the technical expertise, experience, and ability to perform our duties in an accurate, timely and professional manner.

10. Project Management Planning

10.1 Project Staffing

(RFP Section 7.2.10.1)

Myers and Stauffer brings a highly qualified professional team to the provider cost audits and rate setting component of the Iowa Medicaid Enterprise project, experienced and capable of meeting all needs for this project.

Myers and Stauffer is pleased to make available many of the same team members that currently serve the state of Iowa, ensuring a seamless transition for DHS. The following information includes a summary of the qualifications of our project team.

Project Directors

Kris Knerr, CPA, member, will serve as project director and will have ultimate authority and overall responsibility for all components of this project. He will review and approve all reports and deliverables, be available to discuss the progress of the project, attend meetings and provide consulting services to the Department. Mr. Knerr's prior role was the project director for the firm's case mix, technical assistance and other engagements with the state of Iowa. He has directed the design and modeling of case mix reimbursement alternatives, met with legislators and presented testimony to the Human Services Appropriations subcommittee, drafted revised regulations and state plan amendments, directed the design and development of a cost report and MDS database and the calculation of the upper payment limit for nursing facilities. Mr. Knerr has extensive experience assisting other states in identifying and resolving issues surrounding MDS data, case mix reimbursement, and upper payment limit tests.

Jared Duzan, principal, will serve as project director and will work directly with Mr. Knerr to offer strategic input and technical assistance. Mr. Duzan currently serves as the manager for the firm's hospital, physician, managed care, pharmacy, ambulatory provider rate setting, consulting and auditing engagements for our state agency clients. He has consulted with state Medicaid programs in Alaska, Florida, Indiana, Iowa, Kentucky, Nevada, New Mexico, North Carolina, Oklahoma, Missouri and South Carolina. He has more than nine years of experience in public health policy, research, data analysis, utilization review, reimbursement and medical policy consulting. He is directly responsible for the daily operation and execution of the project

activities such as survey research, data collection, rebasing and recalibration of prospective reimbursement systems, data and financial analysis, rate setting, reimbursement studies, cost report reviews and audits and upper payment limit calculations.

Quality Assurance

Keenan Buoy, CPA, member, will provide quality assurance for this engagement. He will work directly with the project directors, Kris Knerr and Jared Duzan, and provide high-level strategic input to assure successful completion of the project and the full satisfaction of DHS. He is the member in charge of the firm's Indianapolis, Indiana, office and oversees operations of the Kentucky and Pennsylvania offices. Mr. Buoy will work with the project directors to ensure successful outcomes. His qualifications include more than 20 years of experience providing consulting, auditing and accounting services to state Medicaid agencies including consulting on a variety of public health policy issues to numerous state agency clients.

Our quality assurance system monitors firm activities and reports to the highest levels of the firm. We have written standard operating procedures that are applied to all engagements. As a part of these procedures, Mr. Buoy will perform quality assurance checks that promote adherence to contract compliance criteria and other management policies. He will oversee quality control reviews and processes and will review deliverables and monitor contract performance milestones.

Account and Implementation Manager

Amy Perry, CPA, will serve as account and implementation manager and be responsible for the day-to-day operations of the project. She is a manager with the firm and has more than 10 years of professional experience with Myers and Stauffer in the area of health care reimbursement. She currently manages the firm's case mix, consulting and reimbursement system design engagements for the states of North Carolina, Louisiana, Kansas, Montana and Nevada. She has developed interactive models to replicate proposed case mix reimbursement systems allowing multiple options to be evaluated quickly and efficiently. Her experience includes managing case mix reimbursement system projects for the states of Iowa, Colorado, Hawaii, New Jersey and Georgia. She has assisted Kansas, New Jersey, Georgia, Colorado, Washington, Montana and Louisiana in preparing analyses to support the Medicare upper payment limit and Medicare/Medicaid rate differential calculations.

Technical Consultant

Kevin Londeen, CPA, member, will provide technical consulting for this engagement. He will work directly with the account and implementation manager. He has 15 years of experience providing consulting, auditing and accounting services to state Medicaid agencies in more than 19 states. He has consulted with state agency clients on a variety of public health policy issues. He has assisted them with the design and implementation of prospective payment systems for acute care, ambulatory care and long term care. He served as lead consultant to the Department of Justice examining fraudulent and abusive Medicare cost reporting practices for hospitals, skilled nursing facilities and home health agencies.

Long Term Care Specialist

Tom Donahue, CPA, will provide accounting, auditing and rate setting support for long term care services. He has 14 years of experience with Myers and Stauffer and has worked exclusively serving Medicaid agencies. His responsibilities include performing quality reviews and assisting on appeal work under our existing contract. Mr. Donahue is also skilled in litigation and hearing support services and has testified on numerous appeals on behalf of Medicaid agencies. Mr. Donahue is very familiar with Iowa rate setting rules, regulations and criteria.

Pharmacy SMAC

Albert Long, MPA, a manager with Myers and Stauffer, will provide SMAC services related to this project, including preparing rate models, rate setting, preparing fiscal impact projections, reporting, policy analysis and recommendations, provider services, and evaluation of opportunities to make changes to SMAC reimbursement. Mr. Long's current responsibilities include creation of statistical and analytical models, policy analysis, program integrity activities, and utilization management activities.

Danyel Holmes is a health policy analyst for Myers and Stauffer's rate setting and consulting engagements. He leads the development, support, and operation of maximum allowable cost schedules for state Medicaid pharmacy programs. His responsibilities include creation and manipulation of complex data sets, analysis of Medicaid claims data for financial and policy support, preparation of written reports, presentations, client support, and management of delegated tasks.

Kim Plake, R.Ph., Ph.D. is a registered pharmacist and a former assistant pharmacy professor at Drake University and a current assistant pharmacy professor at Purdue University. She will be involved with the analysis, review

and processes necessary to establish rates for multi-source prescription drugs as part of the SMAC program.

DRG and APG

Scott Simerly, Ph.D. will lead the DRG/APG services. Dr. Simerly has five years of experience leading reimbursement system design, development and implementation for multiple inpatient prospective reimbursement system engagements including the states of North Carolina, Kansas, Colorado and New Mexico. Dr. Simerly leads the firm's APC Outpatient Prospective Payment System engagement for the Louisiana Medicaid program and he recently completed an engagement with the Medicare program where he studied the reimbursement of high cost drugs within the Medicare APC system. His responsibilities on this engagement will include the creation of analytical reports and statistical models, development of fiscal impact studies, coordination of staff, preparation of project deliverables and management of databases.

Ryan Farrell is a health care policy and reimbursement consultant with extensive experience and skills analyzing and tabulating Medicaid encounter and financial data. Mr. Farrell develops and manipulates complex datasets to produce reports and other deliverables used by our clients. His primary responsibilities and areas of focus have included utilization and expenditure analyses for inpatient hospital services, outpatient hospital services, physician services, dental services and durable medical equipment.

Revenue Maximization

Melenie Burns, CPA, is a senior accountant with Myers and Stauffer. She is responsible for Disproportionate Share Hospital (DSH) consulting for the firm's contract with the state of Indiana, including review and analysis of federal and state legislative initiatives and participation in policy discussions related to intergovernmental transfers (IGT), DSH and upper payment limits. She performs review and analysis of hospital specific limits, performs review of hospital cost and financial data and computes hospital eligibility for enhanced payments. Ms. Burns assists with monitoring account balances and in the administration of payments to participating hospitals.

Greg Cecil, CPA has 20 years of accounting experience in health care accounting. He performs desk reviews of provider financial reports resulting in changes to Medicaid long term care rates. This process includes the application of Medicaid rate setting criteria and generally accepted accounting principles to provider submitted financial and statistical data to arrive at the allowed per diem Medicaid rate. Mr. Cecil has experience preparing and

reviewing provider requests for administrative reconsideration of Medicaid rate determinations.

Rate Setting/Cost Settlement Audits

Clinical Services

Mike Evans, Robyn Pugh, Chris Maben and Robert Hicks, CPA, will assist with performing all project activities related to clinical services. They will also serve in key roles training new staff and reviewing the work performed in compliance with the firm's quality control procedures. They will be responsible for conducting audits and desk reviews, updating programs and procedures, researching allowable costs and calculation issues and providing assistance in the development of audit guidelines.

Long Term Care

Andy Johnson, CPA, Don Catron, CPA, and Cheryl Richter will assist with performing all project activities as related to long term care. They will also serve in key roles training new staff and reviewing the work performed in compliance with the firm's quality control procedures. They will be responsible for conducting audits and desk reviews, updating programs and procedures, researching allowable costs and calculation issues and providing assistance in the development of audit guidelines.

Technical Assistance

Holly Ross has more than eight years of experience in health care auditing and auditing-related tasks. She is responsible for the final review of cost reports, case mix rates, analysis of desk reviews and reconsiderations. In addition, she provides rate setting and final review of group home rates including the application of criteria, rate setting methodology and analysis of reporting requirements. Ms. Ross has assisted with the implementation of new case mix reimbursement systems for nursing facilities, assisting with fiscal impact analyzes, and review of Medicaid rate calculations for accuracy and compliance with administrative rules.

Joann McMasters will provide case mix quality assurance and will be responsible for reviewing resident and audit roster results to ensure accuracy and quality within established standards. She has experience in the development of case mix validation reports for the states of Indiana, Kentucky, Louisiana and North Carolina. She will provide overall direction to our help desk support functions.

Patrice Nicholson, RN, is a registered nurse with more than 30 years nursing experience. She was an active member of the CMS Correction Policy

committee that developed and designed the national MDS correction policy. She interprets and analyzes data collected from the MDS 2.0 and teaches the RUG-III resident classification system in both the 34 and 44 groupers. Ms. Nicholson has assisted states in designing and developing case mix medical record review (audit) processes for case mix systems and trained appropriate personnel.

Programming

Chris Powell will serve as computer programmer and will create, modify, test and document customized software for this engagement. Mr. Powell was the primary programmer for hospital and long term care rate setting applications developed by the firm for use in Kentucky, Kansas, North Carolina, West Virginia, New Mexico and Indiana. His experience includes rewriting selected DRG software modules for a Windows environment and data reporting for a Colorado DRG project, including computation of base year case-mix index.

Mark Sheehan is a senior programmer/analyst with Myers and Stauffer responsible for operation and maintenance of programs and databases for the firm's MDS case mix projects. He routinely performs queries and creates reports.

Contract Support

Sally Bechtel will be responsible for many of the rate setting support activities required for the establishment of reimbursement rates. She will receive the cost reports and perform the initial review for completeness. The cost report is entered into the rate setting system that tracks the progress of the cost report by updating a status log of required events. She will prepare the copies and insure that they are mailed to the appropriate parties. She will also maintain rate setting parameter tables.

Additional staff resources, including senior and staff-level accountants, financial analysts and other professionals from Myers and Stauffer will be utilized as needed to achieve project objectives and assure DHS complete satisfaction with our services.

A. Resumes

(RFP Section 7.2.10.1.1)

We have included resumes for key personnel and project staff on the following pages.

Key Personnel Resumes

Account and Implementation Manager – Amy Perry, CPA

Amy C. Perry, CPA

Position	Account and Implementation Manager
Education	B.S., Accounting, Northeast Missouri State University, Kirksville, Missouri, 1990
Certification	Certified Public Accountant
Employment History	13 years experience with Myers and Stauffer 1991 to present
Experience Relevant to this Project	Ms. Perry, a manager with more than 12 years of experience with the firm, provides consulting and public accounting services to state Medicaid agencies regarding health care reimbursement issues. She serves as a manager with the firm whose primary focus is on design and development of nursing facility rate setting systems for state Medicaid agencies and preparing analyses to support the Medicare upper payment limit and justification of rates to comply with federal requirements. She also has the responsibility for keeping abreast of current statutes, rules and regulations that govern the industry and researching and evaluating the impact of state and federal legislation on nursing facility reimbursement issues. Ms. Perry manages the firm's case mix, consulting and reimbursement system design engagements for the states of Louisiana, Kansas, North Carolina, Montana and Nevada. Her responsibilities include supervising project staff and planning and organizing day-to-day project operations. She has been active in all phases of case mix development and maintenance for projects in Colorado, Georgia, Hawaii, Iowa and New Jersey. She also prepared exhibits used in the presentation of the case mix system to the Iowa, Kansas, Colorado and Montana legislatures. Ms. Perry's experience with nursing facility and ICF/MR rate setting includes researching and developing alternative reimbursement methodologies with emphasis on case mix reimbursement. Her experience includes all phases of design, development, implementation, and maintenance. She has prepared pro forma reimbursement models and financial and statistical analyses that allow states to define multiple reimbursement variables that can be changed interactively. This type of modeling provides states the ability to evaluate multiple options quickly and efficiently. She also assists states with their regulatory process formulating state plan/rule language, reviewing regulations,

and drafting responses to questions from CMS and other interested parties and preparing analyses.

Other Professional Experience

Her auditing, desk review, consulting and rate setting experience for state agencies includes the following states: Alaska, Colorado, Florida, Georgia, Hawaii, Iowa, Kansas, Kentucky, Louisiana, Missouri, Montana, New Jersey, Nevada, North Carolina, and Washington.

Currently, she is assisting North Carolina implement a provider tax program for nursing facilities including preparing analyses to submit to CMS requesting waiver approval.

She has assisted Kansas, New Jersey, Georgia, Colorado, Washington, Montana and Louisiana in preparing analyses to support the Medicare upper payment limit and Medicare/Medicaid rate differential calculations. She has the responsibility for evaluating the impact of state and federal legislation on these calculations.

Ms. Perry has experience in researching and developing alternative reimbursement methodologies for paying nursing facilities for their capital and property-related expenses. She completed a nursing facility reimbursement study for the state of Washington and assisted the states of Nevada and Louisiana in the development and implementation of a Fair Rental Value system.

Ms. Perry served as project manager for an engagement with the state of Kansas to review the adequacy of current reimbursement rates and provide rate adjustment recommendations based on cost data collected from the Community Service Providers (CSP) and Community Developmental Disability Organizations (CDDO) along with relevant economic and market data.

Ms. Perry has performed desk review and rate setting engagements in accordance with Medicaid reimbursement regulations as well as applying Medicare reimbursement regulations that are contained in the Medicare Provider Reimbursement Manual (HIM-15). These engagements necessitate an in-depth understanding of the application of rules specific to the cost reporting and rate setting activities that were performed.

During the Boren era, she prepared studies and analyses to support the Medicare upper payment limit and findings and assurances. She also prepared cost reimbursement rate analyses and regression analyses for litigation purposes and presentation to policy makers and stakeholders.

She researched and prepared a logical analysis on the findings and assurances required to assist the Kansas Department of Social and Rehabilitation Services in the development of a findings process. Analysis included development of a structured process, presented by both verbiage and flowcharts, to comply with federal requirements.

She served as senior analyst for the preparation of long term care and hospital findings for the Missouri Department of Social Services and the Alaska Department of Health and Social Services. She also assisted in the preparation of the 1992 and 1993 studies and analyses that support the Wyoming Health Care Financing findings.

She participated in the design and implementation phases of the Kansas Living Independence for Everyone (LIFE) HCBS waiver for the frail elderly and the physically disabled.

Affiliations

American Institute of Certified Public Accountants
Kansas Society of Certified Public Accountants

Presentations

"Current Trends in Nursing Facility Rate Setting," Myers and Stauffer Workshop, Indianapolis, Indiana, 2003

"RUG-III Case Mix Reimbursement System," North Carolina Medicaid, 4 venues, 2003

"Louisiana Medicaid Nursing Facility Case Mix Reimbursement," Gulf States Association of Homes and Services for the Aging, 2003

"Nursing Facility Case Mix Reimbursement," Louisiana Medicaid, 4 venues, 2002

"New Medicaid Reimbursement System in Iowa," Iowa Association of Homes and Services for the Aging, West Des Moines, Iowa, 2001

References

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Project Staff Resumes

Kristopher J. Knerr, CPA

Position	Project Director
Education	B.A., Accounting, University of South Florida, Tampa, Florida, 1984
Certification	Certified Public Accountant Certified Government Financial Manager
Employment History	12 years of experience with Myers and Stauffer 1992 to present
Experience Relevant to this Project	A member (owner/partner) with Myers and Stauffer, Mr. Knerr is responsible for providing consulting and public accounting services to state agencies regarding health care reimbursement issues. His recent experience includes the following engagements:

- Iowa Nursing Facility Case Mix – 2000 to present

He serves as the project director on the state of Iowa's development of a case mix reimbursement system for nursing facilities. Mr. Knerr developed reimbursement strategies to address the treatment of nursing services within the case mix system, as well as strategies to address non-nursing services including administration, environmental, support care and capital costs. He presented and defended the Department's case mix system proposal at numerous task force meetings, met with legislators to explain the new system and presented testimony to the Human Services Appropriations subcommittee.

- Indiana Nursing Facility Case Mix - 1995 to present

He has served as project manager on the state of Indiana case mix reimbursement system development and implementation project since the project began in 1995. This multi-faceted project included the design, development and implementation of an automated system to collect MDS 2.0 data from over 525 Medicaid certified nursing facilities, the design and modeling of alternative case mix reimbursement methodologies and ongoing operations of the case mix reimbursement system.

Mr. Knerr coordinated case mix work group meetings, prepared and presented alternative case mix and capital reimbursement methodologies, fiscal impact modeling and analyses, draft state regulations and criteria, and responded to technical issues brought forth by the state and provider association representatives.

Mr. Knerr's responsibilities also include supervising the day-to-day completion of tasks performed by MDS help desk personnel, computer programmer, staff accountants and RN consultants involved with the project.

- Kentucky Nursing Facility Case Mix - 1998 to present

He provides project consulting to the Kentucky Department for Medicaid Services on the Development of a RUG-III Case Mix Reimbursement System.

Mr. Knerr presented at case mix work group meetings, prepared case mix reimbursement models and fiscal impact analyses, developed training programs for state and provider groups, and responded to technical issues brought forth by the state and work groups.

- Minnesota Long Term Care Nursing Facility Services - 2002 to present

He serves as project manager on the state of Minnesota's long term care nursing facility services contract. This multi-faceted project includes the design and development of a new system of reimbursement and staff time measurement study for nursing facilities. Mr. Knerr presents at case mix work group meetings, prepares reimbursement models and fiscal impact analyses. He coordinates all activities associated with the staff time measurement study including, facility selection, scheduling, data collection and analysis.

Other Professional Experience

Mr. Knerr has experience modeling, analyzing, drafting and implementing Medicaid regulatory changes. This includes compilation of empirical evidence regarding policy issues for presentation to state Medicaid personnel.

He provides expert testimony and consultation in defense of various suits brought forth by long term care providers in various state and administrative forums.

He has performed analysis and review of provider cost data and relevant economic data used in developing findings to support state Medicaid agency assurances to CMS.

Mr. Knerr has developed cost reporting methodology and forms with instructions for a state Medicaid agency client.

Mr. Knerr has more than three years of experience as a financial analyst with an economic consulting group. He was responsible for evaluating and interpreting the economic impact resulting from circumstances related to specific personal and business litigation. He identified and implemented

applied economic and financial theories. He also formulated and established case valuation plans.

In addition, he has four years of general accounting experience with a medium-sized computer service organization. He managed day-to-day activities of the finance department including preparation of financial statements, planning and implementation of operational, capital and cash flow budgeting. He performed analysis and review of issues relating to generally accepted accounting principles. He also had management and supervision responsibility for 20 technical and professional full-time personnel.

Affiliations

American Institute of Certified Public Accountants
Indiana CPA Society
Iowa Society of Certified Public Accountants
Association of Government Accountants
American Public Human Services Association

Presentations

"Current Status of State Medicaid Case Mix Systems," National Case Mix Conference 2003, Putting Policy into Action: Are we making a Difference, Baltimore, MD, March 2003.

"Unanticipated Acuity Changes: The Impact on Government Assistance Budgets," Case Mix 2001 Conference, New Frontiers in Health Information, Niagara Falls, Canada, October 2001.

"Components of the Medicare Prospective Payment System" and "Impact on State Medicaid Programs," Myers and Stauffer Home Health Workshop, Kansas City, Missouri, December 2000.

"Medicaid Case Mix Implementation and Reimbursement Training," Nursing Facility Training, Indiana Office of Medicaid Policy and Planning. Presented at eight locations throughout Indiana. August/September 1998.

"Developing a Case Mix System: State Agency Perspectives," National Case Mix Reimbursement and Quality Assurance Conference, Cleveland, Ohio, September 1997.

"Case Mix and Fair Rental Value Capital Reimbursement," Health Care Conference, Indiana CPA Society, Indianapolis, Indiana, September 1997.

"Indiana MDS 2.0 and Rug-III Classification Training" - Nursing Facility Training, Indiana Office of Medicaid Policy and Planning, presented at ten locations throughout Indiana in November and December 1996.

"Case Mix Reimbursement" Health Care Conference, Indiana CPA Society, Indianapolis, Indiana, September 19, 1996.

"MDS 2.0 Electronic Transmission Training Seminar," Nursing Facility Training, Indiana Office of Medicaid Policy and Planning. Presented at 10 locations throughout Indiana in April 1996.

References

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Jared B. Duzan

Position	Project Director
Education	B.A. with Distinction, Economics (Quantitative), Indiana University, 1995 Wall Street Journal Award in Economics
Employment History	7 years experience with Myers and Stauffer 1997 to present
Experience Relevant to this Project	Mr. Duzan is a principal/director with Myers and Stauffer and has more than nine years of experience in public health policy and reimbursement. He is responsible for specialized consulting engagements for state social service agencies, including the firm's program integrity, hospital, pharmacy, and ambulatory provider rate setting and auditing engagements. He has consulted the state Medicaid programs in Alaska, Florida, Indiana, Iowa, Kentucky, Missouri, Nevada, New Mexico, North Carolina, Oklahoma and South Carolina. Mr. Duzan is directly responsible for the daily operation and execution of the project activities. Activities include program integrity reviews, policy and procedure analysis, state plan and regulatory amendments, survey research, data collection, rebasing and recalibration of reimbursement systems, data and financial analysis, ambulatory rate setting, reimbursement and medical policy consulting, cost report reviews, and audits. He has assisted state Medicaid programs with public relations to provider associations for the Indiana Medicaid program, Iowa Medicaid program, the Nevada Medicaid program, and the South Carolina Medicaid program. Mr. Duzan is experienced with a multitude of health care providers and delivery settings including pharmacies, hospitals, dentists, advanced practice nurses, health clinics, physicians, managed care organizations, durable medical equipment dealers, telemedicine, home health care, and transportation services. Before joining Myers and Stauffer, Mr. Duzan was a policy and procedure analyst with the state of Indiana, Office of Medicaid Policy and Planning. His primary responsibilities included directing and monitoring the activities of the Surveillance and Utilization Review Unit, policy research and data analysis pertaining to fraud and abuse detection and prevention in all Medicaid program areas, and acute care reimbursement. Secondary responsibilities included budget forecasting, data analysis, and utilization review.

Professional Experience

Manager for a rate setting, auditing, and consulting engagement with the state of Indiana. Engagement also includes support for the pharmacy benefit, Restricted Card Program, MAC fee setting, and pharmacy and prescriber auditing.

Manager for a MAC and Utilization Management engagement with the state of Iowa.

Manager for a hospital upper payment limit engagement with the state of Iowa.

Manager for a voucher agent cost report engagement with the Indiana Family and Social Services Administration.

Manager for a study of reimbursement methodologies for the state of Nevada.

Manager for quarterly financial monitoring of managed care organizations in the state of North Carolina.

Manager for managed care operational reviews for the state of North Carolina.

Manager for a time and administrative cost study for the Indiana Bureau of Child Development

Manager for a telehealth reimbursement research project with the Alaska Native Tribal Health Consortium.

Manager for a study of ICF/MR reimbursement methodology for the state of Florida.

Manager for a study of Medicaid eligibility options for the aged, blind and disabled population for the state of Missouri.

Manager for an evaluation of cost-sharing policies for the Indiana Division of Mental Health.

Associate Instructor of Economics, Indiana University-Indianapolis

Economic Analyst for the state of Indiana, Division of Mental Health (Independent Contractor). Areas of responsibility included the analysis of mental health consumer utilization data and program administration.

Research Analyst and Coordinator, Indiana University, Institute for Social Research. Areas of responsibility included the development of surveys,

collection and analysis of community mental health center utilization data and the review of quality of care, coding issues for former hospital patients.

Other Training

IHS APC Reimbursement—June 2000
HFMA Medicare Cost Report Training – July 1999
Risk-Based Auditing Workshop – November 1999
Medicaid Auditing and Reimbursement Workshop – 1997 and 1998
3M APG Reimbursement – October 1998

Affiliations

American Public Health Association

References

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Keenan S. Buoy, CPA

Position	Quality Assurance
Education	B.B.A., Accounting, Washburn University, Topeka, Kansas, 1982
Certification	Certified Public Accountant
Employment History	22 years experience with Myers and Stauffer 1982 to present
Experience Relevant to this Project	Mr. Buoy, a member (owner/partner) and executive consultant of the firm, is the member in charge of the firm's Indianapolis, Indiana office, and oversees the operations of the Frankfort, Kentucky, and Harrisburg, Pennsylvania, offices. He is experienced in managing large, complex projects and coordinating the efforts of numerous staff. A certified public accountant, Mr. Buoy's 21-year career with Myers and Stauffer has focused on health care reimbursement. His responsibilities include review of state plans for reasonableness, revising state regulations and criteria, developing cost reporting forms and instructions, reviewing cost information accumulated by state agencies for reasonableness and developing rationale for resolution of Medicaid reimbursement policy issues. Currently, Myers and Stauffer is the consultant to the Maryland Health Care Commission on use of the Minimum Data Set (MDS) resident assessment instrument to create data sets for planning and policy development. Mr. Buoy is a member of the project management team for this project. He has extensive experience in the review of Medicaid cost reports and has provided desk or supervisory reviews and attendant rate determinations for many long term care providers. Mr. Buoy provides expert testimony and consultation in the defense of various suits brought forth by long term care providers in various state and federal courts and administrative forums. His assistance includes technical support of state agency officials and their counsel concerning Medicaid reimbursement plans, including relevant state and federal rules and methodologies. He participates with state Medicaid agency clients in various provider reimbursement task force initiatives providing consultation on alternative reimbursement methodologies, fiscal analyses of current and proposed formulas and responding to technical issues brought forth. Task force

participants have included providers, state Medicaid agency officials, budget agency officials and other interest groups.

Mr. Buoy skillfully responds to provider inquiries and rate reconsideration requests concerning reporting requirements and data submission, rate setting procedures, calculations and methodologies and other relevant rate setting issues; contacting long term care facility providers in regard to relevant cost increases/decreases over prior periods; and making appropriate desk review adjustments to the rate case as required.

He responds to departmental inquiries concerning reimbursement issues and provides agency officials with opinions regarding relevant rate setting issues concerning proposed changes to reimbursement formulas and methodologies. He routinely provides assistance in drafting and implementing Medicaid regulatory changes.

Other Professional Experience

Other state Medicaid agency consulting projects he has directed include documentation of findings for state Medicaid agencies in compliance with section 962 of Public Law 96-499. This includes compilation of provider data and pertinent economic factors as relevant to findings required pursuant to 42 CFR 447.253. He assisted a state Medicaid agency in SPECTRUM review performed by CMS. Additionally, he has served as project coordinator on a consulting contract to conduct discovery proceedings in a class action lawsuit brought by health care providers against a state Medicaid agency concerning alleged under payment of Medicaid claims, from 1982 through 1985. In this capacity, he prepared and provided expert testimony in support of the state agency and also prepared and reviewed exhibits.

Affiliations

American Institute of Certified Public Accountants
Indiana CPA Society
American Public Human Services Association

Presentations

"MDS Validation: Its Affect on Quality of Care, Reimbursement and Policy Issues," Case Mix 2001 Conference, New Frontiers in Health Information, Niagara Falls, Canada, October 2001.

References

James M. Verdier, Director of State Health Policy
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Kevin C. Londeen, CPA

Position	Technical Consultant
Education	B.S., Business Administration, Kansas State University, 1984
	Concentrations in Accounting and Finance
Certification	Certified Public Accountant
Employment History	16 years experience with Myers and Stauffer
	1988 to present
Experience Relevant to this Project	Mr. Londeen, a member (owner/partner) and executive consultant with Myers and Stauffer, is responsible for providing consulting and public accounting services to the Medicare program as well as state Medicaid agencies regarding health care reimbursement issues. Most recently, he served as project director and lead consultant to the Department of Justice (DOJ) examining fraudulent and abusive Medicare cost reporting practices of hospitals, skilled nursing facilities and home health agencies.

He has consulted with state agency clients during development of hospital, nursing facility, and intermediate care facility/mental retardation reimbursement systems, including reimbursement processes for routine (administrative and health care) cost and capital cost. These reimbursement systems utilized cost-based and non-cost-based reimbursement approaches and incorporated acuity measures. He has also presented testimony regarding reimbursement studies to legislative committees.

He has provided testimony regarding provider rate and settlement disputes in forums including settlement conferences, administrative hearings and other judicial settings. The participants included providers, judges, hearing officers and program administrators. He presented an alternative reimbursement system (the Medicare Carve-Out System) to the Idaho Senate Subcommittee on Health Care. This system was designed to accurately measure the cost of Medicaid nursing facility services. Implementation of the system resulted in 5% annual savings for the state's nursing facility program.

He assisted several state Medicaid agencies in developing their annual findings and assurances (justifications). He developed studies and analyses

and presented testimony that resulted in resolution of provider rate and settlement disputes.

Mr. Londeen serves as project director on several DRG reimbursement projects including Medicaid agencies in Kansas, North Carolina, and West Virginia. In this capacity he supervises the determination of DRG relative weights, DRG system parameters, and hospital rates. He has also been instrumental in revising state DSH programs in response to changing federal regulations. Maximization of federal funding is a primary endeavor using various methods including supplemental payments, provider taxes and intergovernmental transfers (IGT).

He has significant cost report auditing and reimbursement experience including more than 13 years as audit and desk review project manager examining Medicare and/or Medicaid cost reports for state Medicaid agencies. Mr. Londeen has planned and supervised performance of Medicaid cost report audits and report issuances to ensure compliance with generally accepted or governmental auditing standards and Medicare/Medicaid program requirements. He has provided services to 19 Medicaid agencies on health care reimbursement issues, and planned and conducted audits of hospitals, nursing facilities, intermediate care facilities for the mentally retarded, federally qualified health centers, home health agencies and residential health centers.

Mr. Londeen has served as the lead consultant to Medicaid agencies in the states of Kansas, Idaho, Montana, Louisiana, North Carolina and Colorado, assisting in their development of case mix reimbursement systems. He has developed reimbursement strategies to address the treatment of direct health care, administrative and capital cost reimbursement issues.

Mr. Londeen performs desk review and rate setting engagements in accordance with Medicaid reimbursement regulations as well as applying Medicare reimbursement regulations that are contained in the Medicare Provider Reimbursement Manual (HIM-15). These engagements necessitate an in-depth understanding of the application of rules specific to the cost reporting and rate setting activities that were performed.

In 1992, Mr. Londeen established the firm's Idaho office and hired and trained approximately 20 staff including CPAs, CPA candidates, computer professionals and accounting technicians. He supervised the transition of Idaho Medicaid audit, rate setting and settlement functions from state employees to Myers and Stauffer staff.

Other Professional Experience

Mr. Londeen is a certified public accountant (CPA) and maintains permits to practice public accounting in the following states: Colorado, Idaho, Kansas, Missouri, Montana, New Jersey, New Mexico, North Carolina, West Virginia and Wyoming.

In addition to performing CPA projects, as well as Medicaid program consulting, for each of the above state Medicaid agencies, Mr. Londeen has also assisted the following state Medicaid agencies in a consulting capacity:

- Arkansas Department of Human Services
- Kentucky Department of Medicaid Services
- Louisiana Department of Health and Hospitals
- Indiana Office of Medicaid Policy and Planning
- Iowa Department of Human Services
- Nevada Department of Human Resources
- Washington Department of Health and Social Services
- California Department of Health Services
- Arizona Health Care Cost Containment System
- Florida Agency for Health Care Administration
- North Dakota Department of Human Services
- Texas Health and Human Services Commission

Affiliations

American Institute of Certified Public Accountants

Kansas Society of Certified Public Accountants

Presentations

"Legal, Financial and Political Implications of Medicaid Budget and Rate Shortfalls," American Health Lawyers Association Annual Meeting, San Antonio, Texas, 2003.

"Unanticipated Acuity Changes: The Impact on Government Assistance Budgets," Case Mix 2001 Conference, New Frontiers in Health Information, Niagara Falls, Canada, October 2001.

"Medicare versus Medicaid Case Mix – How are States Coordinating their Medicaid Case Mix System with the Medicare PPS?" National Case Mix Conference, May 2000, Madison, Wisconsin.

"Reimbursement Methodology - Identifying Medicaid Costs," Kevin Londeen, Case Mix and Reimbursement Forum, October 1998, Kansas City, Missouri

Mr. Londeen prepared and delivered the following presentations at the Myers and Stauffer Annual Medicaid Auditing and Reimbursement Workshops:

- "Executive Development," 1996, Topeka, Kansas.
- "Medicare Reimbursement of Federally Qualified Health Centers," 1995, Topeka, Kansas.
- "Accountants' Reports and Materiality Assessment," 1994, Topeka, Kansas.
- "Top-Down Auditing, Medicaid Audit Appeals, Approaches to Home Office Auditing, Hospital Rates & Settlements, and Interim Rates & Class Ceilings (LTC)," 1993, Boise, Idaho.
- "Medicare & Medicaid Program, Top-Down Auditing, OBRA '87, Example Audit Report, CCH Medicare & Medicaid Guide and Code of Federal Regulations, and Idaho Medicaid," 1992, Boise, Idaho.
- "Status Log System & Reports; Importance of Updates and Rate Calculation," 1992, Denver, Colorado.

References

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Thomas M. Donahue, CPA

Position	Long Term Care Specialist
Education	B.S., Business Administration, Indiana University, 1980 Concentration in Accounting
Certification	Certified Public Accountant Certified Government Financial Manager
Employment History	15 years with Myers and Stauffer 1989 to present
Experience Relevant to this Project	Mr. Donahue, a manager with Myers and Stauffer, has more than 14 years of experience in public accounting with an emphasis in health care reimbursement. Mr. Donahue has extensive experience performing and supervising desk reviews of long term care provider financial reports resulting in changes to Medicaid long term care rates. This process includes the application of the Medicaid rate setting criteria and generally accepted accounting principles to provider-submitted financial and statistical data to determine the per diem Medicaid rate. In addition, he is responsible for training and supervising senior and staff accountants performing desk reviews and other projects as assigned.

His experience includes:

- Supervising the desk review of home health agency financial reports used to establish statewide Medicaid reimbursement rates for home health services. This included the promulgation and implementation of rule changes related to reimbursement for home health services.
- Developing the Medicaid reimbursement methodology for hospice services.
- Drafting and implementing Medicaid reimbursement changes for nursing facilities, CRF/DD and ICF/MR.
- Providing expert testimony in administrative appeal hearings and lawsuits in state courts involving Medicaid reimbursement issues. He has provided technical support to state agency officials and their counsel concerning Medicaid reimbursement issues. He has compiled

evidentiary material for hearings and lawsuits including support for Medicaid reimbursement systems and other relevant issues.

- Supervising the recalculation of long term care providers' Medicaid rates due to field audit reports. This process includes incorporating appropriate audit adjustments into the rate review and notifying the state Medicaid agency and long term care facility providers in regard to rate decreases/increases.
- Preparing and reviewing responses to provider requests for administrative reconsideration of rate determinations. This process includes explanation and analysis of the encompassing reporting requirements and data submission, rate setting procedures, calculations, methodologies and other rate setting issues.

Other Professional Experience

Mr. Donahue's other professional experience includes serving as a staff accountant for a nursing home management company. His responsibilities in this position included preparing and analyzing financial statements for several retirement and nursing facilities. He served as assistant controller for a savings and loan and was responsible for preparation and analysis of financial statements and regulatory reports, investment and liquidity planning and supervision of a small accounting staff. He also held the position of auditor for an accounting firm specializing in compliance audits for supervisory committees of federal credit unions.

Affiliations

American Institute of Certified Public Accountants
Indiana CPA Society

Presentations

Mr. Donahue prepared and presented at a Medicaid Cost Reporting Training Seminar for home health agency providers and accountants who provide consulting services for home health agencies.

Mr. Donahue has prepared and presented at several Medicaid Auditing and Reimbursement Workshops presented by Myers and Stauffer for professional staff located in the firm's seven offices. Topics presented include:

- Value-Added Services, Indianapolis, Indiana, 2003
- Professional Ethics for CPAs
- Medicaid Rate/Audit Appeals
- Leadership Skills Development

References

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Indiana Family and Social Services Administration
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Albert J. Long, III

Position	Manager
Education	M.P.A., Public Management, Indiana University, Bloomington, Indiana, 1996 B.A., Political Science, Morris Brown College, Atlanta, Georgia, 1994 Magna Cum Laude Woodrow Wilson Fellow, Public Policy and International Affairs, Lyndon B. Johnson School of Public Affairs; University of Texas, Austin, Texas, Summer 1993
Employment History	5 years experience with Myers and Stauffer 1999 to present
Experience Relevant to this Project	M. Long is a manager in the firm's Indianapolis office. His experiences include fiscal and analytical work in fee-for-service and managed care environments for Medicaid, Medicare and commercial health delivery systems. Mr. Long's career has primarily been dedicated to policy and reimbursement analyses for state Medicaid programs. His current responsibilities include management and oversight of statistical and analytical projects involving Medicaid reimbursement, financial and organizational reviews, reporting, rate setting and utilization management. Mr. Long has accomplished the following achievements in his professional career: ▪ Has led or participated in financial and contract compliance reviews of Medicaid HMOs serving North Carolina Medicaid, New Mexico Medicaid and Indiana Medicaid. ▪ Supported expansion of the Special Education Medicaid Initiative for the New Jersey Medicaid program. ▪ Completed a statewide rate setting initiative for federally subsidized childcare in Indiana, establishing reimbursement rates Indiana pays to childcare providers. In addition, he developed a sliding fee scale for calculation of the parental contribution toward subsidized childcare in Indiana. He implemented and supported a statewide data collection and information system to support Indiana's reporting requirements for the CCDF program.

- Developed HMO capitation strategies and rate setting methodologies for physician networks, hospitals, and individual physician contracts.
- Assisted in the development and application of a statistical protocol for identifying potential candidates for the Indiana Medicaid lock-in program.
- Assisted in the development of the Iowa Medicaid SMAC program and the Indiana Medicaid SMAC program.

Other Professional Experience

Prior to joining Myers and Stauffer, Mr. Long was a policy analyst with the state of Indiana, Office of Medicaid Policy and Planning.. He provided direct oversight of the utilization management functions of the Indiana Medicaid program. He performed oversight of the fiscal agent contracted to perform the operational tasks and focused on drafting, researching and analyzing policies for the efficient operation of the program. He emphasized developing sound medical policy criteria for surveillance and utilization review and prior authorization, auditing Medicaid service providers, detecting inappropriate billing practices (including Medicare crossover claims), and combating fraud. He participated in the development of fee schedules and reimbursement methodologies for physicians and inpatient hospitals. Mr. Long also assisted senior administration by preparing focused reports for pharmacy, physician, dental and managed care services.

Mr. Long also served as network development/provider relations manager for Maxicare of Indianapolis, Indiana. He was responsible for creating and maintaining integrated health care delivery systems to serve managed care members. His primary activities included negotiating contracts, analyzing fiscal implications of contract terms, aggressively managing quality, fostering network growth, examining utilization management and fraudulent billing patterns, providing policy and procedural analysis to contracted entities, coordinating with federal, state and local government, and overseeing reinsurance cases.

In addition, Mr. Long was the project manager for DMG-MAXIMUS, also of Indianapolis, Indiana. In this position, he provided consulting and associated services to state and county governmental agencies. His major clients included the New Jersey Medicaid project and the Indiana Bureau of Child Development. His principal responsibilities included policy development/analysis, program development, service expansion, fiscal impact and risk analysis, rate setting, cost accounting, developing software, conducting software training courses and managing a software-support help desk.

Presentations	"SMAC for Rx/DME and Medical Supplies," Myers and Stauffer Workshop, Indianapolis, Indiana, 2003
References	Pat Nolting, Director Office of Medicaid Policy and Planning 402 W. Washington, Room W382 Indianapolis, IN 46204 Phone: (317) 232-4750 E-mail: pnolting@fssa.state.in.us Kyle Fay, Contract Manager Department of Human Services Division of Medical Assistance 1985 Umstead Drive PO Box 29529 Raleigh, NC 27626-0529 Phone: (919) 857-4263 E-mail: kyle.fay@ncmail.net Stanley Rosenberger, Contract Manager Indiana Division of Family and Children Bureau of Child Development 402 W. Washington, Room W386 Indianapolis, IN 46204 Phone: (317) 232-7923 E-mail: srosenberger@fssa.state.in.us

Danyel C. Holmes

Position	Analyst
Education	Computer Technology, Purdue University, Indianapolis, IN, expected graduation December 2004 A.A., Accounting and Business Management, Indiana Business College, 1995
Employment History	1 year experience with Myers and Stauffer 2003 to present
Experience Relevant to this Proposal	Mr. Holmes serves as a health policy analyst for Myers and Stauffer's rate setting and consulting engagements. He leads the development, support, and operation of maximum allowable cost schedules for state Medicaid pharmacy programs. Mr. Holmes assists in developing cost containment strategies for state Medicaid clients. His responsibilities include creation and manipulation of complex data sets, analysis of Medicaid claims data for financial and policy support, preparation of written reports, presentations, client support, and management of delegated tasks. He also supports programming initiatives, peer review and mentoring, and development of web-based reporting applications. Mr. Holmes has extensive experience with medical utilization data, decision support systems, and electronic reporting (NCPDP, EDI). He possesses strong knowledge of McKesson's HEDIS software package (HealthPlan Reporter, CRMS Data Warehouse, and Chart Review Manager). Additionally, he is an expert user of QMACS, SQL Server, Microsoft Visual FoxPro, Microsoft Access.
Other Professional Experience	Mr. Holmes was previously employed with Advantage Health Solutions (an Indiana HMO) as a data analyst and HEDIS Coordinator. Dates of employment 1997-2003. As a data analyst he developed various reporting packages for employer groups affiliated with Advantage Health Solutions and, provided statistical input regarding health promotion policies with the HMO and employer programs specifically identifying employer enrollment trends, high utilization of medical and pharmacy services, professional to hospital medical cost distribution. Additionally he identified plan members with asthma, diabetes, and congestive heart failure for enrollment in Advantage Health Solutions disease management programs.

Mr. Holmes is familiar with the format, content and uses for medical, pharmacy, and vision claim information, working extensively with HCFA 1500 and UB92 claim forms. He developed systems to convert pharmacy data in the NCPDP format and vision data in the NSF 2.0 format into a format that could be used by Advantage Health Solutions staff.

As HEDIS coordinator, he successfully led Advantage Health Solutions through their first HEDIS audit. This involved developing work plans, completing NCQA's baseline assessment tool, assembling a team of staff and contractors to successfully execute the work plans, preparing staff for interviews with HEDIS auditors, coordinating and developing the production of rates for all HEDIS measures and reviewing rates to ensure compliance with all Medicare, state and federal HEDIS requirements (which required him to calculate statistical rates for several measures under the HEDIS reporting domains).

Mr. Holmes was employed by Sagamore Health Network (an Indiana PPO) as a credentialing specialist and EDI team leader. As a credentialing specialist, he facilitated the operational components of quality improvement process of the provider credentialing/re-credentialing program. The credentialing specialist also served as the credentialing auditor on Sagamore Health Networks Delegation Oversight Committee. In this capacity, he audited credentialing files of PHOs and conducted site visits to provider offices contracted with Sagamore Health Network to ensure compliance with NCQA and Sagamore Health Network regulations. As the EDI team leader, Mr. Holmes coordinated the effective operation of the EDI unit, ensured electronic medical claims were available to claim processors, and identified and assisted in the resolution of any issues within the unit.

Previous to employment with Sagamore Health Network, Mr. Holmes was employed by the Indiana Department of Corrections in the Prison Enterprise Network (PEN) division as an accounting clerk. As an accounting clerk, he reconciled the sales activities for all PEN entities, reconciled various general ledger accounts with Auditor of State accounts (such as cash transfers, accrued payables, revenues and expenses), generated monthly financial statements, reconciled accounts receivable and accounts payable to the general ledger, assisted in the closure of monthly records, and assisted with the biennial budget preparation.

Other Training

HIAA Fundamental of Health Insurance (Part A), 1998
McKesson's HEDIS Boot Camp, (Chicago, IL), 2000, 2001, 2002
NCQA HEDIS Updates and Best Practices, (Los Angeles, CA), 2002

References

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Kimberly S. Plake, R.Ph., Ph.D.

Position	Pharmacist Consultant
Education	Purdue University, West Lafayette, IN Doctor of Philosophy in Pharmacy Administration, January 1999 Specialization: Gerontology Master of Science in Pharmacy Administration, October 1994 Butler University, Indianapolis, IN Bachelor of Science in Pharmacy, Cum Laude (May 1992)
Licensure	Licensure: August 1992-present, Indiana Registered Pharmacist #26017633
Employment History	Purdue University, West Lafayette, IN, Assistant Professor of Pharmacy Practice, August 2003-present Drake University, Des Moines, IA, Assistant Professor of Social and Administrative Sciences, January 1999-July 2003 Purdue University, West Lafayette, IN, Graduate Student Researcher, January 1993-December 1998, Graduate Teaching Assistant, January 1993-December 1998, Research Assistant, May 1993-February 1996 Wells Yeager Best Pharmacy, Lafayette, IN, Staff Pharmacist, October 1995-December 1998 CHARTER Hospital, Lafayette, IN, Consultant Pharmacist, September 1995-March 1996 Arth's Family Pharmacy, Lafayette, IN, Staff Pharmacist, October 1993-August 1995 Illingworth Pharmacy, Linton, IN, Staff Pharmacist, June 1992-October 1992
Experience Relevant to this Project	Dr. Plake is a consulting pharmacist to Myers and Stauffer. Dr. Plake, a former professor at Drake University, is a registered pharmacist and professor of pharmacoeconomics, presently teaching at Purdue University. Dr. Plake has experience working in and operating an independent pharmacy, and her academic interests have included extensive research on clinical, economic, and social issues involving the pharmacy benefit in public health program. Dr. Plake's specific research focus areas include geriatric medicine, indigent care, and survey design.

Affiliations

American Association of Colleges of Pharmacy 1993-present
American Pharmaceutical Association 1992-present
Iowa Pharmacists' Association 1999-2002
Central Iowa Pharmacists' Association 1999-2002
The Gerontological Society of America 1998-2000
American Geriatrics Society 1998-2000
Rho Chi Honor Society
Phi Delta Chi Pharmacy Fraternity
Phi Kappa Phi Honor Society
Indiana Pharmacists' Association 1992-1996; 2003-present

Journal Publications (Peer Reviewed)

Plake KS, Chesnut RJ, and Biebighauser S, (2003) "Impact of a Diabetes Certificate Program on Pharmacists' Diabetes Care Activities." *American Journal of Pharmaceutical Education* (in press).

Johnson JF, Plake KS, and Tice BP, (2003) "Involvement of a Pharmacy College in a Community Diabetes Improvement Project." *Journal of Pharmacy Teaching* (in press).

Plake KS, (2003) "A Course on Chronic Illness: Learning the Patient's Perspective." *American Journal of Pharmaceutical Education*, 67, 31-42.

Barner JC, Desikan R, Plake KS, Purkerson DL, Gupchup GV, Popovich NG, and Mason HL, (1998) "Survey of Course Curricula of Graduate Programs in Social and Administrative Sciences." *American Journal of Pharmaceutical Education*, 62, 128-135.

Popovich NG, Plake KS, Vanvelhuizen-Scott MK, (1996) "Evaluation of Student Attitude Toward Learning from Homework Assignments." *American Journal of Pharmaceutical Education*, 60, 275-281.

Plake KS, Wolfgang AP, (1996) "Impact of Experiential Education on Pharmacy Students' Perceptions of Health Roles." *American Journal of Pharmaceutical Education*, 60, 13-19.

Wolfgang AP, Gupchup GV, Plake KS, (1995) "The Relative Importance of Performance Criteria in Promotion and Tenure." *American Journal of Pharmaceutical Education*, 59, 342-347.

Wolfgang AP, Plake KS, (1994) "Development and Assessment of an Undergraduate Elective Course in Health Policy." *American Journal of Pharmaceutical Education*, 58, 279-283.

Presentations (with peer reviewed abstracts)

Plake KS, Wilhite T, and Krypel L. "Implementation of a Nonprescription Medication Use Service: The Student Experience," AACP Annual Meeting, Minneapolis, MN, July 2003.

Johnson J and Plake KS. "A Survey of Outcomes in a Diabetes Camp for Youth in Iowa," AACP Annual Meeting, Minneapolis, MN, July 2003.

Porter J and Plake KS. "Attitudes of Pharmacists Towards Emergency Contraception," Pharmacy Student Research Conference-Western Region, Denver, CO, May 2003.

Plake KS. "A Course on Chronic Illness: Learning the Patient's Perspective," AACP Annual Meeting, Kansas City, MO, July 2002.

Plake KS. "Development and Evaluation of a Health Behavior Module," AACP Annual Meeting, Kansas City, MO, July 2002.

Plake KS, Chesnut RC, and Biebighauser S. "Evaluation of a Diabetes Certificate Program," AACP Annual Meeting, Kansas City, MO, July 2002.

Sarvis C, Tice A, and Plake KS. "Evaluation of Inhaler Technique Using the Aerosol Inhalation Monitor (AIM)," APhA Annual Meeting, Philadelphia, March 2002.

Plake KS, and Larson L. "Critical Incidents in Pharmacy Education and Professionalization," AACP Annual Meeting, Toronto, Canada, July 2001.

Johnson J, Plake KS, and Tice B. "Involvement of a Pharmacy College in a Community Diabetes Improvement Project," AACP Annual Meeting, Toronto, Canada, July 2001.

Larson L, Bjornson D, Phillips C, Plake KS, and Dewitt J. "An Innovative Curriculum in the Social and Administrative Sciences," AACP Annual Meeting, Toronto, Canada, July 2001.Plake KS, Mason HL, Wolfgang AP. "Lessons Learned from a Community Interdisciplinary Health Care Team Research Experience," APhA Annual Meeting, Washington D.C., March 2000.

Plake KS, Mason HL,Wolfgang AP. "Proposal Poster Presentation: Impact of Interdisciplinary Health Care On Elderly Patients Quality of Life and Health Care Costs," APhA Annual Meeting, Miami, FL, March 1998.

Plake KS, Wolfgang AP. "Proposal Presentation: Impact of Interdisciplinary Health Care On Elderly Patients Quality of Life and Health Care Costs," Midwest Pharmacy Administration Meeting, Madison, WI, August 1996.

Barner JC, Desikan R, Gupchup GV, Plake KS, Purkerson DL, Popovich NG, Mason HL. "Survey of Research Methodology Courses for Graduate Students in Social and Administrative Sciences and Pharmacy Practice," AACP Annual Meeting, Reno, NV, July 1996.

Carter RA, Plake KS. "BARS Instrument to Assess Pharm.D. Students' Academic Preparedness to Enter Clerkship: Comparison of Traditional and Nontraditional Program Students," AACP Annual Meeting, Reno, NV, July 1996.

Wolfgang AP, Gupchup GV, Plake KS. "The Relative Importance of Performance Criteria in Promotion and Tenure Decisions: Perceptions of Pharmacy Faculty Members," AACP Annual Meeting, Philadelphia, PA, July 1995.

Wolfgang AP, Plake KS. "Utilization of a 'Classroom Polling' Assessment Technique in an Elective Health Policy Course," AACP Annual Meeting, Philadelphia, PA, July 1995.

Plake KS, Wolfgang AP. "Impact of Experiential Education on Pharmacy Students' Perceptions of Health Roles," AACP Annual Meeting, Philadelphia, PA, July 1995.

Maciak CA, Plake KS, Gupchup GV, Wolfgang AP. "Consumer Opinions on Prescription Drug Insurance Benefits," APhA Annual Meeting, Orlando, FL, March 1995.

Wolfgang AP, Plake KS. "Development and Assessment of an Undergraduate Elective Course in Health Policy," AACP Annual Meeting, Albuquerque, NM, July 1994.

Plake KS, Wolfgang AP. "Impact of Experiential Education on Pharmacy Students' Perceptions of Health Roles," Midwest Pharmacy Administration Conference, Iowa City, IA, August 1994.

Plake KS, Wolfgang AP. "Older Adults and Prescription Drugs: An Analysis of Need, Economic Barriers, and Quality of Life," APhA Annual Meeting, Seattle, WA, March 1994.

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Scott W. Simerly, Ph.D.

Position	Manager
Education	M.B.A., West Virginia University, Morgantown, West Virginia, 1996 Ph.D., Chemistry, University of Illinois, Urbana, Illinois, 1991 B.S., Chemistry, Iowa State University, Ames, Iowa, 1986
Employment History	8 years experience with Myers and Stauffer 1996 to present
Experience Relevant to this Proposal	Dr. Simerly joined Myers and Stauffer in 1996 and serves as a manager for the firm's inpatient and outpatient hospital reimbursement and physician reimbursement engagements with government health care agencies. Dr. Simerly leads the firm's DRG recalibration and rebasing projects for the states of Kansas, New Mexico, North Carolina, and West Virginia. His responsibilities include the determination of hospital rates and case mix index factors, calculation of DRG relative weights and outlier thresholds, fiscal impact studies, management of databases, preparation of and other statistical analyses. He was involved in similar projects for the states of Colorado and Oregon.
Other Professional Experience	Dr. Simerly has provided analysis for a per diem inpatient hospital reimbursement system for the state of Louisiana. He is also involved in the evaluation of an outpatient prospective payment system for this state. His responsibilities include determining peer groups and payment rates. Dr. Simerly assisted in the evaluation of the reimbursement of high cost drugs under the Health Care Financing Administration's proposed ambulatory patient classifications (APC) outpatient prospective payment system. He has developed specifications and procedures for a statewide health information database on subcontract with the Kansas Department of Insurance (through Miller and Newberg, Consulting Actuaries). He consulted with the state on database capabilities and design of appropriate queries. In West Virginia, besides the annual updating of the DRG system he is responsible for an annual review of the RBRVS system and the determination of the annual rate update.

He has also constructed modifiable reimbursement models comparing Kansas and Alaska physician reimbursement to surrounding states, Medicare and private insurance rates.

In addition, he has performed statistical analysis of pharmacy survey information for engagements with the states of Kansas and Kentucky.

Presentations

"Price vs. Cost Reimbursement," Myers and Stauffer Workshop, Indianapolis, Indiana, 2003

Publications

"Comparative Reactivity Studies of $[Re_7C(CO)_{21}Rh(CO)_2]^{2-/1-}$. Evidence of Enhanced Inter- and Intramolecular Lability for a Metal Cluster Radical." American Chemical Society Meeting, August 1990.

"Synthesis, Characterization and Crystal Structure of $[PPN][Re_7C(CO)_{21}P(OPh)_3]$. Stereodynamic Comparison with Isoelectronic Heptarhenium Carbido Clusters." *Inorganic Chemistry*, 1992, *31*, 5416.

"Synthesis and Characterization of Tetratolylhydroporphyrins and their N-Methylated Derivatives." Manuscript in preparation (Fall 1996).

References

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Ryan M. Farrell

Position	Senior Financial Analyst
Education	B.A., Finance, Ball State University, Muncie, Indiana, 1999
Employment History	5 years experience with Myers and Stauffer 1999 to present
Experience Relevant to this Project	Mr. Farrell serves as a senior health care policy and reimbursement consultant for the firm's hospital and rate setting engagements. His responsibilities include creation and manipulation of complex data sets, analysis of Medicaid expenditure trends, integrity monitoring for Medicaid reimbursement systems, preparation of written and oral reports and presentations, identification of abhorrent provider billing and/or reimbursement practices. Mr. Farrell develops statistical models and assists in developing cost containment strategies for state Medicaid clients. Mr. Farrell brings extensive experience with Medicaid utilization data and Decision Support Systems, Microsoft Visual FoxPro, SQL Server, Microsoft Access and Microsoft Excel. He is also familiar with the format, content and uses for Medicaid claims information, working extensively with HCFA 1500, UB92, Dental, Pharmacy and Shadow Claims received from Medicaid fiscal agent contractors.
Other Professional Experience	Prior to joining Myers and Stauffer, Mr. Farrell obtained a degree in finance from Ball State University. He also gained long term care certification and marketed long-term health insurance.
Presentations	"SMAC for Rx/DME and Medical Supplies," Myers and Stauffer Workshop, Indianapolis, Indiana, 2003 "The Future of Outpatient PPS," Myers and Stauffer Workshop, Indianapolis, Indiana, 2003
References	Gregory L. Puls, Development Officer Zeta Beta Tau Foundation 3905 Vincennes Road, Suite 300 Indianapolis, IN 46268-3057 Phone: (317) 334-1898 x 212 Michelle Mobley, Marketing Manager

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Melenie Burns, CPA

Position	Senior Accountant
Education	B.A., Accounting, Ball State University, 1996
Certification	Certified Public Accountant
Employment History	4 years experience with Myers and Stauffer 2000 to present
Experience Relevant to this Project	Ms. Burns, a senior accountant with Myers and Stauffer, is responsible for Disproportionate Share Hospital (DSH) consulting for the firm's contract with Indiana's Office of Medicaid Policy and Planning. This includes review and analysis of federal and state legislative initiatives and participation in policy discussions related to Intergovernmental Transfers (IGT), DSH, and Upper Payment Limit (UPL). Her duties include reviewing and analyzing hospital specific limits, computing hospital eligibility for enhanced payments, and coordinating with the fiscal agent contractor and Office of Financial Management (OFM) for the release of enhanced payments. She assists the OFM and state budget agency in monitoring account balances for the indigent care trust fund, attends and monitors fund distributions, and coordinates and meets with the hospital association. Her experience includes preparing public notices, state plan amendments and regulatory changes. Ms. Burns has also been actively involved in other hospital reimbursement projects including policy and procedure analysis, survey research, data collection, data and financial analysis, reimbursement and medical policy consulting and cost report reviews and audits.
Other Professional Experience	Prior to joining Myers and Stauffer, Ms. Burns was a staff accountant with David Culp and Company, a public accounting firm. Dates of employment 1997 – 2000. Her primary responsibilities included planning and directing audits, data analysis and financial statement and tax return preparation.
Other Training	HFMA Medicare Cost Report Training – July 2000
Affiliations	AICPA Indiana CPA Society

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W. Gregory Cecil, CPA

Position	Manager
Education	B.S. Business Administration, Indiana University, 1983 Concentration in Accounting
Certification	Certified Public Accountant Certified Government Financial Manager
Employment History	13 years experience with Myers and Stauffer 1991 to present
Experience Relevant to this Project	Mr. Cecil has 20 years of accounting experience in both industry and public accounting, almost all of which has been in the health care field. As a manager with Myers and Stauffer, he oversees quality assurance for the Indianapolis office. During his career with Myers and Stauffer, he has performed or supervised the desk review of provider financial reports resulting in changes to their Medicaid long term care rates. This process includes the application of Medicaid rate setting criteria and generally accepted accounting principles to provider submitted financial and statistical data to arrive at the allowed per diem Medicaid rate. He has many years of experience preparing or reviewing provider requests for administrative reconsideration of Medicaid rate determinations. This process includes the explanation and analysis encompassing reporting requirements and data submission, rate setting procedures, calculations, methodologies and other rate setting issues. Mr. Cecil compiled evidentiary material for use in administrative appeal hearings and provider litigation in various jurisdictions, including support for Medicaid reimbursement systems, residential care program reimbursement systems and other relevant issues contested. He has also compiled information in response to departmental inquiries including developing proforma calculations and methodologies concerning relevant rate setting criteria issues. He supervised the review of provider-submitted documentation requesting a change in provider status to determine if the transactions met Medicaid criteria requirements for new provider certification. In addition he worked with the Iowa Department of Human Services and the Indiana Office of Medicaid Policy and Planning in developing regression and

fiscal impact models for requesting broad based and uniform tax waivers from CMS for nursing facility quality assurance tax plans. This included developing various alternative plans that complied with federal regulations and assisting in drafting state plan amendments and regulations.

He worked with the Minnesota Department of Human Services for the development of a value based reimbursement system for nursing facilities. This involved the use of Medicare cost report data for modeling a case mix reimbursement system that included incentives for rewarding providers for meeting quality and efficiency standards. This included developing fiscal impact models designed to achieve Sate policy objectives, presenting results to State policy makers and stakeholders, and assisting in drafting legislative reports and statutory language.

He supervised the development and implementation of a case mix rate setting computer application system for the establishment of Medicaid rates for nursing facilities. This included establishing documentation standards, specification development, designing data input mechanisms, designing rate calculation processes, designing rate output mechanisms and electronic transmission standards, and informational data report designs. In addition, he has assisted in developing the rate setting methodology including cost reporting forms and instructions for establishing Medicaid rates for nursing facilities based on facility specific resident assessments including drafting regulation language.

He assisted in developing the rate setting methodology for establishing Medicaid rates for CRF/DD providers and ICF/MR providers based on provider historical costs and statistics including cost report forms and instructions, and drafting regulation language. He also assisted in developing the methodology for reimbursing a new licensure level of care for CRFs/DD including assisting the State in negotiating with stakeholders on the cost structure and developing methods for establishing rates as providers under the new licensure level entered the system.

He assisted in developing the rate setting methodology for establishing Medicaid rates for state-operated intermediate care facilities for the mentally retarded including cost report forms and instructions for establishing Medicaid rates, and drafting regulation language.

Mr. Cecil has supervised the desk review of provider financial reports resulting in changes to their residential care program rates since 1995. This process includes the application of residential care program rate setting criteria and generally accepted accounting principles to provider submitted financial

and statistical data to arrive at the allowed per diem rate. He has prepared or reviewed provider requests for administrative reconsideration of residential care program rate determinations. This process includes the explanation and analysis encompassing reporting requirements and data submission, rate setting procedures, calculations, methodologies and other rate setting issues. He also assisted in redesigning the rate setting methodology including cost reporting forms and instructions for establishing rates for residential care programs.

Other Professional Experience

Mr. Cecil has more than five years experience with a retirement center and nursing home chain providing the following duties: preparation and supervisory review of corporate financial statements, analysis and review of issues relating to generally accepted accounting principles, development, implementation and maintenance of internal control procedures, and supervision and training of accounting staff.

Affiliations

American Institute of Certified Public Accountants
Indiana CPA Society
Association of Government Accountants

Presentations

"Federal Funds Maximization," Myers and Stauffer Workshop, Indianapolis, Indiana, 2003

"Nursing Facility Reimbursement Regulation Changes," Nursing Homes Administrators Seminar, Cloverdale, Indiana, June 2002

Rate setting workshop for the Indiana Division of Disability, Aging and Rehabilitative Services. The presentation was to room and board assistance providers, assistance of residents in county home providers and accountants who provide consulting services to health care providers. May 1994.

References

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Andrew C. Johnson, CPA

Position	Staff Accountant
Education	B.S., Accounting, Indiana University/Purdue University at Indianapolis, Indiana, Kelley School of Business, Indianapolis, Indiana, 1999
Certification	Certified Public Accountant
Employment History	3.5 years experience with Myers and Stauffer 2000 to present
Experience Relevant to this Project	Mr. Johnson, an in-charge accountant with Myers and Stauffer, performs Medicaid long-term care cost report reviews for the firm's state agency clients. His responsibilities include review of provider documentation and performing analytical reviews. He is also responsible for incorporating both financial and MDS audits into rates. Mr. Johnson's audit responsibilities include verifying accuracy of data received from other state contractors, implementing changes as needed into rates and recommending penalties as required by rule. In addition, he assists on rate setting projects for the firm. Currently, Mr. Johnson is a team lead assisting the state of Minnesota on conducting time studies at nursing facilities. The data collected is being used to establish weights for RUG scores of special needs units (i.e. Huntington, Alzheimer and Traumatic Brain Injury) to be used in implementing a Case-Mix reimbursement system. Along with cost report reviews, Mr. Johnson has assisted the state of North Carolina with updating the state's private ICF/MR Medicaid reimbursement process. The project included analyzing cost data to develop rate medians. Those medians were used to model rate impact for the state and individual providers. The project also requires analysis between implementing either NC-SNAP or DDP assessment tools into the reimbursement methodology. In addition, Mr. Johnson has worked on assisting the state of Indiana and Iowa on the electronic submission of long-term care cost reports. The projects included designing programs that can be transferred by electronic means from providers to the rate setting contractors. The programs have been designed to meet state filing requirements as well as assist the rate setting contractors to detect any deficiencies in the report.

He has also been involved in modeling revisions to the Residential Care Assistance Program (RCAP) reimbursement system in the state of Indiana. Mr. Johnson has projected expenditures to assist in budget analysis and to evaluate the effect of proposed changes to the reimbursement rates. He has also assisted in the modeling of the new reimbursement systems including the design of the new cost report form for the RCAP program.

Other Professional Experience

Mr. Johnson previously served as a staff accountant for five years at Charles A. Spillman and Company, PC. Employment dates 1995 to 2000. In this position, he audited financial statements and prepared tax returns for both corporate and individual clients. His clients included doctors' and lawyers' offices, manufacturers, and contractors. Mr. Johnson also performed budget analysis and prepared forecasts and projections for management purposes as well as for obtaining financing. He was the team leader on several software consulting engagements. He prepared income and payroll tax returns for both federal and state governments.

Affiliations

American Institute of Certified Public Accountants
Indiana CPA Society

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Donald W. Catron, CPA

Position	Audit Supervisor
Education	B.S., University of Kansas, Lawrence, Kansas
Certification	Certified Public Accountant
Employment History	6 years experience with Myers and Stauffer 1998 to present
Experience Relevant to this Project	Mr. Catron is an audit supervisor with Myers and Stauffer with a focus on health care audits for state Medicaid agencies. Mr. Catron provides audit and reimbursement services for the long term care facilities in the state of Colorado (February, 1994 - Present), audit and reimbursement services for the long term care and ICF/MR facilities in the state of North Carolina. (April, 2000 - Present), and audit and reimbursement services for the long term care facilities and home health agencies in the Commonwealth of Kentucky (May, 1995 - December, 2000). His experience includes the analytical review of cost reports, pre-field planning and field testing of financial records including payroll, resident funds, property and equipment, cash, leases and expenses. He applies Medicaid laws and regulations to provider cost reports and accounting information, GAAP to financial reporting of providers and GAAS to audit planning, audit program provisions, and audit evidence. He communicates with providers regarding audit questions and adjustments and prepares documentation. He conducts exit conferences and communicates audit findings.
Other Professional Experience	Mr. Catron's previous experience includes researching laws and regulations for application of Internal Revenue Code and Regulations for client tax return preparation. In this capacity, he routinely researched complex tax issues and interviewed and counseled tax clients. He also has six years experience in public accounting performing audit, accounting and tax and computer consulting. His clients included a wide variety of for-profit and not-for-profit entities, as well as individuals.
References	Anna Bransford, Financial Manager Medical Assistance Division 2025 S. Pacheco Street, B-100 Santa Fe, NM 87505

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Cheryl L. Richter, CIA

Position	Staff Accountant
Education	M.S., International Business Concentration Management, Roosevelt University, Schaumburg, Illinois, 2000 B.S., Accounting and Business Administration, Judson College, Elgin, Illinois, 1994, Graduated with High Distinction
Certification	Institute of Internal Auditors Certified Internal Auditor
Employment History	2 years experience with Myers and Stauffer 2001 to present
Experience Relevant to this Proposal	Ms. Richter serves as a staff accountant for Myers and Stauffer. She is responsible for conducting field audits following agreed upon procedure reviews of hospital cost reports to determine actual cost for establishment of the DRG base rate. Her duties include cost analysis of charges, review of state allocation methods and records and analytical procedures to determine risk areas utilizing comparative data. She has performed pharmacy desk reviews and field examinations of cost surveys for the states of Texas and Kentucky. Ms. Richter has performed desk reviews of Freestanding Rural Health Clinic Settlements for the state of North Carolina. Ms. Richter is currently working on the New Mexico Medicaid long term care engagement. She is responsible for conducting desk reviews following agreed upon procedures to assist in evaluating Long-Term Care Facility Financial and Statistical Reports (Cost Reports) for nursing facilities and intermediate care facilities for the mentally retarded (ICF/MR). Her duties include defining materiality levels, identifying risk areas and relevant findings to be incorporated into the development of the Desk Review plan.
Other Professional Experience	Ms. Richter's previous experience includes serving as an auditor for Sears, Roebuck and Company. Employment dates 2000 to 2001. She assisted with the audit planning including control and risk assessments. She created and conducted audit testing and ensured that all audit program objectives were met. She also served as a compliance auditor for UDL Laboratories Pharmaceutical Repackager (subsidiary of Mylan Laboratories). Employment dates 1997 to 2000. She was responsible for audit compliance with Code of Federal

Regulations. She prepared ARCOS reports for submission to the DEA and coordinated and conducted training on cGMP regulations.

She worked for the Audit Bureau of Circulations as a technical reviewer and reviewed auditor work papers for completeness and accuracy. She provided performance feedback to audit staff management for follow-up and assisted clients with preparation of circulation Publisher's Statements. She also compiled trade journal publication circulation data for industry news releases.

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Michael L. Evans

Position	Senior Accountant
Education	B.S., Accounting, Illinois Wesleyan University, Bloomington, Illinois
Employment History	5.5 years experience with Myers and Stauffer 1998 to present
Experience Relevant to this Project	Mr. Evans, a senior accountant with Myers and Stauffer, has more than 20 years of audit and reimbursement experience. He has served as lead auditor on many of the firm's engagements for state agency clients including a recent hospital consolidation project. Mr. Evans is currently assisting the firm on special projects for the U.S. Department of Justice and the federal Health Care Financing Administration. In addition, he has assisted two fiscal intermediaries performing cost report audit and verification duties. His experience encompasses skilled nursing facilities, hospitals and home health agencies. Mr. Evans has served as the in-charge auditor on three home health agency focused reviews that were performed under contract for Wellmark, Inc., a Medicare fiscal intermediary. Prior to joining Myers and Stauffer, Mr. Evans worked for a Medicare fiscal intermediary and provided provider education in the areas of reimbursement and cost report preparation, rate setting and monitoring, cost report desk reviews and field audits related to both freestanding and provider-based home health agencies. During his eight-year tenure as reimbursement supervisor for a hospital with a large provider-based home health agency, he was responsible for interim rate/cost limit computations and monitoring, payment verifications, cost report preparation, Medicare audits and updates on regulatory changes affecting HHA reimbursement.
Other Professional Experience	Mr. Evans' previous experience includes more than ten years serving as the third party reimbursement specialist for all Medicare, Medicaid and Champus reimbursement functions at two different large hospitals. His duties included payment verifications, cost report preparation and filing, interim rate computations and monitoring, intern and resident tracking and reporting, and computation of monthly contractual allowances. He also maintained current knowledge of reimbursement regulations and compliance issues and provided

upper management with interpretations and financial impact computations of new and proposed regulations.

Mr. Evans has more than 12 years Medicare audit and reimbursement experience with two different Medicare fiscal intermediaries. He was responsible for Medicare audits, desk reviews and rate setting functions for all types of Medicare providers including skilled nursing facilities, hospitals, home health agencies and other types of providers. His duties also involved provider relations and training.

Presentations

"CCH: Research and Internet-Based Training," Myers and Stauffer Workshop, Indianapolis, Indiana, 2003

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Robyn Pugh

Position	Accounting Supervisor
Education	B.B.A., Accounting, Washburn University, Topeka, Kansas, 1995
Employment History	8 years experience with Myers and Stauffer 1996 to present
Experience Relevant to this Project	Ms. Pugh serves as project supervisor and performs desk reviews, field audits and computes settlements for skilled nursing facilities, hospitals, home health agencies and federally qualified health centers cost reports submitted by providers for Myers and Stauffer engagements with the following state agencies:

- New Mexico Human Services Department
- Kentucky Department for Medicaid Services
- Louisiana Bureau of Health Services Financing
- North Carolina Department of Health and Human Services
- Colorado Department of Health Care Policy and Financing

She participated in the design of the status log database for the New Mexico Human Services Department project, which established a tracking system for cost reports through various phases of the project.

Her auditing and desk review responsibilities include the analysis of exceptional cost profiles for variances, verification and computation of TEFRA target rates, verification of charge and utilization data and the computation of settlement amounts. She applies GAAS to audit planning, audit program provisions and audit evidence and applies GAAP to financial reporting of providers.

In addition, she conducts field testing of financial records including expenses, cash, leases, payroll, and property and equipment. She conducts exit conferences, communicates with providers concerning audit questions and adjustments and reviews work performed by support staff.

Ms. Pugh participated in the establishment and implementation of Prospective Payment System (PPS) rates for FQHC and RHC in New Mexico and Arizona.

Other Professional Experience

Ms. Pugh's additional experience includes conducting quarterly analytical reviews of financial data, observing inventory procedures and interviewing client personnel with a state lottery system.

References

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Christopher R. Maben

Position	Senior Accountant
Education	B.S., Business Administration, Kansas State University, Manhattan, Kansas, 1992
Employment History	8 years experience with Myers and Stauffer 1996 to present
Experience Relevant to this Project	Mr. Maben serves as senior accountant and performs desk reviews, field audits and computes settlements for skilled nursing facilities, hospitals, home health agencies and federally qualified health centers. He has assisted with the following state agencies:

- New Mexico Human Services Department
- Kentucky Department of Medicaid Services
- Colorado Department of Health Care Policy and Financing
- North Carolina Department of Medical Assistance

His auditing and desk review responsibilities include:

- Analytical review of cost reports.
- Prefield planning.
- Field testing of financial records including payroll, resident funds, property and equipment, cash, leases and expenses.
- Application of Medicaid laws and regulations to provider cost reports and accounting information
- Application of GAAP to financial reporting of providers.
- Application of GAAS to audit planning, audit program provisions and audit evidence.
- Communication with providers regarding audit questions and adjustments.
- Communication of audit findings.
- Documentation of issues and rationale for position.
- Exit conference issues.

References

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Robert J. Hicks, CPA

Position	Senior Accountant
Education	B.S., Accounting, University of Missouri at Kansas City, 1994
Certification	Certified Public Accountant
Employment History	Less than 1 year experience with Myers and Stauffer 5 years with TriSpan Health Services 1999 to 2004
Experience Relevant to this Project	Previous to being employed by Myers and Stauffer, Mr. Hicks was a supervising senior auditor, Medicare audit for Tri Span Health Services. His job responsibilities required an extensive understanding of the Medicare environment. His job duties included performing Medicare desk reviews/focused reviews of various health care providers, supervisory review of auditors' Medicare desk reviews/focused reviews of various health care providers, implementation of new Medicare regulations, designed and maintained updated Medicare desk review checklists. Mr. Hicks assisted health care providers and consultants with Medicare regulation interpretations. Mr. Hicks supervised seven Medicare staff auditors, in-charge auditors and senior auditors.

Holly L. Ross

Position	Senior Accountant
Education	B.S., Accounting, Moorhead State University, Moorhead, Minnesota, 1995
Certification	Candidate for Certified Public Accountant
Employment History	6 years experience with Myers and Stauffer 1998 to present
Experience Relevant to this Project	Ms. Ross has more than eight years of experience as an accountant with a focus on health care auditing and auditing-related tasks. She has supervised home health staff with responsibility for the final review of cost reports, consultation with external clients and project team leadership. Ms. Ross is responsible for the final review of case mix rates. Her duties involve the development of staff accountants, analysis of desk reviews and reconsiderations. In addition, she provides rate setting and final review of group home rates including the application of criteria, rate setting methodology and analysis of reporting requirements. Ms. Ross has assisted with the implementation of new case mix reimbursement systems for nursing facilities, assisting with fiscal impact analyzes, and review of Medicaid rate calculations for accuracy and compliance with administrative rules. Ms. Ross served as accountant for a Medicaid Waiver project. She was responsible for assisting with cost survey design, writing cost survey instructions, performing on-site cost survey reviews and training providers and staff accountants. As consultant to a Medicaid fiscal agent, she assisted in the development of a bank reconciliation system, reviewed financial internal controls and wrote computer service requests for the enhancement of IndianaAIM. Ms. Ross served as accountant for a Medicaid accounts receivable project. She was responsible for assisting with the identification of potential policy and procedure modifications to minimize account receivable, consulting with the Medicaid fiscal agent and external clients.

In addition, she has served as accountant for a Medicare on-site focused review project and was responsible for the review of resident medical records, payroll reports and timekeeping logs.

Other Professional Experience

Ms. Ross served as an auditor with a Medicare fiscal intermediary. Her responsibilities involved in-depth reviews of medical financial statements to determine appropriate Medicare reimbursement.

She served as an accountant for an international agricultural company. She was responsible for accounts payable, general ledger, inventory and financial system conversions.

She served as an intern for Diagnostic Medical Systems Company. Her duties included cash management statement preparation, accounts payable, accounts receivable and general ledger.

Ms. Ross also served as auditor for a state lottery. In this capacity, she complied audit work papers and verified compliance with GAAP and state laws.

In total, Ms. Ross' accounting experience has included a broad range of duties, including exposure to various general ledger software packages, the handling of financial statements and financial accounts payable/receivable activities, auditing, and financial consulting services.

References

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Joann McMasters

Position	Financial Analyst
Education	B.A., Secondary Education, Math and Business Administration, Indiana State University, 1965
	PL/SQL class for advanced users at Oracle Education Center, 1999
Employment History	8 years experience with Myers and Stauffer 1996 to present
Experience Relevant to this Project	A technical services coordinator with Myers and Stauffer, Ms. McMasters is responsible for database management and supervision of all help desk activities for long term care facilities.

- Indiana Case Mix Project – February 1996 to present

Ms. McMasters organized and implemented the help desk operations for nursing facilities in April 1996. During the initial set-up phase, the help desk provided assistance to 528 Medicaid-certified facilities to begin transmission of the MDS data to the state BBS collection system. All 528 facilities successfully transmitted MDS data files within the first 90 days of implementation. This required resolution of many technical issues with vendor software, facility hardware and numerous connectivity issues.

She was instrumental in the development of the Time-Weighted Roster Report for case mix reimbursement and the production of the OMPP Resident Profile Report. She verified case mix reports for accuracy of data and created queries to produce statistical reports on various clinical issues using MDS data.

Ms. McMasters managed the Indiana CMS MDS database and communication servers from June 1998 to May 2000. She currently supervises and coordinates all activities of technical help desk representatives. She has analyzed MDS and OASIS data to ensure data integrity and implemented plans to correct a major data integrity issue with gender discrepancy on over 3,500 assessments in 2000. In May 2000 all providers were issued new user Ids and passwords to connect to the CMS MDS server. At this time the method of connecting to upload files was changed. The Myers and Stauffer help desk assisted all providers with the new user Ids, passwords, and with all connection and security issues with Internet Explorer and Netscape. In addition, she participated in the CMS/IFMC Error Edit task force project for

MDS and OASIS. This project involved editing the existing error message for the implementation of the 1.10 data specifications for MDS. The team also added definitions and tips to these edits to enhance the use and readability of the Error Message document for facility use. OASIS transmission training was provided to all Indiana HHA during spring 2000.

- Kentucky Medicaid Rate Setting Case Mix Project

Ms. McMasters' responsibilities included setup of a CMS parallel server, installation of software, restoration of data files using Arcserve for NT, and set-up of the Oracle databases and the DMS software. She created queries to produce statistical reports using MDS data, determined and verified a unique identifier for Medicaid facilities, verified Medicaid case mix reports for accuracy of data and discovered that the state set-up for data collection utilizing the three-page quarterly form was not collecting all required fields to produce a RUG value for the quarterly assessments. Ms. McMasters developed a plan that allowed the Medicaid office to produce a RUG score on the assessments that were collected during the time period that the state was not collecting all the required data. In addition, she provided training to staff to continue this project at the firm's Kentucky office. Quality assurance for all Medicaid reports is performed by the Indianapolis Myers and Stauffer help desk staff.

- Virginia Case Mix Project

Ms. McMasters' responsibilities included setting up a CMS parallel server, imported Oracle tables and created a new instance of Oracle MDS tables on the CMS parallel server. She analyzed the data and discovered that not all RUG fields on the three-page quarterly were being collected.

- Iowa Case Mix Project

Ms. McMasters' responsibilities included setting up a CMS parallel server, imported Oracle tables and created a new instance of Oracle MDS tables on the CMS parallel server. She analyzed the data and discovered that not all RUG fields on the three-page quarterly were being collected. In order to comply with HIPAA requirements a method to extract the MDS Oracle data was designed and put in use in April 2003. This required changes to the method of importing the data on the CMS parallel server and additional quality assurance checks to ensure that with this new method all MDS data was being received for the case mix project. Quality assurance checks are performed to ensure that the residents selected for the case mix roster are appropriate and have the correct payor type assigned.

- Louisiana Case Mix Project

Ms. McMasters' responsibilities included setting up a CMS parallel server, imported Oracle tables and created a new instance of Oracle MDS tables on the CMS parallel server. She analyzed the data and discovered that not all RUG fields on the three-page quarterly were being collected. MDS Oracle data is updated twice a quarter. Case Mix Roster Listings are issued twice a quarter and quality assurance checks are performed to ensure that the residents selected for this roster are appropriate and have the correct payor type assigned. Case Mix roster listings are prepared and mailed to providers. PHI guidelines are adhered to in the distribution of the case mix roster listings and in the management of the MDS Oracle tables.

- North Carolina Case Mix Project

Ms. McMasters responsibilities included setting up an Oracle parallel server to store the NC MDS data, importing the MDS data into the standard MDS Oracle data structure, ensuing that privacy and confidentially of the PHI is maintained. Data integrity issues (duplicate residents, delinquent or missing assessments) were discovered and communicated to the state. Provider assistance with Medicaid Case Mix reports is being provided.

- Minnesota Case Mix Project

A parallel MDS Oracle server was setup and maintained for the Case Mix project. Resident roster listings that included RUG-III information and payor types for all facilities for multiple time periods were provided to the accountants.

- Mississippi Time Study

The Mississippi time study was conducted during the summer and fall of 2001. Ms. McMasters scheduled the providers and staff for this project. Data integrity, accuracy, and completeness were reviewed for each provider.

- Minnesota Time Study

The Minnesota time study began in the summer of 2003 and will be finished in March 2004. Ms. McMasters and Windy Tamplin were responsible for the scheduling of providers and staff. More rigorous data integrity checks were implemented for this time study. Resident condition update forms (MPAF form) were completed for many of the time study residents. These forms were encoded and imported into the existing MDS data for Minnesota. Resident roster listings were extracted from this data for comparison to information received from the providers and to ensure that the time study data would be easily linked to the MDS data.

Other Professional Experience

Ms. McMasters' previous experience includes 12 years of supervising and coordinating a multi-tier help desk customer service center. She was an instructor at a technical institute for computer systems and software applications for eight years and the faculty director for four years.

Presentations

Ms. McMasters made presentations at the following seminars:

- MDS 101 Technical Report Training, 2001, 2002, 2003
- New Correction Policy and Edit Specifications seminar for long term care facilities at 7 locations, 2000
- Transmission Transition seminar for long term care facilities, 1999
- Electronic Transmission Training seminar for Medicare-only certified nursing facilities, 1998
- Case Mix Documentation Standards Training for long term care facilities, 1998
- OASIS Automation training seminar for home health agencies at 2 locations, 1998
- Ten Steps to Success in MDS Automation seminar for long term care facilities in 8 locations, 1997

References

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Patrice Nicholson, RN

Position	MDS Nurse
Education	B.A., Health Care Administration, Capital University, completed 1993 A.D., Nursing, Sinclair Community College, completed 1974
Certification	Registered Nurse Certified Registered Nurse Assessment Coordinator, 2001
Employment History	9 years experience with Myers and Stauffer 1995 to present
Experience Relevant to this Project	Ms. Nicholson, a nurse consultant with Myers and Stauffer, has 30 years of experience in the nursing field. Ms. Nicholson interprets and analyzes data collected from the MDS 2.0 and teaches the RUG-III resident classification system in both the 34 and 44 grouper. She was an active member of the HCFA Correction Policy committee that developed and designed the new correction policy nationally. Ms. Nicholson has assisted states in designing and developing a medical record review (audit) process for case mix systems and trained appropriate personnel, both state and provider for the past seven years. Ms. Nicholson has experience in the Medicare Prospective Payment System (PPS) used in the skilled nursing facilities. She is knowledgeable about the criteria that determine skilled nursing and skilled rehabilitation levels of care for Medicare SNF. Ms. Nicholson has provided training to nursing facility staff on completion of the Minimum Data Set, PPS assessment schedule, OBRA schedule, PPS RUG-III 44 Group Classification system, and establishing the correct HIPPS codes used to bill Medicare stays to the fiscal intermediary. She also has experience in the Medicare Post Payment Review process and provides consultation to state Medicaid programs to develop a medical record review system to determine whether the clinical record supports the appropriate RUG classification level for the rate setting process. Ms. Nicholson's specific case mix and MDS review experience includes: ▪ North Carolina Division of Medical Assistance – February 2003 to Present Coordinated with DMA the training of RNs to complete the MDS in Adult Care Home population. Modified the MDS2.0 specifically for this group of clients. Once the MDS were complete the data was entered and analyzed and compared to North Carolina long term care population as a comparison. A report was presented to DMA with an analysis in August 2003 and December 2003.

- Louisiana Department of Health and Hospitals – September 2001 to Present

Ms. Nicholson served as assistant project director for the design and implementation of the Louisiana Medicaid MDS review for the previous two years. She trained and supervised RNs in the field and developed the entire review process from the work plan, work papers, and provider education, state facility training to the follow-up reports to the facility. A help desk was developed to assist facility staff regarding report questions. In addition, she has developed and presented two different state training workshops, which included in all, 13 venues and approximately 1800 attendees.

- Indiana Office of Medicaid Policy and Planning – November 1995 to present

As nurse consultant, her responsibilities include developing training materials and providing training on various topics to providers statewide. She works closely with state personnel, performs facility visits throughout the state and trouble-shoots program and user problems. In addition, she assists with clinical help desk calls. Ms. Nicholson has been directly involved in the development of the state audit/validation program for Medicaid.

- Kentucky Case Mix Project – September 1999 to present

As nurse consultant, Ms. Nicholson presented training seminars for the state of Kentucky regarding pre-launch RUG-III resident 34-classification system, various state specific reports and implementation of the 1997 Update 3-page Quarterly. Most recently, Ms. Nicholson has been directly involved in the development of the state audit/validation program for Medicaid.

- State of Florida Case Mix Project – March 1997

As nurse consultant, Ms. Nicholson presented case mix training seminars for the state of Florida.

Other Professional Experience

Director of Nursing, Indiana (1994 - 1995). Responsible for all operations and clinical administration in 130-bed nursing facility. Manager of the 20-bed Medicare unit; responsible for making Medicare level determinations. Assess patients for possible admission to facility, including meeting PASARR criteria. Responsible to screen 450Bs and Level I's. Tracking mechanisms developed to monitor problem areas. Participation in MDS completion and care planning conferences as indicated. Chairman of Quality Assurance operations within the facility.

Director of Nursing, Ohio (1990 - 1994). Responsible for all operations and clinical administration for a 100-bed nursing facility including a 12-bed Medicare distinct unit. Established tracking tools to assure that care was properly provided and documented within the facility. Implemented RAI process as mandated by OBRA '87, including MDS completion, care planning and interdisciplinary care conferences. Worked with RUG-III classification system as the state of Ohio converted to a case-mix payment system with electronic submission of MDS data. Scheduled and presented in-service meetings. Required to manage department within budgetary limitations. Deficiency free survey 1994.

Director of Nursing, Ohio (1990). Responsible for all operations and clinical administration for a new 100-bed nursing facility. Responsibilities included clinical responsibility for opening of a new facility, State of Ohio survey, implementing all clinical management systems, new pharmacy system, hiring and scheduling of new staff during growth period.

Director of Nursing, Ohio (1987 - 1990). Responsible for all operations and clinical administration for a 51-bed nursing facility. Conducted in-house certification training for nurses assistants. Provided consultation to adjoining 19-bed intermediate care facility. Responsible for scheduling and management of clinical staff and services. Functioned as assistant director of nursing prior to appointment as director.

Director of Nursing, Indiana (1985 - 1986). Responsible for total operations of nursing department, including staffing, scheduling, staff meetings, purchasing, quality assurance and regulatory reports in an acute care facility. Functioned as Director of Home Health prior to appointment as Director of Nursing. Responsibilities included client assessments, staff supervision, patient care plans and compliance with regulatory requirements. Planned and organized an emergency care seminar for health professionals and officials in a two-county area. Designed an assessment tool and developed a follow-up audit on billing process which captured previous losses estimated to be $10,000 - $12,000 per year. Assisted in transition in billing patterns to the diagnosis related group (DRG) system.

Registered Nurse/Nurse Supervisor, Indiana (1974 - 1985). Progressive professional development from staff nurse responsible for patient care to house supervisor responsible for overall provision of care and staffing within an acute care facility.

Affiliations

National Association of Subacute and Post Acute Care
National Association of Directors of Nursing Admin/Long Term Care

Indiana Association of Directors of Nursing Admin/Long Term Care

Publications

- Developed state Supportive Documentation Guidelines for Indiana, Kentucky, Louisiana, and North Carolina. Was also submitted to CMS.
- Development and design of a hand reference pocket tool that guides a clinician through the 5.12 34 and 44 RUG-III Grouper. This spiral reference tool has been requested from the east to the west coast.
- Development and design of numerous medical record/MDS audit collection tools for state personnel.
- Developed training criteria for RUG-III classification in both the 5.01 version and the 5.12 version.
- Development of state specific supportive documentation guidelines.
- Development of the Indiana Resident Profile Fact Book.
- Indiana Case Mix Training Manual.
- Various articles in the Case Mix of Indiana newsletter.
- Various articles in the Louisiana Advisor newsletter.

Presentations

Presented RUG-III provider training throughout 10 venues in North Carolina, November 2003.

Presented for the National Association of Subacute/Post Acute Care, September 2003.

Presented for the National Association of Subacute/Post Acute Care, September 2002.

Presented for the national Case Mix Conference 2001: New Frontiers in Health Information, October 2001.

"MDS Validation: Its Affect on Quality of Care, Reimbursement and Policy Issues," Case Mix 2001 Conference, New Frontiers in Health Information, Niagara Falls, Canada, October 2001.

Presented six Medicaid MDS 2.0 audit seminars. Fall 2000.

Presented at the National Case Mix conference addressing how states can improve MDS accuracy. May 2000.

Presented seven seminars throughout Indiana to review the details of the implementation of the new edits and data specs proposed by the Health Care and Financing Administration (HCFA). March 2000.

Presented eight seminars throughout Indiana to review components of the case mix system. Summer 1999.

Presented six seminars in Indiana to provide a thorough review of the Supportive Documentation requirements. March 1999.

Guest speaker at Manchester, England, to present the RUG-III resident classification system and advantages of MDS implementation. March 14, 1999.

Presented six seminars in Indiana to review the new proposed case-mix rule implementation and a thorough review of the Time-Weighted Guidelines for Medicaid rates. December 1998.

Presented RUG-III resident classification system and advantages of MDS implementation at a conference in London, England. December 1998.

Training in the state of Indiana explaining the Medicaid Case Mix Reimbursement System and documentation requirements. A total of 10 seminars were held throughout the state. August/September 1998.

Presented to the American College of Health Care Administrators regarding the RUG-III Classification System. July 1998.

Presented at the Case Mix Documentation Standards Training Seminars held in Indiana where 10 seminars were held throughout the state. June/July 1998.

Presented to the Indiana CPA Society regarding the RUG-III Classification System. September 1997 and September 1998.

Presented at the Indiana Health Care Association Spring conference. Topics included case mix reimbursement and RUG-III resident classification. May 1997.

Statewide training in Indiana in preparation for Case Mix Reimbursement for Medicaid licensed facilities. Total of 16 seminars. April/May and September 1997.

References

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J. Chris Powell

Position	Programmer/Analyst
Education	B.A. Accounting, Washburn University, Topeka, Kansas, 1990
Employment History	8 years experience with Myers and Stauffer 1996 to present
Experience Relevant to this Project	Mr. Powell serves as the primary programmer for hospital rate setting applications developed by Myers and Stauffer. Rate setting applications have been developed for the states of Kansas, New Mexico, North Carolina, West Virginia, Alaska, Iowa, Kentucky and Indiana. His experience includes developing DRG software modules for a Windows environment Mr. Powell also creates programming utility software for DRG engagements, including editing and grouping routines and procedures for relative weight computation.
Other Professional Experience	Mr. Powell has also been a key developer for long term care rate setting modules. His work includes development of cost report entry, tracking, auditing, and reporting systems for New Mexico, Colorado, Kentucky, Indiana and Iowa. He also developed the LTC rate setting module for the state of Kentucky including computation of base year case-mix index. He has also processed the Health Care Utilization Project (HCUP) Nationwide Input Sample (NIS) database from 1994 thru 1999. Mr. Powell's previous experience includes serving as assistant manager for a six-doctor pediatric practice as well as a minor emergency clinic. He provided accounting, payroll and tax work for 12 medical practices as well as programming, installation, training and support for the following: medical billing program, payroll program, time sheet program, time card program and contact manager. He was also an active member of the Kansas Medical Group Management Association for five years. His programming skills include Microsoft Visual FoxPro 6.0 and Visual Basic. His network skills include the complete installation of both hardware and software for several peer-to-peer networks such as Novell Lite and Personal Novell as well as Windows 98. He offers support and administration of Personal NetWare, Windows, MAGIX and UNIX Networks
Presentations	"XFRX, Generic StatLog, Cost Report Data Extraction," Myers and Stauffer Workshop, Indianapolis, Indiana, 2003

Publications	"*Incrementing Numbers and Dates*," FoxPro Advisor, September 1999. The article describes a User Interface that will increment or decrement date, numeric or currency valued fields. “SQL Tip,” FoxPro Advisor, August 1998. The tip was about imbedding inline IF statements in SQL statements.
Affiliations	Midwest FoxPro Users Group
References	Kent Vincent Austin K. Vincent Atty. 2222 SE Pennsylvania Topeka, KS 66605 Phone: (785) 234-0022 Michael L Laccheo, MD 1119 SW Gage Blvd Topeka, KS 66604 Phone: (785) 271-6000 Steve Iliff, CPA 3500 SW Gage Topeka, KS 66606 Phone: (785) 235-2617

Mark Sheehan

Position	Programmer/Analyst
Education	New Palestine High School, 1991
Employment History	8 years experience with Myers and Stauffer 1996 to present
Experience Relevant to this Project	Mr. Sheehan is a senior programmer/analyst with Myers and Stauffer responsible for operation and maintenance of programs and databases for the MDS Case Mix project in the firm's Indianapolis, Indiana office. He routinely performs queries and creates reports on the data, as requested. Currently, Mr. Sheehan is responsible for the development of the electronic review system for the state of Louisiana. That system will be used by teams of nurses to review MDS records and transmit their results back to a central database. For the Minnesota Time Study project, he is responsible for merging time data with resident MDS assessment information and providing the results to analysts for further review. Mr. Sheehan has extensive experience with personal computers using DOS and Windows operating systems. His programming skills include FoxPro, SQL Server, Oracle and BASIC.
Other Professional Experience	Mr. Sheehan previously served as a help desk representative in the firm's Indianapolis, Indiana office (1 year). His responsibilities included providing over-the-phone technical support, BBS maintenance and production of daily reports regarding BBS and help desk activity. He subsequently served as help desk coordinator in the firm's Topeka, Kansas, office (2 years) where he was responsible for providing responses to provider's technical inquiries regarding the electronic submission of MDS 2.0 data and supervising help desk representatives in performing similar duties. He was responsible for maintenance of the HCFA MDS System for the state of Kansas. In addition, he produced a training manual used to instruct nearly 1200+ nursing facilities in Kansas, Idaho, Florida and Nebraska on electronic transmission to the HCFA MDS system. He conducted seven training sessions in Florida and one in Kansas.
References	Greg Arling, Ph.D Associate Professor of Health Administration

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Sally A. Bechtel

Position	Support Staff
Employment History	8 years experience with Myers and Stauffer 1996 to present
Experience Relevant to this Project	Ms. Bechtel oversees the receipt of hospital, FQHC, and RHC cost reports Her duties include, but are not limited to, generating cost report reminder letters, log-in of reports in statlog, and generating follow-up letters. Ms. Bechtel sets up new providers when enrolled into the Medicaid program. She handles hospital, FQHC, and RHC change of ownerships (CHOWS). Her duties in this capacity include, but are not limited to, contacting the provider regarding Myers and Stauffer's function with Medicaid, obtaining provider specific information for the statlog, preparing initial statewide median cost-to-charge ratio and assisting EDS to initialize ratios and other pertinent information. Ms. Bechtel prepares out-of-state hospital cost-to-charge ratios. She performs clerical reviews of hospital and FQHC cost reports. Her duties include reconciliation of expenses and revenues from the trial balance to the cost report, reconciliation of the trial balance expenses and revenue to the audited financial statements, reconciliation of the total patient days from the cost report to the applicable work paper. Ms. Bechtel performs clerical reviews of hospital and FQHC cost reports. Her duties include, but are not limited to, reconciliation of expenses and revenues from the trial balance to the cost report, reconciliation of the trial balance expenses and revenue to the audited financial statements, reconciliation of the total patient days from the cost report to the applicable work paper. She performs desk reviews of hospital cost reports. Her duties include, but are not limited to, reconciliation of the Medicaid Statistical Report (MSR) to the cost report, propose adjustments, as necessary, enter adjustments into Health Financial Systems (HFS) to adjust the days, discharges and charges on the as submitted cost report. Ms. Bechtel participated in on-site medical education reviews in spring and summer 2002. Ms. Bechtel assists providers with DRG inquiries and claim requests.

References

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B. Organization and Staffing Charts
(RFP Section 7.2.10.1.2)

We have successfully established and staffed other office operations following award of a new project and propose a similar approach for this project. Our plan will utilize the following strategies to staff the IME cost audits and rate setting project team:

- Qualified, experienced and proven management talent will relocate from our existing offices to form the core onsite management team.
- Owner management will provide extensive support to the onsite management team.
- Qualified and experienced staff from our existing offices will be offered positions to relocate to the Des Moines area.
- Subject matter experts from our existing offices will provide project assistance during implementation and ongoing support, as necessary.
- Qualified candidates will be recruited from the Des Moines metropolitan area.

Onsite Management

Upon notice of award, we will relocate two highly qualified, experienced, and proven managers. Amy Perry, our proposed Account and Implementation Manager, has been employed with the firm since 1991 and has held numerous positions of increasing responsibility over that time. Most recently, Ms. Perry has managed and supervised several of the firm's large Medicaid engagements in the states of Louisiana and North Carolina. Mr. Tom Donahue, a manager and long term care specialist, has been employed with the firm since 1989 and most recently managed the firm's home health agency and long term care rate setting project for the state of Indiana. Mr. Donahue also provides consulting services to DHS staff on nursing facility and ICF/MR services covered under the firm's contracts with DHS. Both Ms. Perry and Mr. Donahue will be 100% dedicated to the Iowa Medicaid Enterprise project.

Early in the fourth quarter of 2004, we will present to the DHS Project Director a candidate to fill the Operations Manager position that is required by January 1, 2005. This candidate will meet all education, experience and other qualification required by the RFP and be 100% dedicated to the IME project.

Owner Management

Kris Knerr and Jared Duzan will serve as project directors. They are owners in the firm and have ultimate authority and overall responsibility for all components of this project. Each project director currently serves in this same

capacity to DHS. Both Mr. Knerr and Mr. Duzan will each dedicate 50% of their time to the Iowa Medicaid Enterprise project. The majority of their activities will be performed onsite at the temporary office and later at the IME facility. Mr. Knerr and Mr. Duzan are both committed to the success of the IME initiative, and will make all efforts necessary to ensure DHS' complete satisfaction with our services.

Other Myers and Stauffer Staff Relocations

During the implementation phase of the project, management will identify qualified, experienced staff from other Myers and Stauffer offices and offer these staff IME positions and relocation packages. Based on past experience with opening six offices, we anticipate between three and five current employees will accept offers and transfer to Des Moines. These staff will fill positions available in the operations phase, and are anticipated to occur no later than the second and third quarters of 2005. These staff will be 100% dedicated to the IME project.

Subject Matter Experts

During the implementation phase, subject matter experts from our other offices will assist the project team with planning, development and implementation task activities. Subject matter experts are current staff that have knowledge and experience with a particular subject area such as auditing, rate setting, SMAC, revenue maximization strategies, or DRG and APG rebasing. During the implementation phase, we anticipate that up to 10 staff will contribute to the project as subject matter experts. This involvement will vary from as little as a few weeks to several months, depending on the task and responsibilities. These staff will be under the direct supervision and control of our onsite management team and will be onsite at our temporary office and the IME facility as necessary. The overall commitment for subject matter resources during the implementation phase is anticipated at three FTE.

Many operational tasks are specialized in nature and the delivery of service is infrequent. For example, the most labor intensive activities associated with rebasing DRG and APG rates are concentrated during a short time period that occurs only every three years. Having sufficient onsite staff available to meet an intermittent need is inefficient. Therefore, subject to DHS review and approval, we propose to supplement these types of work activities with subject matter expert staff located in our other offices. Any work performed by staff outside of our office at the IME will be under the direct control and supervision of our project management team in Des Moines. As necessary, these staff will perform their activities onsite at the IME. We anticipate the annual involvement of subject matter experts during the operations phase to average two to three FTE per year.

Recruitment

During the implementation phase, we will begin recruitment activities to hire and train qualified staff. Candidates with experience in healthcare auditing, accounting, financial analysis, and programming, as well as administrative support personnel, will be hired and will participate in appropriate training. We expect to hire between 10 and 13 staff from the Des Moines metropolitan area beginning in the first quarter of 2005. These staff will be 100% dedicated to the IME project.

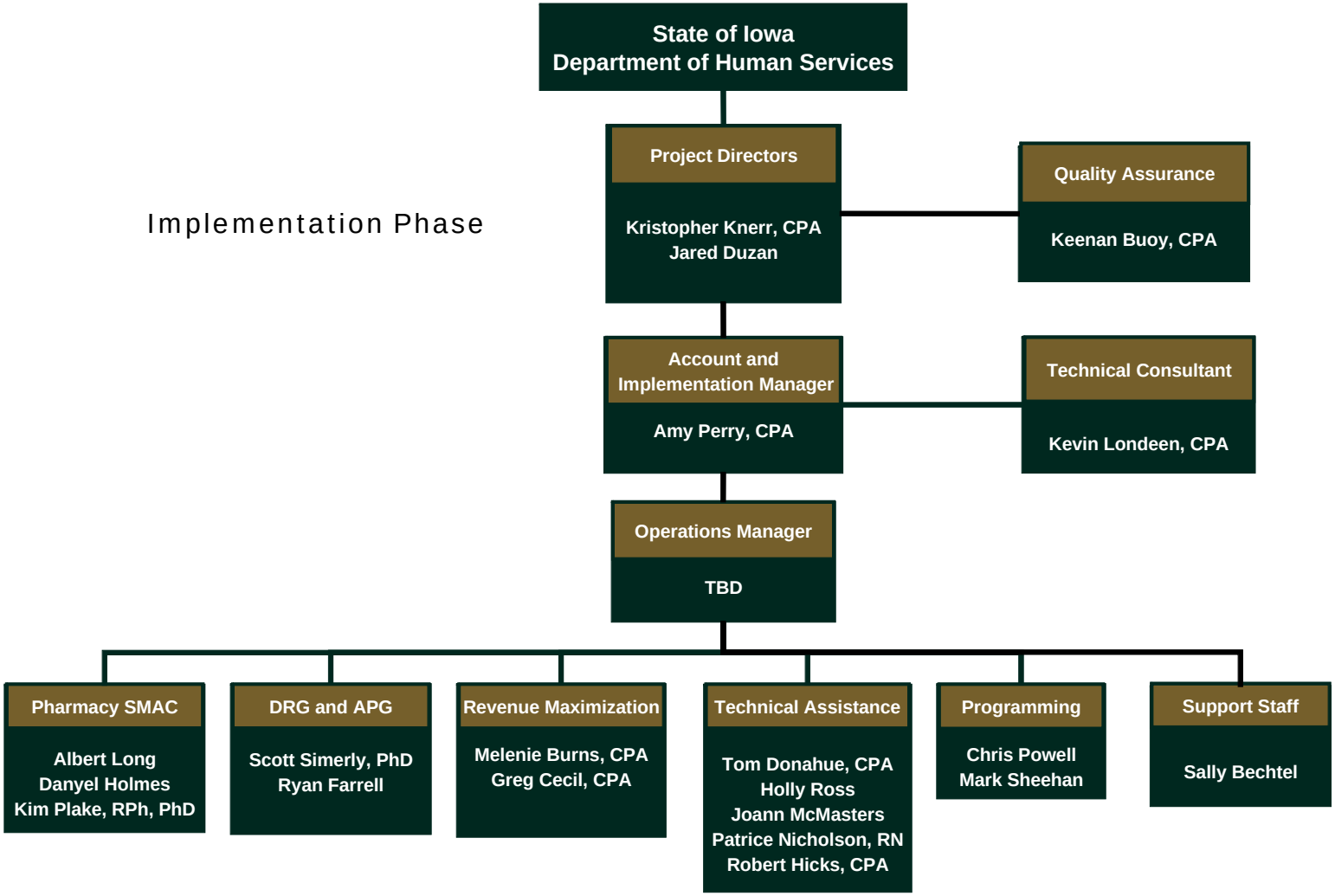
The following table identifies the estimated number of full time equivalent personnel, by staff title, which will be dedicated to the IME cost audits and rate setting project. The table is further broken down between the implementation and operations phases of the project.

Staff Title	FTEs dedicated during Implementation Phase	FTEs dedicated during Operations Phase
Project Director	1	1
Quality Assurance Director	.25	.15
Technical Consultant	.25	.20
Account/Implementation Manager	1	1
Operation Manager	.5	1
Accountants/Auditors	2	7
Paraprofessional		7
Analysts	1.75	1
Pharmacist Consultant	.25	.25
Programmers	1	1
Administrative Support	1	1
Subject Matter Experts (e.g., Nurses, Accountants, Analysts, Programmers)	3	2
Total FTE	12.00	22.6

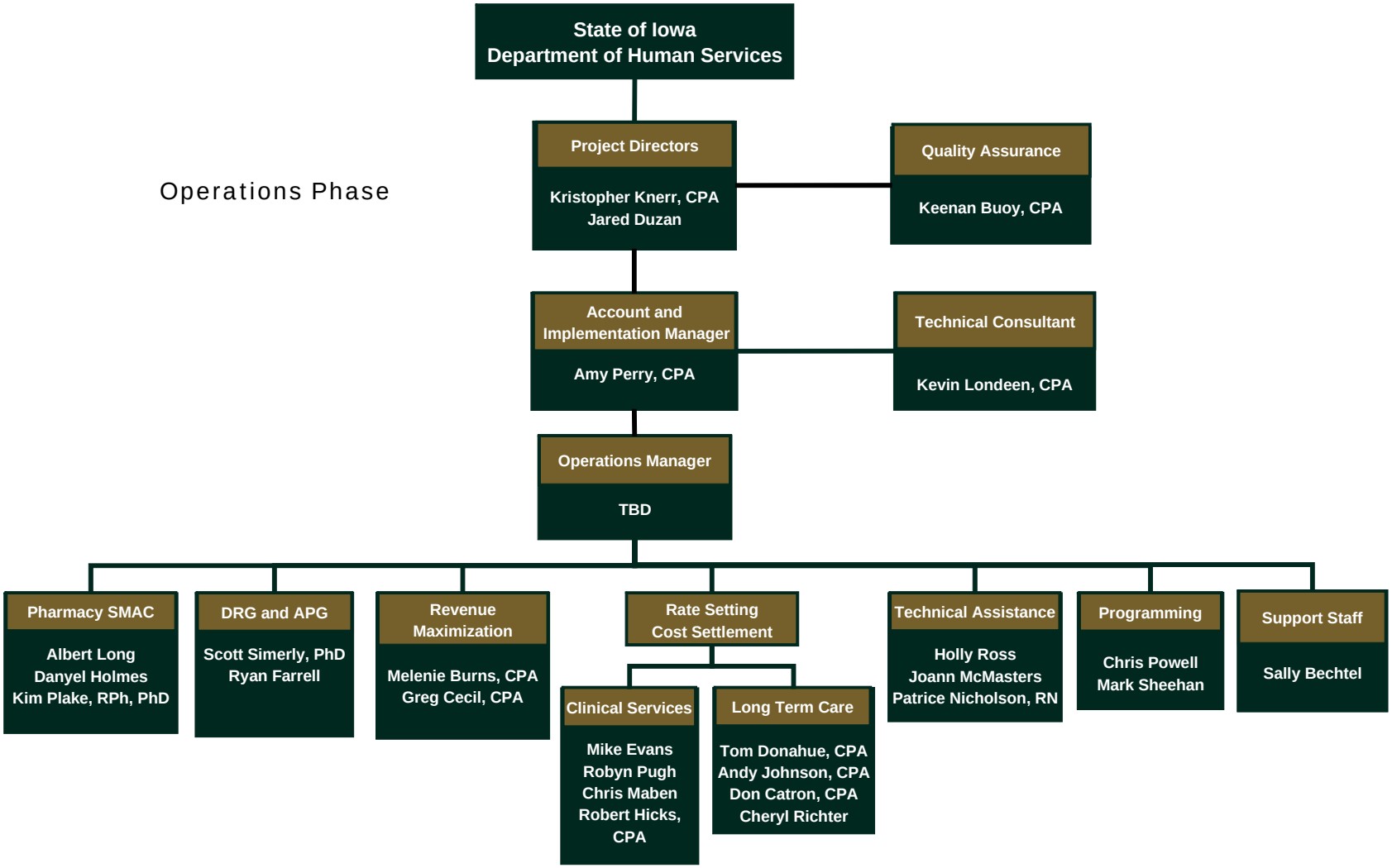
During the operations phase of the project, we expect approximately 22-23 full time equivalent staff will be available to work on project tasks and responsibilities. Nineteen of these staff will be located at the IME facility and dedicated 100% to the provider cost audits and rate setting contract. The remaining staff will be subject matter experts from other Myers and Stauffer offices. This staff will be available onsite at the IME for technical assistance and support as necessary.

The following two organizational charts show our proposed staffing organization to accomplish the work described in the RFP. The first chart shows our organization structure for the implementation phase, followed by our proposed organizational structure for the operations phase. The charts indicate key personnel and additional project staff.

Implementation Phase



Operations Phase



Job Descriptions

The following job descriptions reflect the minimum requirements for the staff positions identified on the organizational chart. These job descriptions reflect staffing categories utilized within our firm.

Managers – Managers are the principal client contact persons. Projects are assigned to managers who coordinate all client services specified in the contract. He/she has the authority to commit the firm to timeframes and delivery of contract services, and respond to client needs, including discussion of contract changes within the firm's policies and procedures. He/she keeps the owners informed of problems and issues that arise on engagements and recommends solutions. Advancement to manager is based on the needs of the firm and individual qualifications.

Supervisors - Supervisors provide day-to-day management oversight, develop and deliver staff training programs and provide supervision of project personnel. In some cases, duties may be similar to managers. They coordinate project staffing, scheduling, and review activities. They communicate with clients and providers regarding routine and non-routine matters, and assist in presentations to clients and or other groups as well as assist in developing, organizing, and writing documents such as audit programs, manuals, reports, and proposals. They also assist in addressing informal reconsideration and appeal issues. Supervisors report to managers, members, or principals.

Seniors - Seniors have sufficient experience to be in-charge of large engagements. They train, coordinate and supervise Staff on team assignments toward completion of designated tasks. Seniors usually are certified public accountants and have at least three to four years of relevant experience. Seniors have an in-depth understanding of one or more practice areas and have achieved sufficient command of procedures and techniques to serve as lead person on a field audit (if applicable) or oversee a project task of similar scope. They assist in preparation of position statements and production of documents for informal reconsideration and appeals.

Staff - Staff are guided by a senior who provides direction, answers questions and reviews engagement progress. Staff are familiar with the policies and procedures of the firm. As staff gain experience and proficiency, they are given more difficult assignments and greater responsibility. They have sufficient knowledge and understanding of routinely assigned tasks to enable their successful completion without close supervision. Experienced Staff will serve as informal training resource for new employees. After gaining some experience, a staff level accountant may be an in-charge on small field

assignments. Staff are college graduates and are usually certified public accountants or CPA candidates.

Programmers/Analysts - Programmers/Analysts are generally experienced in Visual Foxpro, SQL or other data base applications. They have the ability to effectively identify project requirements, develop system designs in a manner consistent with the firm's overall quality control standards, and complete projects (or supervise their completion) in a timely manner. They are able to communicate, verbally and written, with accountants and other programmers to understand project needs, solve problems, document, and design efficient solutions.

Financial analysts - Financial analysts are experienced in analyzing health-related data, reimbursement issues, and other related agency policies and procedures. Financial analysts generally have a degree in finance and at least 1 to 3 years of healthcare experience. They are proficient in current computer tools including MS SQL. Financial analysts work closely with other project staff and assist in developing reports, queries, or other analysis to support a project or engagement.

MDS Nurses - MDS nurses have extensive medical backgrounds and many years of experience with Medicare and various state Medicaid long-term care programs as well as the Minimum Data Set (MDS) and the RUG-III classification methodology including presenting workshops on the proper completion of the instrument and the development of appropriate supporting documentation. They possess excellent organization and communication skills as their responsibilities involve considerable interaction with state agency clients and provider groups. They work closely with project management to insure the successful implementation of state policies and procedures as well as compliance with applicable laws and regulations.

Pharmacist Consultant – Pharmacists serve in the operation and support of a SMAC program by recommending and evaluating drug selection criteria, assisting in the assessment of market sources for drugs, assessing and researching therapeutic equivalency ratings for drugs, assisting in the identification of narrow therapeutic ratio drugs, monitoring other drug issues (shortages, recalls, scientific controversy, etc.), providing pharmaco-economic observations and analysis, assisting with market research and reimbursement rate issues, serving as a professional resource for state staff and peers, providing expert testimony or opinion as necessary, reviewing clinical issues and questions, and by reviewing provider and recipient utilization trends and cases, as necessary. Pharmacists have extensive clinical and academic experience, have attained at least an R.Ph. designation, are knowledgeable of

local and national pharmacy operations and laws and practice standards, and are licensed to practice in at least one state.

Support Staff - Support staff assist other project staff in the successful completion of project tasks. They have excellent communication and organizational skills, good judgment, and the ability to coordinate multiple tasks in a dynamic environment. Qualifications include maturity and proficiency with word processing applications, spreadsheets, and power point.

C. Subcontractors

(RFP Section 7.2.10.1.3)

Myers and Stauffer does not propose any subcontractors for this project. The personnel, facilities and equipment included in this proposal will perform the tasks in this project.

10.2 Draft Project Plan for Contract Phases

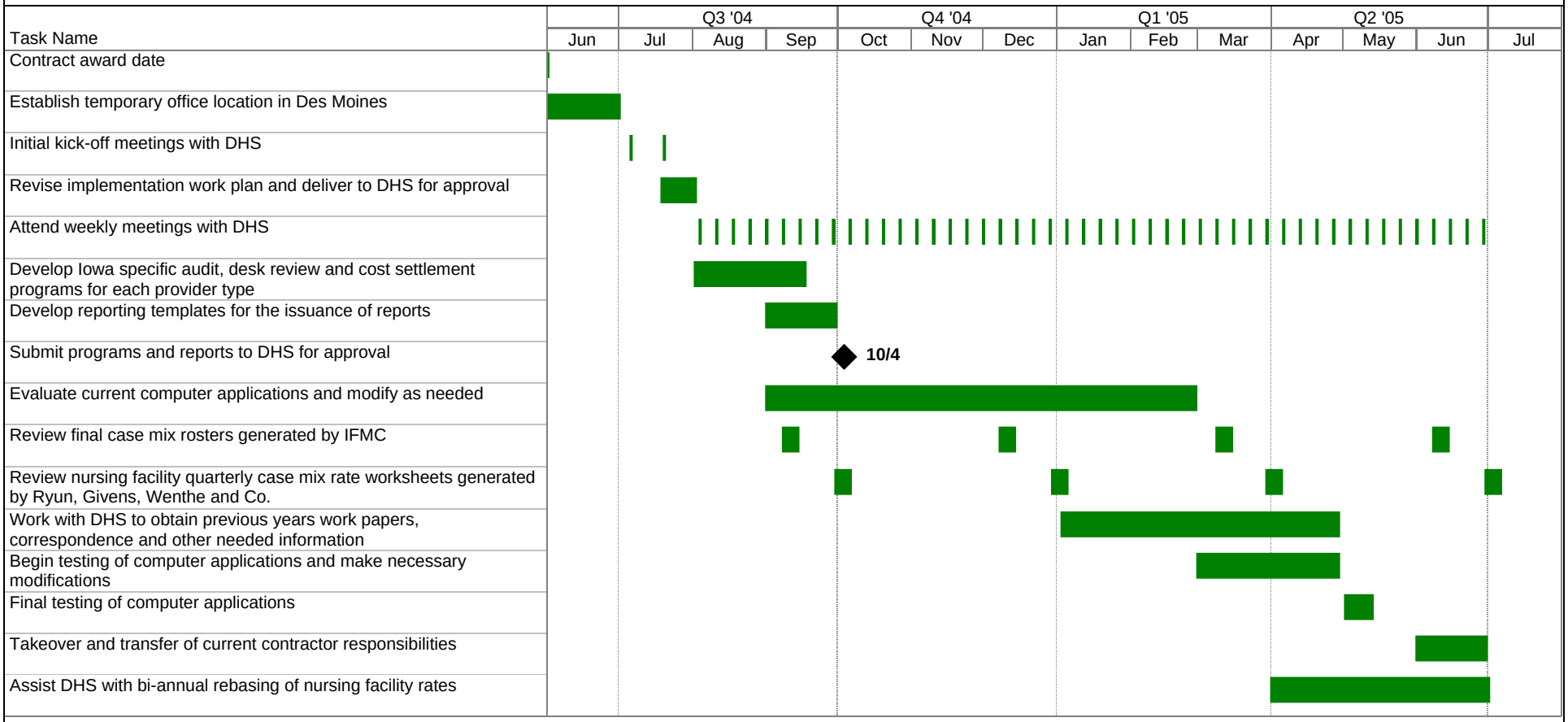
(RFP Section 7.2.10.2)

To illustrate the detailed tasks that will be performed in order to successfully complete each service requirement we have provided a draft project plan below. Tasks have been separately identified for each of the three phases.

Each service requirement's draft project plan provides a detailed list of tasks and completion dates for the DDI phase and first year of the operations phase. It is anticipated that the tasks and completion dates for years two through contract end would be similar to the first year of the operations phase. We have provided one turnover phase draft project plan that reflects tasks that will be completed for all service requirements. Project team members have the experience to evaluate, adopt and make refinements to ensure contract time frames and requirements are met.

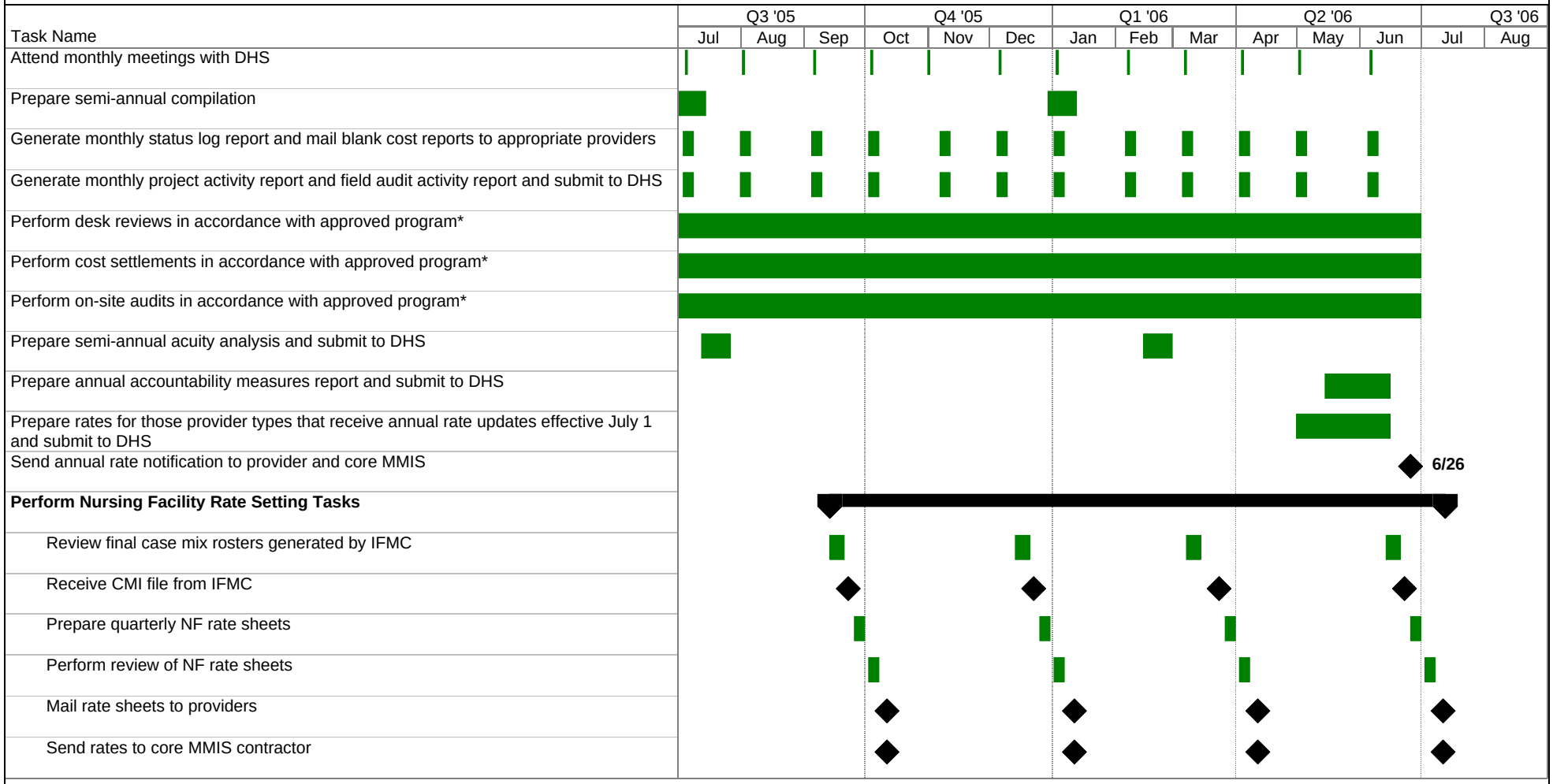
Timeframes for each type of service and service provider (desk review, on-site audit or cost settlement) will vary based upon the receipt of the cost report. Rather than showing all required tasks, such as 66 on-site nursing facility audits on the work plan, we selected July 1, 2005, as the receipt of a cost report and provided a separate example work plan for each of the required services (desk review, on-site audit and cost settlement). The example work plan presents a detailed list of tasks with completion dates that we propose to follow to successfully complete each engagement.

Rate Setting, Cost Settlements and Cost Audits Function Draft Project Plan
Design, Development and Implementation Phase: July 1, 2004 - June 30, 2005



Task Milestone Summary

Rate Setting, Cost Settlements and Cost Audits Function Draft Project Plan
Operations Phase Year 1: July 1, 2005 - June 30, 2006



Task Milestone Summary

* We have provided a separate detailed list of tasks and completion dates from receipt of cost report to delivery of final report.

Rate Setting, Cost Settlements and Cost Audits Function
Proposed Detailed List of Tasks and Completion Dates for Cost Settlements, Desk Reviews and On-Site Audits

Task Name	Jun	Jul	Aug	Sep	Oct	Nov
		Q3 '05			Q4 '05	
Cost settlement (example schedule of completion dates for C/R received 07/01/05)						
Receive completed cost report						
Input cost report into database and assemble notebook						
Obtain PS&R report from core MMIS contractor			7/29			
Perform first level review and cost settlement calculation						
Perform review procedures						
Send draft settlement package to DHS for review			8/16			
Finalize settlement including interim rate adjustments, as necessary						
Final review of settlement						
Enter adjustments into cost report database						
Issue final settlement package to DHS						
Send final settlement and NPR to provider and Revenue Collection contractor. Notify core MMIS contractor if interim rate is adjusted						
Desk review (example schedule of completion dates for C/R received 07/01/05)						
Receive completed cost report						
Input cost report into database and assemble notebook						
Perform risk assessment procedures						
Perform desk review						
Request additional data from provider, if necessary						
Receive additional information and complete remaining desk review steps						
Perform review procedures						
Complete draft desk review report						
Deliver draft desk review to DHS						
Prepare final desk review report						
Perform final review of desk review report						
Enter adjustments into cost report database						
Issue final desk review report package to DHS				8/29		
Send final desk review report to provider. Rate notification to provider and core MMIS contractor when necessary				8/30		

Task Milestone Summary

Rate Setting, Cost Settlements and Cost Audits Function
Proposed Detailed List of Tasks and Completion Dates for Cost Settlements, Desk Reviews and On-Site Audits

Task Name	Jun	Jul	Aug	Sep	Oct	Nov
		Q3 '05			Q4 '05	
On-site audit (example schedule of completion dates for C/R received 07/01/05)						
Receive completed cost report						
Input cost report into database and assemble notebook						
Request PS&R report from core MMIS contractor when appropriate based on provider type						
Perform prefield risk assessment procedures						
Perform scheduling and other administrative procedures						
Perform on-site field audit						
Send provider letter with a detailed list of outstanding information			**8/16**			
Receive additional information and complete remaining audit procedures						
Perform audit review procedures						
Perform necessary tasks to resolve issues raised during review						
Complete draft audit report package						
Deliver draft audit report package to DHS and provider					**10/1**	
Resolve provider concerns						
Prepare final audit report package						
Perform review of final audit report package						
Enter adjustments into cost report database						
Issue final audit report package to DHS						**10/29**
Notify provider and core MMIS contractor of any rate revisions based on audit adjustments						**10/29**

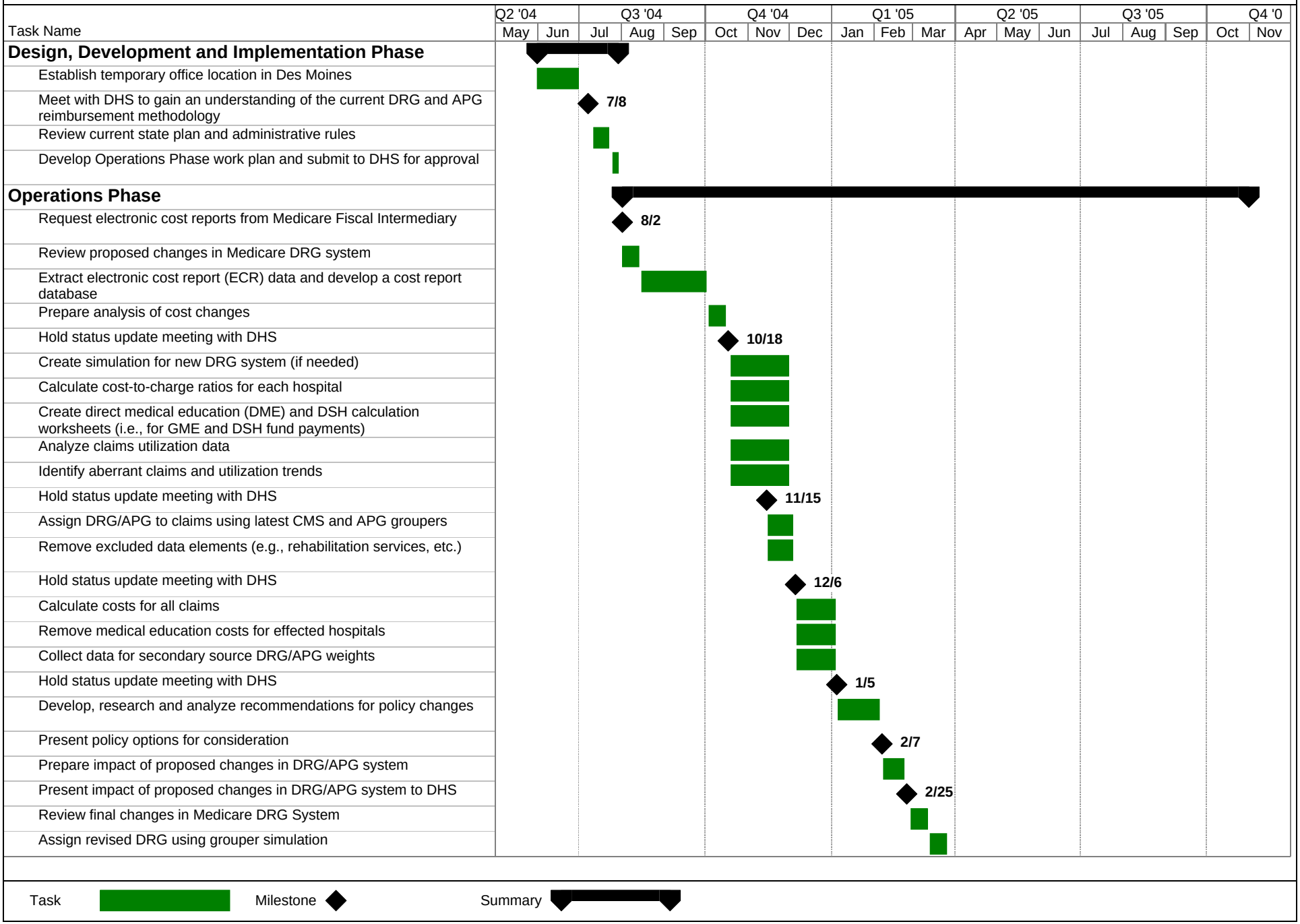
Task Milestone Summary

State Maximum Allowable Cost Program Rate Setting Function Draft Project Plan: July 1, 2004 - June 30, 2005

Task Name	2 '04		Q3 '04			Q4 '04			Q1 '05			Q2 '05			
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Design, Development and Implementation Phase															
Establish temporary office location in Des Moines															
Initial kick-off meeting															
Develop Operations Phase work plan and submit to DHS for approval															
Operations Phase															
Periodically examine SMAC rates, published pricing information, the Federal upper limit, service provider's acquisition cost information, and other available Iowa pharmaceutical market indicators to determine adequacy of the SMAC rates															
Hold status update meeting with DHS															
Update and maintain SMAC program reimbursement rates															
Coordinate with other contractors to update and maintain the SMAC reference file for claims processing.															
Analyze and monitor important trends in reimbursement, service utilization, and fiscal outcomes. Review findings with DHS															
Prepare and submit to DHS an update on SMAC program operation and utilization trends															
Perform annual acquisition cost study															
Assist DHS in development, evaluation and implementation of policies supporting the SMAC program															
Prepare provider information release and notify pharmacy providers of changes to SMAC reimbursement rates															
Coordinate a review of proposed SMAC drugs and rates with the DUR Board of Pharmacy and Therapeutics Committee, as requested by DHS															
Assist DHS in managing relationships with the Iowa Pharmacy Association and other industry representatives, as requested by DHS															
Notify POS contractor of changes to SMAC reimbursement rates															
Prepare provider manual changes, administrative rule changes, or State Plan Amendments to reflect policy and/or rate changes as necessary															
Provide support by telephone, fax, e-mail, website or other means to investigate and respond to service provider, regulatory or other stakeholder questions and concerns regarding the SMAC program															
Provide web-based reference materials such as the SMAC drug groups, rates by NDC code, and the Federal Upper Limit for Iowa Medicaid pharmacy providers															

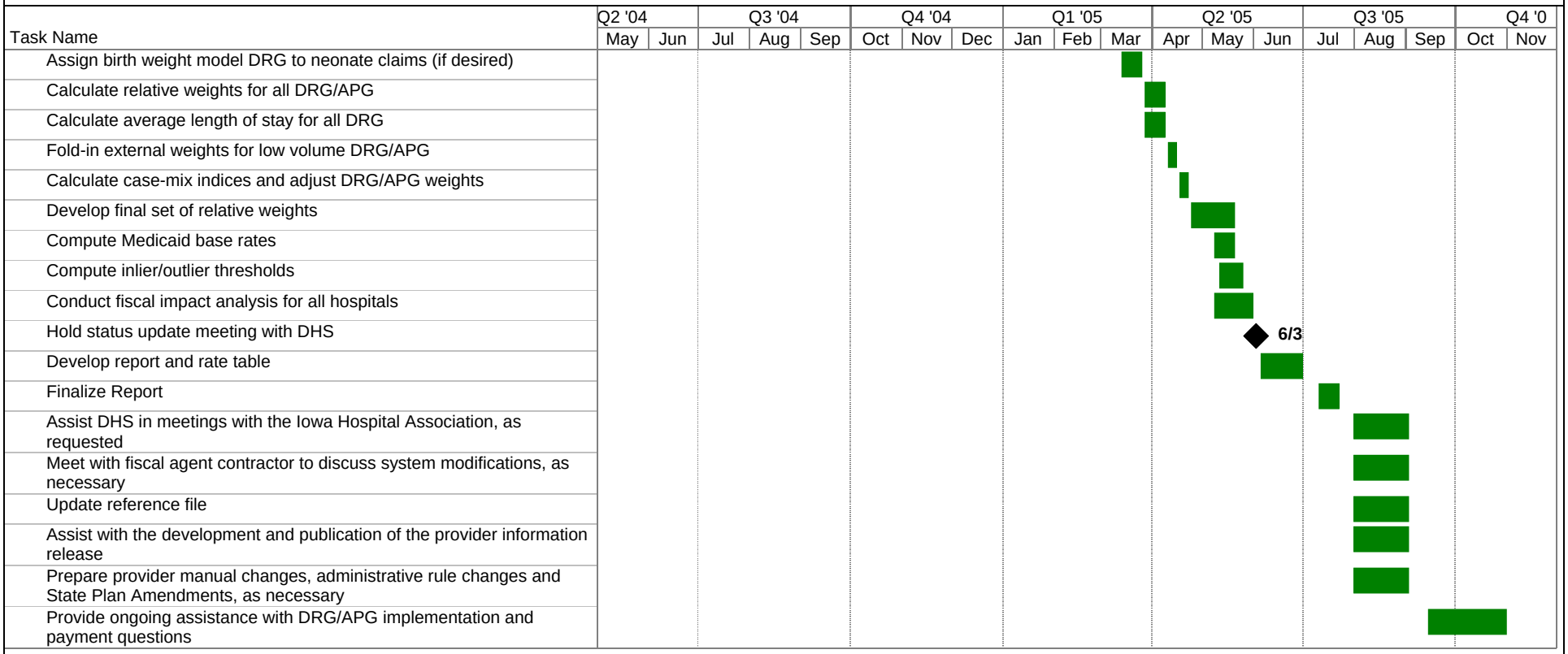
Task Milestone Summary

Rebasing and DRG and APG Recalibration Function Draft Project Plan: July 1, 2004 - October 31, 2005



Task Milestone Summary

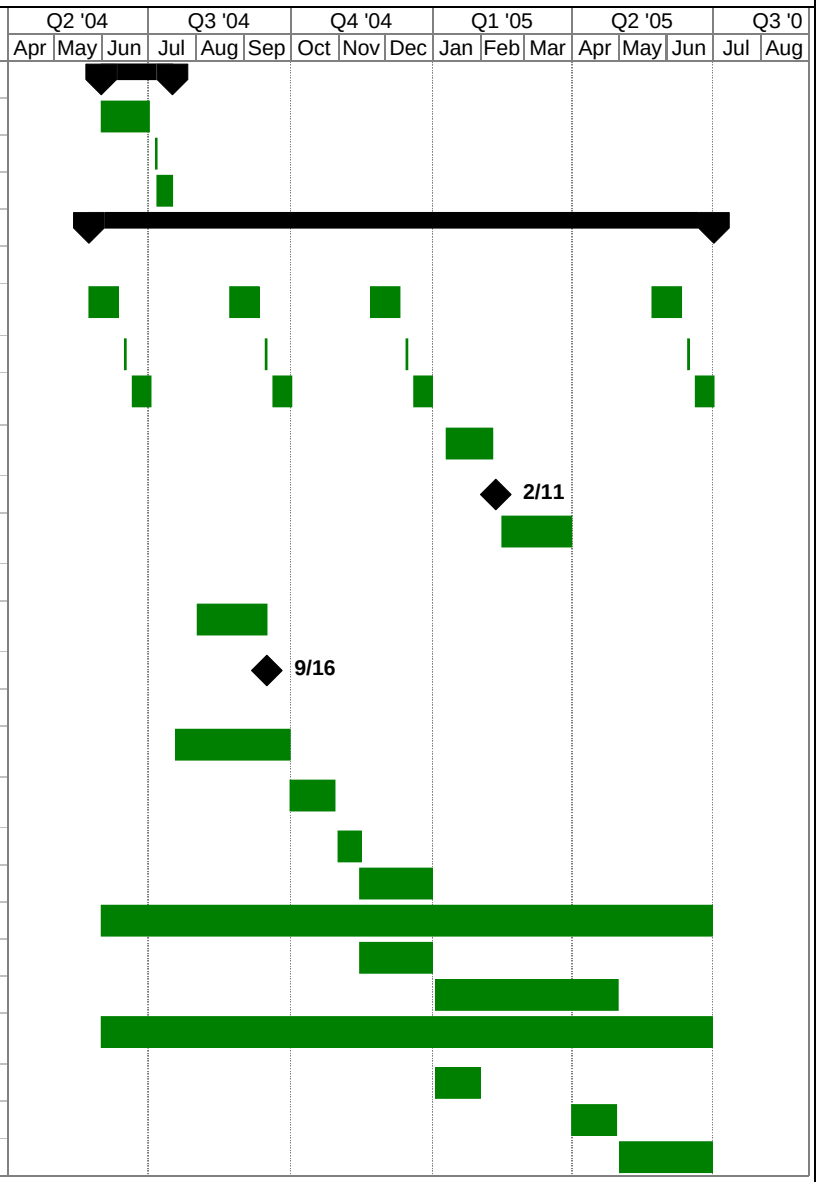
Rebasing and DRG and APG Recalibration Function Draft Project Plan: July 1, 2004 - October 31, 2005



Task Milestone Summary

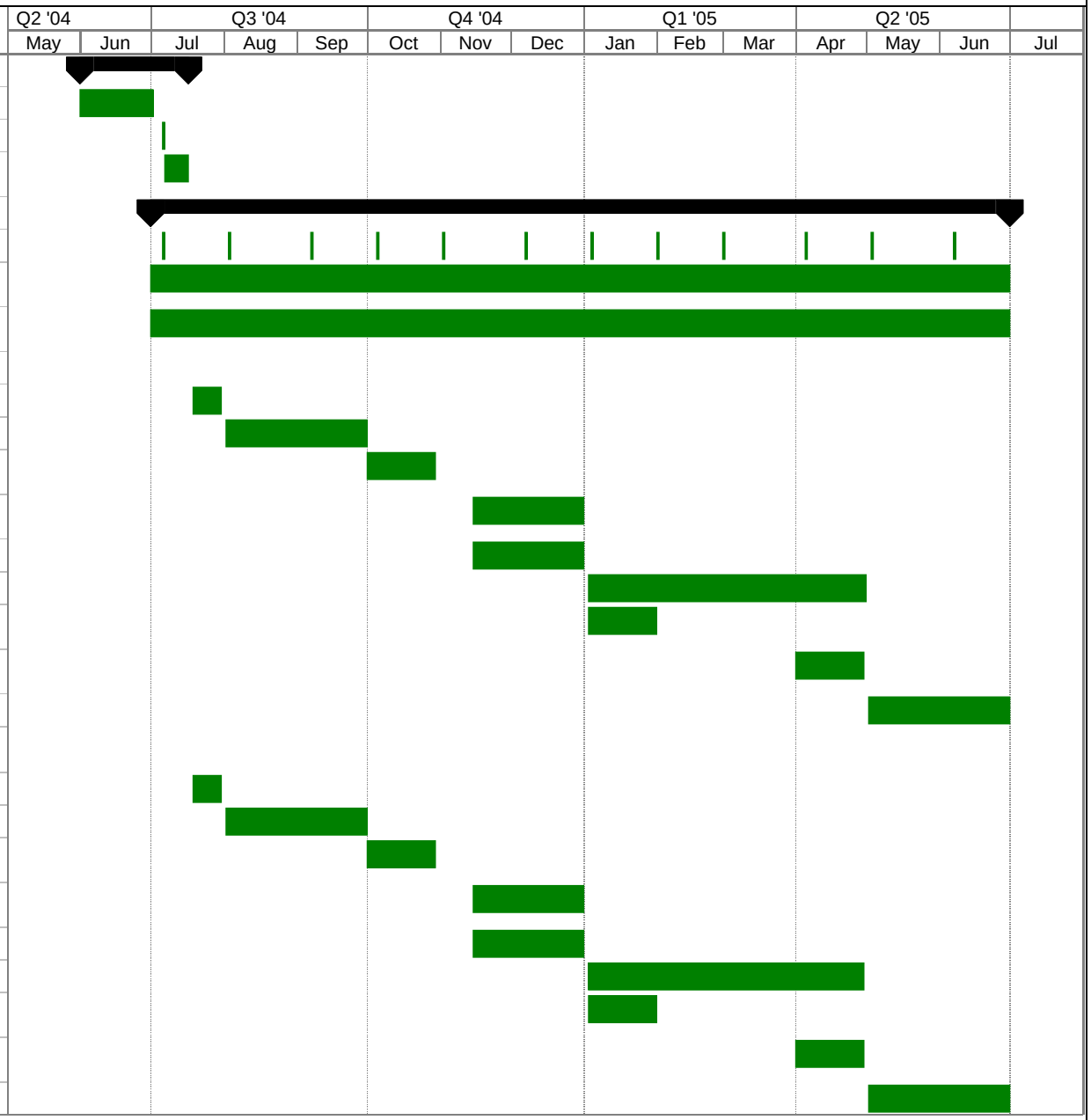
Revenue Maximization Function Draft Project Plan: July 1, 2004 - June 30, 2005

Task Name
Design, Development and Implementation Phase
Establish temporary office location in Des Moines
Initial kick-off meeting
Develop Operations Phase work plan and submit to DHS for approval
Operations Phase
Prepare Hospital UPL Calculations
Research and analyze most appropriate, defensible and efficient methodologies for determining the Upper Payment Limits (UPL). Analyze changes in Medicare reimbursement methodologies
Hold status update meeting with DHS; review research findings with DHS
Prepare preliminary UPL calculations for all state government-owned or operated, non-state government owned or operated and privately owned and operated hospitals
Prepare analysis of Pros and Cons of proposed methodologies. Prepare analysis and/or discussion of major assumptions used in the analysis for DHS consideration
Hold status update meeting with DHS
Prepare final UPL calculations for all state government-owned or operated, non-state government owned or operated and privately owned and operated hospitals
Prepare Nursing Facility UPL Calculations
Prepare UPL calculations for all state government-owned or operated, non-state government owned or operated and privately owned and operated nursing facilities
Hold Status update meeting with DHS
Research and Develop UPL Methodologies for Physician or other Medical Professional Services
Research and develop methodology to maximize federal Medicaid reimbursement for physician or other medical professional services
Prepare report and submit to DHS on recommended methodology. Report will identify Pros and Cons, as well as major assumptions, with proposed methodology. Review and discuss with DHS
Calculate rates based on approved methodology
Assist with state plan and administrative rule changes if recommendation is implemented
Prepare Iowa Medicaid provider information release(s), as necessary
Prepare and assist will provider manual changes to reflect new policies
Assist with presentations to stakeholders and/or interested parties explaining new methodology
Assist DHS in managing relationships with the Iowa Hospital Association, the Iowa Health Care Association, or other industry representatives, as requested by DHS
Prepare specification changes to MMIS claims payment system
Review output from MMIS claims payment system to evaluate implementation of specification changes
Assist DHS and other IME contractors with final implementation of approved methodologies



Task Milestone Summary

Reimbursement Technical Assistance and Support Function Draft Project Plan: July 1, 2004 - June 30, 2005



Task Name

Design, Development and Implementation Phase

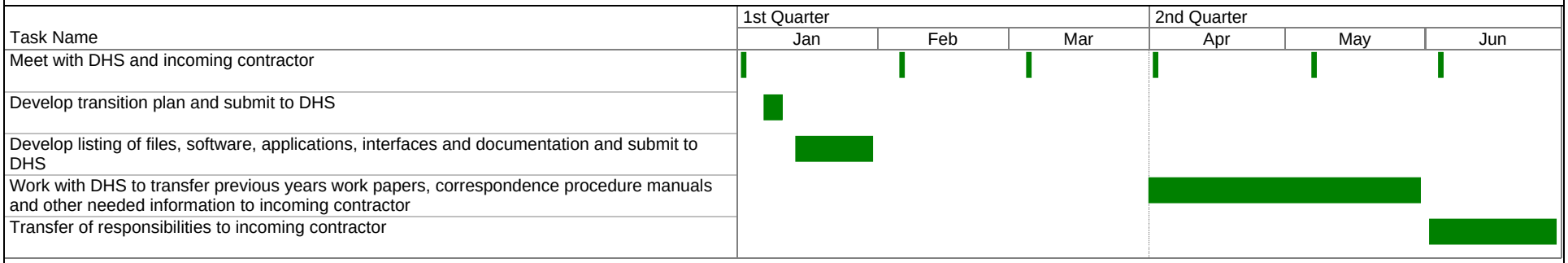
- Establish temporary office location in Des Moines
- Initial kick-off meeting
- Develop Operations Phase work plan and submit to DHS for approval

Operations Phase

- Participate in monthly meetings with DHS
- Maintain monitoring and reporting system for nursing facilities (LTCIS and MDS information system)
- Provide analysis and evaluation of NF financial and assessment data for policy review as requested by DHS
- **Reimbursement Methodology for bed-hold days**
  - Review current methodology
  - Develop alternative methodologies and discuss with DHS
  - Prepare report and submit to DHS on recommended methodology
  - Assist with state plan and administrative rule changes if recommendation is implemented
  - Assist will provider manual changes to reflect new policies
  - Assist with presentations explaining new methodology
  - Prepare specification changes to MMIS claims payment system
  - Review output from MMIS claims payment system to evaluate implementation of specification changes
  - Assist with final implementation and on-going monitoring
- **Crossover Claim Reimbursement Methodologies for Hospitals and Nursing Facilities**
  - Review current methodology
  - Develop alternative methodologies and discuss with DHS
  - Prepare report and submit to DHS on recommended methodology
  - Assist with state plan and administrative rule changes if recommendation is implemented
  - Assist will provider manual changes to reflect new policies
  - Assist with presentations explaining new methodology
  - Prepare specification changes to MMIS claims payment system
  - Review output from MMIS claims payment system to evaluate implementation of specification changes
  - Assist with final implementation and on-going monitoring

Task Milestone Summary

Provider Cost Audits and Rate Setting Component Draft Project Plan
Turnover Phase: January 1 - June 30 of Final Contract Year



Task

Rate Setting, Cost Settlements and Cost Audits Function
Allocation of Resources by Job Category

	Project Director	Quality Assurance Director	Technical Consultant	Account and Implementation Manager	Managers	Supervisors	Senior and Staff Accountant/ Analyst	Support Staff	Subject Matter Experts	Total
Design, Development and Implementation Phase										
Establish temporary office location in Des Moines	50%			50%						
Initial kick-off meeting with DHS	X			X	X					
Revise implementation work plan and deliver to DHS for approval	20%		10%	30%	40%					100%
Attend weekly meetings with DHS	X			X	X					
Develop Iowa specific audit, desk review and cost settlement programs for each provider type	10%	5%	20%	25%	20%	15%		5%		100%
Develop reporting templates for the issuance of reports	10%	5%	20%	25%	20%	15%		5%		100%
Submit programs and reports to DHS for approval				100%						100%
Evaluate current computer applications and modify as needed	15%			25%	20%				40%	100%
Review final case mix rosters generated by IFMC				10%	15%	55%	10%		10%	100%
Review nursing facility quarterly case mix rate worksheets generated by Ryun, Givens, Wenthe and Co.				10%	15%	55%	15%	5%		100%
Work with DHS to obtain previous years work papers, correspondence and other needed information	10%			25%	25%	20%		20%		100%
Begin testing of computer applications and make necessary modifications	5%			15%	15%	30%		10%	25%	100%
Final testing of computer applications	10%	5%		25%	25%	15%			20%	100%
Takeover and transfer of current contractor responsibilities	15%	5%		50%	30%					100%
Assist DHS with bi-annual rebasing of nursing facility rates	15%			15%	20%	25%		10%	15%	100%

An X indicates those staff that will be in attendance at meetings.

Rate Setting, Cost Settlements and Cost Audits Function
Allocation of Resources by Job Category

	Project Director	Quality Assurance Director	Technical Consultant	Account and Implementation Manager	Managers	Supervisors	Senior and Staff Accountant/ Analyst	Support Staff	Subject Matter Experts	Total
Operations Phase										
Attend monthly meetings with DHS	X			X	X					
Prepare semi-annual compilation	10%	5%		10%	20%	20%		15%	20%	100%
Generate monthly status log report and mail blank cost reports to appropriate providers				5%	10%	10%	55%	20%		100%
Generate monthly project activity report and field audit activity report and submit to DHS				5%	10%	10%	55%	20%		100%
Perform desk reviews in accordance with approved program				5%	10%	15%	40%	30%		100%
Perform cost settlements in accordance with approved program				5%	10%	15%	40%	30%		100%
Perform on-site audits in accordance with approved program				5%	10%	25%	30%	30%		100%
Prepare semi-annual acuity analysis and submit to DHS	10%	5%		10%	20%	20%		15%	20%	100%
Prepare annual accountability measures report and submit to DHS	10%	5%		10%	20%	20%		15%	20%	100%
Prepare rates for those provider types that receive annual rate updates effective July 1 and submit to DHS	10%	5%		15%	15%	15%	20%	10%	10%	100%
Send annual rate notification to provider and core MMIS				5%	10%	15%	40%	30%		100%
Review final case mix rosters generated by IFMC				10%	15%	55%	10%		10%	100%
Prepare quarterly NF rate sheets							60%	40%		100%
Perform review of NF rate sheets				10%	15%	55%	15%	5%		100%
Mail rate sheets to providers						5%	20%	75%		100%
Send rates to core MMIS contractor				5%	5%	90%				100%

An X indicates those staff that will be in attendance at meetings.

State Maximum Allowable Cost (SMAC) Program Rate Setting Function
Allocation of Resources by Job Category

	Project Director	Quality Assurance Director	Technical Consultant	Account and Implementation Manager	Managers	Senior and Staff Accountant/ Analyst	Support Staff	Subject Matter Experts/ Pharmacists Consultant	Total
Design, Development and Implementation Phase									
Establish temporary office location in Des Moines	50%			50%					100%
Initial kick-off meeting	X			X	X				
Develop Operations Phase work plan and submit to DHS for approval	20%			5%	75%				100%
Operations Phase									
Periodically examine SMAC rates, published pricing information, the Federal Upper Limit, service provider's acquisition cost information, and other available Iowa pharmaceutical market indicators to determine adequacy of the SMAC rates	5%	4%		1%	10%	75%		5%	100%
Hold monthly status update meeting with DHS	X			X	X				
Update and maintain SMAC program reimbursement rates	10%	4%		1%	20%	50%	10%	5%	100%
Coordinate with other contractors to update and maintain the SMAC rate file for claims processing		3%		1%	6%	90%			100%
Analyze and monitor important trends in reimbursement, service utilization, and fiscal outcomes. Review findings with DHS	5%	5%		1%	20%	64%		5%	100%
Prepare and submit to DHS an update on SMAC program operation and utilization trends	10%			2%	73%	15%			100%
Perform annual acquisition cost study	2%	3%		1%	20%	45%	29%		100%
Assist DHS in development, evaluation and implementation of policies supporting the SMAC program	20%	5%		5%	50%	10%		10%	100%
Prepare provider Information Release and notify pharmacy providers of changes to SMAC reimbursement rates	5%	1%		1%	75%	15%	3%		100%
Coordinate a review of proposed SMAC drugs and rates with the DUR Board and Pharmacy and Therapeutics Committee, as requested by DHS	10%			5%	40%	35%		10%	100%

An X indicates those staff that will be in attendance at meetings.

State Maximum Allowable Cost (SMAC) Program Rate Setting Function
Allocation of Resources by Job Category

	Project Director	Quality Assurance Director	Technical Consultant	Account and Implementation Manager	Managers	Senior and Staff Accountant/ Analyst	Support Staff	Subject Matter Experts/ Pharmacists Consultant	Total
Assist DHS in manageing relationships with the Iowa Pharmacy Association and other industry representatives, as requested by DHS	20%	2%		5%	73%				100%
Notify POS contractor of changes to SMAC reimbursement rates		3%		2%	15%	80%			100%
Prepare provider manual changes, administrative rule changes, or State Plan Amendments to reflect policy and/or rate changes, as necessary	10%	3%		5%	67%	10%	5%		100%
Provide support by telephone, fax, e-mail, website or other means to investigate and respond to service provider, regulatory or other stakeholder questions and concerns regarding the SMAC program	2%	1%		1%	20%	70%	5%	1%	100%
Provide web-based reference materials such as the SMAC drug groups, rates by NDC code, and the Federal Upper Limit for Iowa Medicaid pharmacy providers	5%			1%	20%	59%		15%	100%

An X indicates those staff that will be in attendance at meetings.

Rebasing and DRG and APG Recalibration Function
Allocation of Resources by Job Category

	Project Director	Quality Assurance Director	Technical Consultant	Account and Implementation Manager	Managers	Senior and Staff Accountant/ Analyst	Support Staff	Subject Matter Experts	Total
Design, Development and Implementation Phase									
Establish temporary office location in Des Moines	50%			50%					100%
Meet with DHS to gain an understanding of the current DRG and APG reimbursement methodology	X			X	X				
Review current state plan and administrative rules	10%	5%		25%	50%	10%			100%
Develop Operations Phase work plan and submit to DHS for approval	10%			20%	50%	20%			100%
Operations Phase									
Request electronic cost reports from Medicare Fiscal Intermediary				5%	10%	85%			100%
Review proposed changes in Medicare DRG system	10%			5%	50%	35%			100%
Extract electronic cost report (ECR) data and develop a cost report database				5%	10%	60%	10%	15%	100%
Prepare analysis of cost changes	5%			5%	25%	50%	15%		100%
Hold status update meeting with DHS	X			X	X				
Create simulation for new DRG system (if needed)	5%				20%	35%		40%	100%
Calculate cost-to-charge ratios for each hospital	5%				10%	55%	20%	10%	100%
Create direct medical education (DME) and DSH calculation worksheets (i.e., for GME and DSH fund payments)	5%			5%	20%	55%	15%		100%
Analyze claims utilization data	5%			5%	10%	70%	10%		100%
Identify aberrant claims and utilization trends	5%			5%	35%	40%	15%		100%
Hold status update meeting with DHS	X			X	X				
Assign DRG/APG to claims using latest CMS and APG groupers	5%				35%	30%		30%	100%
Remove excluded data elements (e.g. rehabilitation services, etc.)	5%				10%	70%	15%		100%
Hold status update meeting with DHS	X			X	X				
Calculate costs for all claims	5%			5%	15%	60%	15%		100%
Remove medical education costs for effected hospitals	5%				20%	60%	15%		100%
Collect data for secondary source DRG/APG weights	5%			5%	25%	55%		10%	100%
Hold status update meeting with DHS	X			X	X				
Develop, research and analyze recommendations for policy changes	5%	5%		10%	30%	30%		20%	100%

An X indicates those staff that will be in attendance at meetings.

Rebasing and DRG and APG Recalibration Function
Allocation of Resources by Job Category

	Project Director	Quality Assurance Director	Technical Consultant	Account and Implementation Manager	Managers	Senior and Staff Accountant/ Analyst	Support Staff	Subject Matter Experts	Total
Present policy options for consideration	5%			15%	50%	30%			100%
Prepare impact of proposed changes in DRG/APG system	5%			5%	50%	25%		15%	100%
Present impact of proposed changes in DRG/APG system to DHS	5%			5%	50%	25%		15%	100%
Review final changes in Medicare DRG System	5%			5%	70%	10%		10%	100%
Assign revised DRG using grouper simulation	5%				20%	65%	10%		100%
Assign birth weight model DRG to neonate claims (if desired)	5%				40%	45%	10%		100%
Calculate relative weights for all DRG/APG	10%			5%	30%	40%		15%	100%
Calculate average length of stay for all DRG	10%				15%	70%	5%		100%
Fold-in external weights for low volume DRG/APG	10%				15%	70%	5%		100%
Calculate case-mix indices and adjust DRG/APG weights	10%			5%	15%	60%	10%		100%
Develop final set of relative weights	10%			5%	25%	50%	10%		100%
Compute Medicaid base rates	10%			5%	35%	40%	10%		100%
Compute inlier/outlier thresholds	10%				15%	65%	5%	5%	100%
Conduct fiscal impact analysis for all hospitals	10%			5%	30%	45%		10%	100%
Hold status update meeting with DHS	X			X	X				
Develop report and rate table	10%	5%		10%	45%	25%	5%		100%
Finalize Report	10%	5%		10%	70%	5%			100%
Assist DHS in meetings with the Iowa Hospital Association, as requested	50%			25%	15%	10%			100%
Meet with fiscal agent contractor to discuss system modifications, as necessary	10%			25%	40%	25%			100%
Update reference file				5%	20%	75%			100%
Assist with the development and publication of the provider information release	10%			15%	25%	25%		25%	100%
Prepare provider manual changes, administrative rule changes and State Plan Amendments, as necessary	10%			10%	40%	25%	15%		100%
Provide ongoing assistance with DRG/APG implementation and payment questions	5%			10%	50%	25%	5%	5%	100%

An X indicates those staff that will be in attendance at meetings.

Revenue Maximization Function
Allocation of Resources by Job Category

	Project Director	Quality Assurance Director	Technical Consultant	Account and Implementation Manager	Managers	Senior and Staff Accountant/ Analyst	Support Staff	Subject Matter Experts	Total
Design, Development and Implementation Phase									
Establish temporary office location in Des Moines	50%			50%					100%
Initial kick-off meeting	X			X	X				
Develop Operations Phase work plan and submit to DHS for approval	20%	5%		20%	55%				100%
Operations Phase									
Research and analyze most appropriate, defensible, and efficient methodologies for determining the Upper Payment Limits (UPL). Analyze changes in Medicare reimbursement methodologies	40%			10%	20%	15%	5%	10%	100%
Hold status update meeting and review research findings with DHS	X			X	X				
Prepare preliminary UPL calculations for all state government-owned or operated, non-state government owned or operated and privately owned and operated hospitals	40%	5%		5%	20%	20%		10%	100%
Prepare analysis of Pros and Cons of proposed methodologies. Prepare analysis and/or discussion of major assumptions used in the analysis for DHS' consideration	10%			10%	40%	25%	5%	10%	100%
Hold status update meeting with DHS	X			X	X				
Prepare final UPL calculations for all state government-owned or operated, non-state government owned or operated and privately owned and operated hospitals	40%	5%		5%	20%	20%		10%	100%
Prepare UPL calculations for all state government-owned or operated, non-state government owned or operated and privately owned and operated nursing facilities	10%	5%		5%	40%	30%		10%	100%
Hold status update meeting with DHS	X			X	X				
Research and develop methodology to maximize federal Medicaid reimbursement for physician or other medical professional services	40%			10%	30%	10%		10%	100%

An X indicates those staff that will be in attendance at meetings.

Revenue Maximization Function
Allocation of Resources by Job Category

	Project Director	Quality Assurance Director	Technical Consultant	Account and Implementation Manager	Managers	Senior and Staff Accountant/ Analyst	Support Staff	Subject Matter Experts	Total
Prepare report and submit to DHS on recommended methodology. Report will identify Pros and Cons, as well as major assumptions, with proposed methodology. Review and Discuss report with DHS	15%	5%		10%	40%	15%	5%	10%	100%
Calculate rates based on approved methodology	10%	5%		10%	35%	35%		5%	100%
Assist with state plan and administrative rule changes if recommendation is implemented	20%	5%		10%	40%	15%	5%	5%	100%
Prepare Iowa Medicaid provider Information Release(s), as necessary	5%			5%	45%	35%	10%		100%
Prepare and assist with provider manual changes to reflect new policies, rates or methodologies.	5%			5%	45%	35%	10%		100%
Assist with presentations to stakeholders and/or interested parties explaining new methodology	20%			10%	70%				100%
Assist the Department in managing relationships with the Iowa Hospital Association, the Iowa Health Care Association, or other industry representatives, as requested by DHS	20%	5%		10%	65%				100%
Prepare specification changes to MMIS claims payment system, as necessary	10%			5%	55%	30%			100%
Review output from MMIS claims payment system to evaluate implementation of specification changes	10%			5%	55%	30%			100%
Assist the Department and other IME contractors with final implementation of approved methodologies	10%			10%	50%	30%			100%

An X indicates those staff that will be in attendance at meetings.

Reimbursement Technical Assistance and Support Function
Allocation of Resources by Job Category

	Project Director	Quality Assurance Director	Technical Consultant	Account and Implementation Manager	Managers	Supervisors	Senior and Staff Accountant/ Analyst	Support Staff	Subject Matter Experts	Total
Design, Development and Implementation Phase										
Establish temporary office location in Des Moines	50%			50%						100%
Initial kick-off meeting	X			X	X					
Develop Operations Phase work plan and submit to DHS for approval	20%			30%	50%					
Operations Phase										
Participate in monthly meetings with DHS	X			X	X					
Maintain monitoring and reporting system for nursing facilities (LTCIS and MDS information system)		5%		10%	10%	15%	40%	20%		100%
Provide analysis and evaluation of NF financial and assessment data for policy review as requested by DHS	10%			10%	15%	25%	30%	10%		100%
Reimbursement Methodology for bed-hold days										
Review current methodology	15%			10%	15%	25%	35%			100%
Develop alternative methodologies and discuss with DHS	15%			10%	25%	25%	25%			100%
Prepare report and submit to DHS on recommended methodology	15%	5%		10%	15%	25%	15%	15%		100%
Assist with state plan and administrative rule changes if recommendation is implemented	10%	5%		15%	30%	20%	20%			100%
Assist will provider manual changes to reflect new policies	10%	5%		15%	15%	15%	30%	10%		100%
Assist with presentations explaining new methodology				15%	50%	35%				100%
Prepare specification changes to MMIS claims payment system		5%		10%	35%	25%	25%			100%
Review output from MMIS claims payment system to evaluate implementation of specification changes				10%	25%	40%	25%			100%
Assist with final implementation and on-going monitoring	10%	5%		15%	20%	20%	20%	10%		100%

An X indicates those staff that will be in attendance at meetings.

Reimbursement Technical Assistance and Support Function
Allocation of Resources by Job Category

	Project Director	Quality Assurance Director	Technical Consultant	Account and Implementation Manager	Managers	Supervisors	Senior and Staff Accountant/ Analyst	Support Staff	Subject Matter Experts	Total
Crossover Claim Reimbursement Methodologies for Hospitals and Nursing Facilities										
Review current methodology	15%			10%	15%	25%	35%			100%
Develop alternative methodologies and discuss with DHS	15%			10%	25%	25%	25%			100%
Prepare report and submit to DHS on recommended methodology	15%	5%		10%	15%	25%	15%	15%		100%
Assist with state plan and administrative rule changes if recommendation is implemented	10%	5%		15%	30%	20%	20%			100%
Assist will provider manual changes to reflect new policies	10%	5%		15%	15%	15%	30%	10%		100%
Assist with presentations explaining new methodology				15%	50%	35%				100%
Prepare specification changes to MMIS claims payment system		5%		10%	35%	25%	25%			100%
Review output from MMIS claims payment system to evaluate implementation of specification changes				10%	25%	40%	25%			100%
Assist with final implementation and on-going monitoring	10%	5%		15%	20%	20%	20%	10%		100%

An X indicates those staff that will be in attendance at meetings.

11. Corporate Organization, Experience and Qualifications

11.1 General Information

(RFP Section 7.2.11)

Legal Structure

Myers and Stauffer is a limited liability company organized in the state of Kansas and registered to conduct business in the state of Iowa.

In the fall of 1998, Myers and Stauffer LC created a new entity called M&S Consulting Services, Inc. to participate with various consulting engagements of the firm. This entity was subsequently merged with Century Business Services, Inc. Century is a leading provider of outsourced business services to small and medium-sized companies throughout the nation.

Myers and Stauffer LC is a member-owned certified public accounting firm, and will perform the entire Iowa Medicaid Enterprise project. All owners (member and principals) of the firm are identified in the firm organizational chart.

Iowa Business License and Professional License

Myers and Stauffer has been granted a permit to practice as a CPA firm from the Iowa Department of Commerce. A copy of the firm's professional license and certificate of authority from the Iowa Secretary of State and the firm's insurance certificates are included on the following pages.

Fields of Opportunities

STATE OF IOWA

IOWA DEPARTMENT OF COMMERCE
PROFESSIONAL LICENSING AND REGULATION

THIS IS TO CERTIFY THAT THE BELOW NAMED HAS BEEN GRANTED A PERMIT TO PRACTICE AS A FIRM OF CPA'S

PERMIT NO: 2004-0007 EXPIRES: 06/30/05

MYERS AND STAUFFER, LC
8555 NORTH RIVER ROAD
SUITE 360
INDIANAPOLIS, IN 46240

Myers and Stauffer LC
signature

Fields of Opportunities

STATE OF IOWA

IOWA DEPARTMENT OF COMMERCE
PROFESSIONAL LICENSING AND REGULATION

THE PERSON NAMED BELOW, HAVING MET THE REQUIREMENTS AND BEING IN GOOD STANDING IN OTHER RESPECTS, IS ISSUED

Myers and Stauffer LC
signature

IOWA

No. W00238771
Date: 04/25/2000

SECRETARY OF STATE

490FLC-000240079
MYERS AND STAUFFER LC

CERTIFICATE OF AUTHORITY

The Secretary of State acknowledges receipt of the following document:

Application for Certificate of Authority

The document was filed on April 24, 2000, at 08:12 AM, and the Certificate of Authority is effective as of April 24, 2000, at 08:12 AM.

The amount of $100.00 was received in full payment of the filing fee.

CHESTER J. CULVER SECRETARY OF STATE

Printed on Recycled Paper

Client#: 2372 CENTBUS

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 02/27/04

PRODUCER
CBIZ Insurance Services, Inc.
9302 Lee Highway Suite 200
Fairfax, VA 22031
703 654-6300

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURED
Century Business Services, Inc.
CBIZ M&S Consulting Services, Inc.
4123 SW Gage Center Drive, Suite 200
Topeka, KS 66604

INSURERS AFFORDING COVERAGE	NAIC #
INSURER A: Hartford Insurance	
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
		GENERAL LIABILITY				EACH OCCURRENCE	$
		COMMERCIAL GENERAL LIABILITY				DAMAGE TO RENTED PREMISES (Ea occurrence)	$
		CLAIMS MADE / OCCUR				MED EXP (Any one person)	$
						PERSONAL & ADV INJURY	$
						GENERAL AGGREGATE	$
		GEN'L AGGREGATE LIMIT APPLIES PER:				PRODUCTS - COMP/OP AGG	$
		POLICY / PRO-JECT / LOC					
		AUTOMOBILE LIABILITY				COMBINED SINGLE LIMIT (Ea accident)	$
		ANY AUTO					
		ALL OWNED AUTOS				BODILY INJURY (Per person)	$
		SCHEDULED AUTOS					
		HIRED AUTOS				BODILY INJURY (Per accident)	$
		NON-OWNED AUTOS					
						PROPERTY DAMAGE (Per accident)	$
		GARAGE LIABILITY				AUTO ONLY - EA ACCIDENT	$
		ANY AUTO				OTHER THAN AUTO ONLY: EA ACC	$
						AGG	$
		EXCESS/UMBRELLA LIABILITY				EACH OCCURRENCE	$
		OCCUR / CLAIMS MADE				AGGREGATE	$
							$
		DEDUCTIBLE					$
		RETENTION $					$
A		**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY**	30WNMF4640	09/30/03	09/30/04	WC STATU-TORY LIMITS / OTH-ER	
A		ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED?	30WBRMF4641	09/30/03	09/30/04	E.L. EACH ACCIDENT	$1,000,000
		If yes, describe under SPECIAL PROVISIONS below				E.L. DISEASE - EA EMPLOYEE	$1,000,000
						E.L. DISEASE - POLICY LIMIT	$1,000,000
		OTHER					

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

CERTIFICATE HOLDER

Iowa Department of Human Services
Hoover State Office Building
1305 East Walnut Street, 5th Floor
Des Moines, IA 50319

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE
Gary E. Dougherty

© ACORD CORPORATION 1988

IMPORTANT

If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

DISCLAIMER

The Certificate of Insurance on the reverse side of this form does not constitute a contract between the issuing insurer(s), authorized representative or producer, and the certificate holder, nor does it affirmatively or negatively amend, extend or alter the coverage afforded by the policies listed thereon.

Client#: 52154 MYERSTA

ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 02/27/2004

PRODUCER
CBIZ-Fairfax
9302 Lee Highway Suite 200
Fairfax, VA 22031
703 654-6343

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURED
Myers and Stauffer, LC
4123 Southwest Gage Ctr. Dr.
Topeka, KS 66604

INSURERS AFFORDING COVERAGE	NAIC #
INSURER A: Hartford Insurance Co.	
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
A		GENERAL LIABILITY	42SBAFM9189	09/01/03	09/01/04	EACH OCCURRENCE	$1,000,000
		X COMMERCIAL GENERAL LIABILITY				DAMAGE TO RENTED PREMISES (Ea occurrence)	$300,000
		CLAIMS MADE X OCCUR				MED EXP (Any one person)	$10,000
						PERSONAL & ADV INJURY	$1,000,000
						GENERAL AGGREGATE	$2,000,000
		GEN'L AGGREGATE LIMIT APPLIES PER:				PRODUCTS - COMP/OP AGG	$2,000,000
		POLICY PRO-JECT LOC					
A		AUTOMOBILE LIABILITY	42SBAFM9189	09/01/03	09/01/04	COMBINED SINGLE LIMIT (Ea accident)	$1,000,000
		ANY AUTO					
		ALL OWNED AUTOS				BODILY INJURY (Per person)	$
		SCHEDULED AUTOS					
		X HIRED AUTOS				BODILY INJURY (Per accident)	$
		X NON-OWNED AUTOS					
						PROPERTY DAMAGE (Per accident)	$
		GARAGE LIABILITY				AUTO ONLY - EA ACCIDENT	$
		ANY AUTO				OTHER THAN AUTO ONLY: EA ACC	$
						AGG	$
A		EXCESS/UMBRELLA LIABILITY	42SBAFM9189	09/01/03	09/01/04	EACH OCCURRENCE	$2,000,000
		X OCCUR CLAIMS MADE				AGGREGATE	$2,000,000
							$
		DEDUCTIBLE					$
		X RETENTION $ 10000					$
		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY				WC STATU-TORY LIMITS / OTH-ER	
		ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED?				E.L. EACH ACCIDENT	$
		If yes, describe under SPECIAL PROVISIONS below				E.L. DISEASE - EA EMPLOYEE	$
						E.L. DISEASE - POLICY LIMIT	$
		OTHER					

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

CERTIFICATE HOLDER

Iowa Department of Human Services
Attn: Mary Tavegia
5th Floor, Hoover State Office
Bldg., 1305 East Walnut Street
Des Moines, IA 50319-0114

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE
CBIZ Benefits & Insurance Services

© ACORD CORPORATION 1988

IMPORTANT

If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

DISCLAIMER

The Certificate of Insurance on the reverse side of this form does not constitute a contract between the issuing insurer(s), authorized representative or producer, and the certificate holder, nor does it affirmatively or negatively amend, extend or alter the coverage afforded by the policies listed thereon.

CERTIFICATE OF INSURANCE

DATE (MM/DD/YY) 01/22/04

PRODUCER
Aon Insurance Services
1411 Opus Place, Suite 250
Downers Grove, IL 60515

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

COMPANIES AFFORDING COVERAGE

COMPANY A Continental Casualty Company
COMPANY B
COMPANY C
COMPANY D

INSURED
Myers and Stauffer LC
4123 SW Gage Center Drive
Topeka, KS 66604-1833

COVERAGES

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

CO LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
	GENERAL LIABILITY				GENERAL AGGREGATE	$
	COMMERCIAL GENERAL LIABILITY				PRODUCTS-COMP/OP AGG.	$
	CLAIMS MADE / OCCUR				PERSONAL & ADV. INJURY	$
	OWNER'S CONT. PROT.				EACH OCCURRENCE	$
					FIRE DAMAGE (Any one fire)	$
					MED EXP. (Any one person)	$
	AUTOMOBILE LIABILITY				COMBINED SINGLE LIMIT	$
	ANY AUTO					
	ALL OWNED AUTOS				BODILY INJURY (Per person)	$
	SCHEDULED AUTOS					
	HIRED AUTOS				BODILY INJURY (Per accident)	$
	NON-OWNED AUTOS					
					PROPERTY DAMAGE	$
	GARAGE LIABILITY				AUTO ONLY - EA ACCIDENT	$
	ANY AUTO				OTHER THAN AUTO ONLY	
					EACH ACCIDENT	$
					AGGREGATE	$
	EXCESS LIABILITY				EACH OCCURRENCE	$
	UMBRELLA FORM				AGGREGATE	$
	OTHER THAN UMBRELLA FORM					$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY				STATUTORY LIMITS	
	THE PROPRIETOR/PARTNERS/ EXECUTIVE/OFFICERS ARE: INCL / EXCL				EACH ACCIDENT	$
					DISEASE - POLICY LIMIT	$
					DISEASE - EACH EMPLOYEE	$
A	OTHER Professional Liab lity	ABF 188181819	9/14/03	9/14/04	Annual Aggregate	$2,000,000

CERTIFICATE HOLDER

Iowa Department of Human Services
5th Floor, Hoover State Office Building
1305 East Walnut Street
Des Moines, Iowa 50319-0114

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING COMPANY WILL ENDEAVOR TO MAIL 45 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO MAIL SUCH NOTICE SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE COMPANY, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

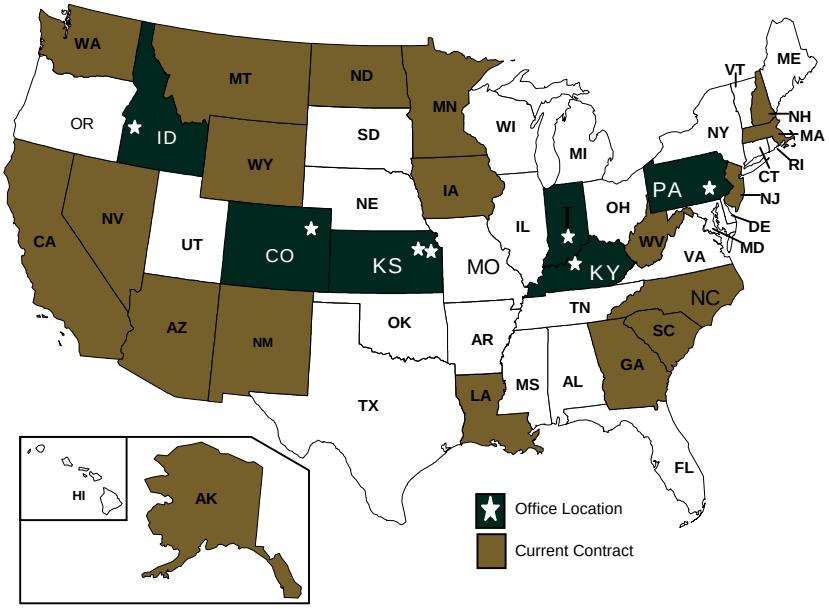
History of Organization

Incorporated in 1977, Myers and Stauffer LC provides accounting and consulting services to governmental health care agencies. With a more than 27-year history in the ever-changing health care arena, we understand the demands policymakers face managing government health care systems. Our goal is to match our experience and staff to the unique needs of each project. Our professionals are knowledgeable and experienced in performing payment system consulting services, data management and reporting and a wide array of other health care related services, we have earned a reputation for being creative and innovative in assisting our clients adapt to the dynamic health care environment.

With seven offices located throughout the United States, our health care practice has assisted state agencies address reimbursement issues for hospitals, long term care facilities, home health agencies, federally qualified health centers, rural health clinics, pharmacy providers, physicians and other practitioner providers within 35 state agency Medicaid programs. Our experience includes assisting in the development of reimbursement systems, defending rates based on cost reporting and audit findings as well as the results of providers' administrative and judicial challenges. We are also experienced at performing data management and analysis services to assist our clients in better managing government-sponsored health care programs.

Myers and Stauffer currently has active engagements with Medicaid agencies in more than 25 states on various health care related projects. Working with government agencies on health care related projects accounts for virtually all of the firm's activity. The firm's health care practice has attained a national reputation and has been successful in a wide variety of health care related projects.

Our current experience, as illustrated on the following map, enables us to draw upon the best practices in the country to address the unique health care environment in Iowa.



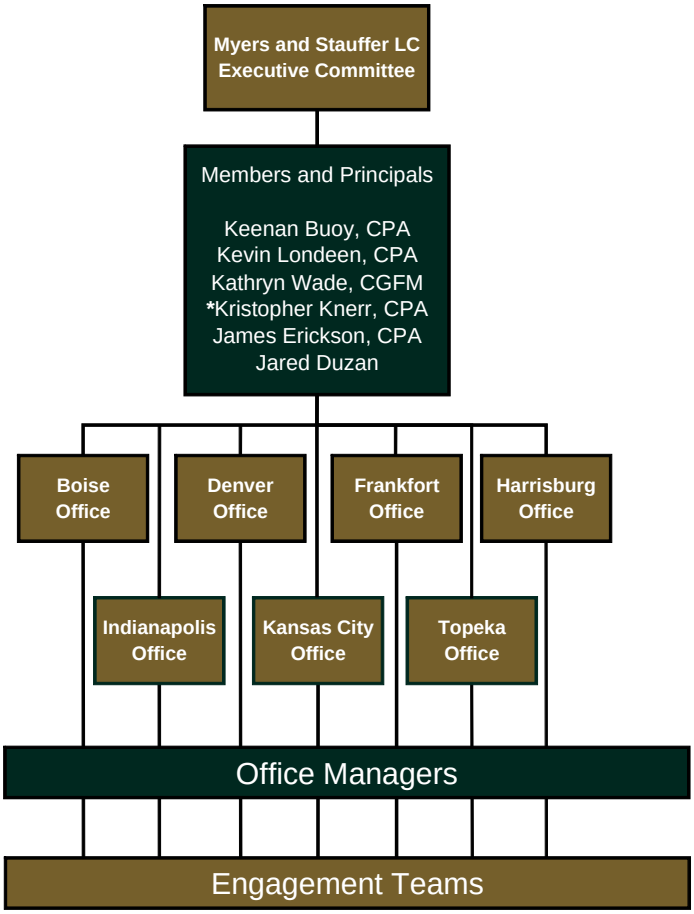
Myers and Stauffer has a staff of more than 160 people available across the firm with considerable academic training and specialized experience in health care consulting and reimbursement. In addition to certified public accountants, our project teams include registered nurses, managed care consultants, financial analysts and computer information systems professionals. Our firm also has established relationships with medical professionals, including physicians, dentists, pharmacists and others, to assist us on a consulting basis with complex issues that involve their respective areas of expertise.

Myers and Stauffer professional staff understands cost reporting requirements and rate setting issues. Our accountants are knowledgeable of generally accepted accounting principles, generally accepted auditing standards and governmental auditing standards. We provide additional educational opportunities for staff through attendance at national health care conferences, training courses sponsored by the American Institute of Certified Public Accountants (AICPA) and periodic in-house workshops to supplement their knowledge of Medicare and Medicaid reimbursement principles.

Structure of Organization

The following chart displays the corporate organizational structure of Myers and Stauffer. Kris Knerr, CPA, a member with the firm, will serve as project director and be responsible for oversight of the Iowa Medicaid Enterprise project within the firm.

Myers and Stauffer LC
Firm Organizational Chart



* Responsible for oversight of the Iowa Medicaid Enterprise project.

Proposed Executive, Management and Technical Staff

We are pleased to designate a project staff that has significant experience with the Iowa Medicaid program. The following table identifies the experience and depth of our executive, management and technical staff.

Name	Proposed Project Staff – Experience and Qualifications Relevant to RFP Requirements						
	Role on Project	Tenure with Myers and Stauffer	Experience with Rate Setting, Cost Settlements and Cost Audits	Experience with State Maximum Allowable Cost Program Rate Setting	Experience with Rebasing and DRG and APG Recalibration	Experience with Revenue Maximization	Experience with Reimbursement Technical Assistance and Support
Kris Knerr, CPA	Project Director	12					
Jared Duzan	Project Director	7					
Keenan Buoy, CPA	Quality Assurance	22					
Kevin Londeen, CPA	Technical Consultant	16					
Amy Perry, CPA	Account/Imp-lementation Manager	13					
Tom Donahue, CPA	Long Term Care Specialist	15					
Albert Long	Pharmacy SMAC	5					
Danyel Holmes	Pharmacy SMAC	1					
Kim Plake, RPh, PhD	Pharmacy SMAC	Consul-tant					
Scott Simerly, PhD	DRG/APG	8					
Ryan Farrell	DRG/APG	5					
Melenie Burns, CPA	Revenue Maximization	4					
Greg Cecil, CPA	Revenue Maximization	13					
Holly Ross	Technical Assistance	6					
Joann McMasters	Technical Assistance	8					
Patrice Nicholson, RN	Technical Assistance	9					
Robert Hicks, CPA	Technical Assistance	<1					
Mike Evans	Rate Setting Cost Settlement	5.5					
Robyn Pugh	Rate Setting Cost Settlement	8					
Chris Maben	Rate Setting Cost Settlement	8					
Andy Johnson, CPA	Rate Setting Cost Settlement	3.5					

Name	Proposed Project Staff – Experience and Qualifications Relevant to RFP Requirements						
	Role on Project	Tenure with Myers and Stauffer	Experience with Rate Setting, Cost Settlements and Cost Audits	Experience with State Maximum Allowable Cost Program Rate Setting	Experience with Rebasing and DRG and APG Recalibration	Experience with Revenue Maximization	Experience with Reimbursement Technical Assistance and Support
Don Catron, CPA	Rate Setting Cost Settlement	6					
Cheryl Richter	Rate Setting Cost Settlement	2					
Chris Powell	Programming	8					
Mark Sheehan	Programming	8					
Sally Bechtel	Support	8					

Partnership Relationships with the Community

Myers and Stauffer has an existing relationship with the State of Iowa Department of Human Services. Since our firm specializes in services for state government agencies, we have not developed additional partnership relationships elsewhere in the state.

Experience Relevant to the Services Described in this RFP

Many of the services described in the RFP represent a continuation of the tasks that Myers and Stauffer currently provides to the state. By virtue of this experience, our firm and our project team have a detailed knowledge of the state's reimbursement methodologies and the procedures necessary to properly administer them. Since 2000, we have provided the following services to DHS:

- Design, development and implementation of a case mix reimbursement system for nursing facilities.
- State MAC/Utilization Management
- Reimbursement, Upper Payment Limit
- ICF/MR Provider Assessment
- Payment Accuracy Measurement

The table below identifies projects Myers and Stauffer is either currently providing or has provided within the last three years that are similar to the services described in the RFP. All projects listed were completed on time and within budget. Section 11.2 of our proposal highlights our most relevant experience including project summaries with detailed information about each project.

State	Client	Project Description
Alaska	Department of Health and Social Services	Medicaid Provider Audit
California	Department of Health Services	Medi-Cal Reimbursement Rate Support Services
Colorado	Department of Health Care Policy and Financing	Audit and Rate Setting for Medicaid Long Term Care Facilities
Colorado	Department of Health Care Policy and Financing	NF, Hospital, ICF/MRs Upper Limit Calculation
Idaho	Department of Health and Welfare	Medicaid Audit Services
Indiana	Division of Disability, Aging and Rehabilitation Services	Desk Review, Consulting
Indiana	Family and Social Services Administration	Developed Rates and Cost Model
Indiana	Office of Policy and Planning	Long Term Care Rate Setting Services
Indiana	Office of Policy and Planning	Hospital Payment Rate Setting and Audit Services, with State MAC Rate Setting
Iowa	Department of Human Services	State MAC/Utilization Management
Iowa	Department of Human Services	Reimbursement, UPL
Iowa	Department of Human Services	ICF/MR Provider Assessment
Kansas	Department of Social and Rehabilitation Services	Review Rate Structure
Kansas	Department of Social and Rehabilitation Services	Rate Setting and Resident Status Review
Kansas	Department of Social and Rehabilitation Services	DRG Rate Setting
Kansas	Department on Aging	IGT
Kentucky	Department for Medicaid Services	Desk Review

State	Client	Project Description
Kentucky	Department for Medicaid Services	Rate Setting
Kentucky	Department for Medicaid Services	NFs and Adult Day Desk Review and Cost Settlement
Kentucky	Department for Medicaid Services	FQHCs, RHCs and PCCs Rate Setting
Louisiana	Department of Health and Hospitals	Rebasing Hospital Rates
Louisiana	Department of Health and Hospitals	Medicare Upper Limit Calculation
Louisiana	Department of Health and Hospitals	DRG Rate Setting
Minnesota	Department of Human Services	Evaluate Payment System
Minnesota	Department of Human Services	UPL Consulting
Minnesota	Department of Human Services	Develop Reimbursement and Quality Profile System
Montana	Department of Public Health and Human Services	PAP Audit
Montana	Department of Public Health and Human Services	Nursing Facility Audit
Montana	Department of Public Health and Human Services	Nursing Facility Medicare Upper Limit, Case Mix
Nevada	Health Care Financing and Policy Division	Medicaid Rate Study
New Jersey	Department of Health and Senior Services	UPL, IGT
New Jersey	Department of Health and Senior Services	LTC Facility Auditing
New Mexico	Department of Human Services	Nursing Facility Audit, AUP's
New Mexico	Department of Human Services	Hospital Audit and Desk Review
North Carolina	Department of Health and Human Services	DSH Reimbursement Consulting

State	Client	Project Description
Washington	Department of Social and Health Services	IGT Consulting
West Virginia	Public Employees Insurance Agency	DRG/APC/RBRVS
Wyoming	Department of Health	Medicaid Rate Setting, Rebasing and Case Mix Consultation and Development

Other Contracts or Projects

Myers and Stauffer's current experience with state Medicaid agencies includes the following projects:

State	Client	Project Description
Georgia	Department of Community Health	Nursing Facilities Case Mix Services
Idaho	Department of Health and Welfare	Payment Accuracy Measurement
Indiana	Office of Policy and Planning	Payment Accuracy Measurement
Iowa	Department of Human Services	Payment Accuracy Measurement
Kansas	Department of Social and Rehabilitation Services	Data Base Management
Kansas	Department of Social and Rehabilitation Services	Consulting
Kentucky	Department for Medicaid Services	Fraud and Abuse, Utilization Management
Kentucky	Department for Medicaid Services	Payment Accuracy Measurement
Louisiana	Department of Health and Hospitals	Case Mix
Maryland	Health Care Commission	MDS Resident Assessment
Maryland	Health Care Commission	Consulting
Montana	Department of Justice	Hospital Consolidation Financial Review

State	Client	Project Description
New Hampshire	Division of Elderly and Adult Services	MDS Validation Program
North Carolina	Department of Health and Human Services	Managed Care, Monitoring and Evaluation
Pennsylvania	Department of Public Welfare	Case Mix Rate Calculation and Analysis
Pennsylvania	Department of Public Welfare	Automated Cost Report System
South Carolina	Department of Health and Human Services	Fraud and Abuse, Utilization Management
South Carolina	Department of Health and Human Services	Payment Accuracy Measurement

11.2 Contractor Experience Levels - Professional Services Components

(RFP Section 7.2.11.1.2)

A. Rate Setting, Consulting and Cost Audit Experience

Myers and Stauffer provides data collection, management and analysis services to help our government clients assess Medicaid recipient health care needs, utilize resources and establish reimbursement/payment rates. We have experience working on both state-specific and nationwide issues. This experience provides our staff with direct knowledge of resident assessments, resource utilization measurement, payment options and verification systems available to government programs. We are able to draw upon this knowledge to assist our existing and new clients in addressing their unique health care challenges.

Health Care Cost Analysis and Program Payment Experience

Myers and Stauffer's experience includes assisting Medicaid agencies with long term care facility reimbursement issues on engagements covering a wide spectrum of services. The list of long term care facility services we provide to states includes:

- Cost report desk reviews and audits.
- Cost report design and database development.
- Computerized payment/rate systems.
- Case mix reimbursement systems, including services that support:
    1. Case mix weights, time studies and service screening initiatives.
    2. Electronic MDS collection systems by providing clinical and MDS submission training, maintaining a help desk for technical assistance of provider submission, producing information newsletters and performing data verification/validation.
    3. Payment system design, modeling and presentations of alternative payment systems and rule promulgation.
    4. MDS verification design, provider training and technical support.

- House and administer the MDS/OASIS standard state data collection systems, including the provision of support for providers and agencies.
- Serving as state contract manager for HCFA's Multistate Nursing Home Case Mix and Quality (MNHCMQ) demonstration project.
- Consulting to states on Medicare cost reporting, and definitions of allowable costs and reimbursement issues that have an impact on Medicaid nursing facility cost and reimbursement.
- Assisting with state plan development, preparing Medicaid justifications and assisting with the state's assurances to CMS.
- Drafting Medicaid reimbursement regulations.
- Providing testimony in rate appeals or settlement disputes.
- Providing training to a Medicare Fiscal Intermediary on the prospective payment system including the RAI process, RUG classification and documentation to support the billing process.

Myers and Stauffer's experience includes audits and desk reviews of nursing facilities, intermediate care facilities for the mentally retarded, hospitals, federally qualified health centers, rural health clinics, home health agencies and community residential facilities for developmentally disabled. Myers and Stauffer processes more than 4,000 cost reports annually, performing a variety of services including cost report verification, rate calculation and reimbursement settlement reconciliations. The following table illustrates our current annual cost report responsibilities. This table, however, does not reflect the multiple functions, such as desk reviews, audits and rate calculations performed on an individual cost report.

State	Number of Health Care Provider Cost Report Responsibilities Processed Annually for State Agency Clients						
	SNF/NF	Hospital	ICF/MR	FQHC/ RHC	HHA	Other	Total
Colorado	206						206
Idaho	74	76	63	42	74		329
Indiana	516	154	559	8	250		1,487
Kansas	370	145	40				555
Kentucky	276	105	12				393
N. Carolina	120	146					266
New Mexico							

State	Number of Health Care Provider Cost Report Responsibilities Processed Annually for State Agency Clients						
	SNF/NF	Hospital	ICF/MR	FQHC/ RHC	HHA	Other	Total
	80	48	41	24	40		233
Pennsylvania	660						660
Wyoming	36		4	1		13	54
Total:	2,338	674	719	75	364	13	4,183

Cost Settlement Experience

Myers and Stauffer has substantial experience with Medicare/Medicaid cost settlement experience. We have not, however, served as a Medicare fiscal intermediary.

Our Medicare/Medicaid cost settlement experience has been obtained under contract with state Medicaid agencies or under subcontracts for Medicare fiscal intermediaries (FI). In addition to our FI subcontracting experience, we have also obtained Medicare cost settlement experience by performing cost settlements for Medicaid programs that adopted Medicare retrospective cost settlement principles within the Medicaid state plan. Our Medicare/Medicaid cost settlement experience includes the following states and provider services:

Medicare/Medicaid Cost Settlement Experience							
		Provider Type					
State	Service Term	NF	Hospital I/P	Hospital O/P	FQHC	RHC	HHA
Idaho	1992 – Present						
New Mexico	1995 – Present						
Indiana	1995 – Present						
Kentucky	1998 – Present						
Montana	1991 - Present						
North Carolina	1998 - Present						

As shown above, we have performed cost settlement services for several states for many years. Our staff is knowledgeable of Medicare/Medicaid reimbursement principles, settlement (cost reporting) software programs, and the proper application of settlement (claims) data issues.

B. State Maximum Allowable Cost Program Rate Setting Experience

We have collected and analyzed acquisition cost from over one million pharmaceutical invoice line items. We have performed field visits at more than 600 pharmacies across the country.

Myers and Stauffer has more than 27 years experience in Medicaid pharmacy programs including currently setting SMAC rates for three states and conducting more than 40 pharmacy cost surveys in response to federal Medicaid regulations in 17 states. Many of these studies have included an analysis of drug ingredient acquisition costs.

Myers and Stauffer has performed SMAC rate setting activities for the state of Indiana since 2001, the state of Iowa since 2002 and the state of Idaho since 2003. For these engagements, Myers and Stauffer participated in meetings with state officials and other stakeholders including local pharmacist associations. These meetings aided the respective states to make strategic decisions to gain maximum cost savings while preserving the best possible relationship with the pharmacy industry. Myers and Stauffer provided critical assistance in SMAC policy design and subsequent rulemaking. After significant review of multi-source drug utilization, collection of acquisition cost data from participating pharmacies and statistical analysis, Myers and Stauffer has continuously set SMAC rates specific to the unique environments of each state and assisted in efforts to present new rates to the industry.

In addition to engagements directly related to SMAC program activities, Myers and Stauffer has significant experience in assisting states with an overall review of prescription drug ingredient reimbursement via acquisition cost studies. In recent years, Myers and Stauffer has performed pharmaceutical acquisition cost studies in California, Kentucky, Louisiana, Arkansas and Wyoming. Myers and Stauffer also consulted to the state of Idaho on acquisition cost issues in 1998. For these studies, Myers and Stauffer collected hundreds of thousands of pharmaceutical purchase invoice line items, and accumulated the data in our proprietary invoice database format. The primary component of these studies involved performing a statistically valid analysis comparing pharmacy actual acquisition cost with published prices including the AWP, WAC and Federal Upper Limit, and Direct Price. For states with SMAC programs already in place, these studies included an evaluation of existing SMAC pricing relative to acquisition cost.

In addition to understanding the acquisition cost structure of pharmacies, Myers and Stauffer brings the state of Iowa significant experience with the

overhead and labor cost structure of retail and institutional pharmacies. Our responsibilities during each of the numerous pharmacy dispensing cost studies we have conducted included developing a dispensing cost survey instrument, conducting desk and field reviews of information submitted by pharmacies, performing cost allocations and statistical analyses, and developing reimbursement options and recommendations.

By virtue of this extensive experience, we have acquired a detailed understanding of the operations of retail and institutional pharmacies, including cost structures and the relationships that are part of distribution networks. We have collected and analyzed data from thousands of pharmacies, ranging from small independent operations to the largest national chains.

In conducting our pharmacy consulting practice, we have developed internal tools and resources to assist our state agency clients in evaluating their pharmacy programs. In addition to specialized application programs, we maintain online databases of *current and historical* drug information, including National Drug Codes (NDC), generic code number (GCN), Average Wholesale Price (AWP), Federal Upper Limits (FUL), package sizes, etc. Similarly, we maintain a database of the current and historical state reimbursement formulas and related information (e.g. co-pays).

In addition to these resources and in the course of our various pharmacy engagements, we have built proprietary databases, covering such areas as pharmacy costs, ingredient acquisition cost by product and type of pharmacy, and third-party and cash customer revenue by product and type of pharmacy.

Our Medicaid pharmacy practice includes analysis of policy issues and litigation support.

Myers and Stauffer's consulting practice has assisted states in the study and implementation of pharmacy reimbursement policy. In addition to cost and statistical analyses, our services have included policy analysis, provider relations, development of regulations and State Plan amendments (and assistance in securing CMS approval), and litigation support. We have evaluated the issue of Medicaid reimbursement for pharmacist cognitive services in Kansas, and also conducted a statistical analysis of the impact of changing prior-authorization policies for SSRI anti-depressants.

During the spring of 1999, we assisted the Kentucky Office of the Attorney General in defending state Medicaid pharmacy reimbursement rates in *Tinsley et al v. Cabinet for Human Services*. We also provided litigation support to the Attorney General's Office in Washington State, in *Allenmore v. DSHS*, an action involving the state's pharmacy reimbursement program during the period 1989 through 1994.

Myers and Stauffer has completed a contract for CMS that studied high cost drugs in the proposed outpatient hospital prospective payment system. For this project, we collected and analyzed acquisition and utilization cost data for drugs supplied to Medicare outpatients.

In the spring of 2000, Myers and Stauffer performed a review of the Pharmaceutical Benefits Manager (PBM) for the Oklahoma State and Education Employees Group Insurance Board. This project included verification of the PBM's implementation of the plan's prescription benefit through a thorough review of claims data. Additionally, through a consulting phase of the project, the structure of the plan's prescription benefit was analyzed including an evaluation of the plan's dispensing fees, ingredient reimbursement rates and MAC fee schedule.

C. Rebasing and DRG and APG Recalibration Experience

Since 1992, Myers and Stauffer has provided DRG rate setting and related consulting services to eight states: Alaska, Colorado, North Carolina, Kansas, Indiana, New Mexico, West Virginia and Oregon. The DRG system in North Carolina was designed by Myers and Stauffer and replaced that state's former per-diem reimbursement system. Currently, Myers and Stauffer is in the process of overhauling the West Virginia DRG system to address payment inequities. The firm has provided these states with reimbursement system options to address issues related to neonatal, psychiatric, and rehabilitation services. In servicing these DRG rate setting engagements, the firm has developed and refined specialized computer software tools that allow us to conduct the routine portions of the rate setting and modeling processes with superior efficiency. As a result, project team members are able to spend more time on analysis.

The firm's expertise in hospital rate setting is enhanced by our experience in a number of other states with various hospital projects. In recent years, Myers and Stauffer has provided rate setting, reimbursement system development support, and hospital cost report audits to government agencies in 12 states (including the seven DRG projects discussed above).

The firm also provides hospital cost report review, analysis and cost settlements for the states of Indiana, Idaho and New Mexico. The firm conducts hospital cost report audits for the Medicaid agencies in Alaska, New Mexico, Indiana, and Kentucky, and in 1994 we conducted on-site financial studies of hospital cost reports for the Commonwealth of Pennsylvania as part of that state's initiative to develop new cost finding rules. Myers and Stauffer has consulted to the states of Missouri and South Dakota on inpatient findings

and assurances and has provided Connecticut with litigation support in a Boren Amendment lawsuit.

Myers and Stauffer has assisted its clients with the development of disproportionate share hospital (DSH) payment plans, state plan development and with the on-going operation of DSH payment systems. We are knowledgeable of federal DSH payment requirements and with techniques various Medicaid agencies have used within the DSH program to further leverage federal participation within state Medicaid programs.

Our state Medicaid DSH experience includes:

- Idaho Division of Medicaid, Department of Health and Welfare
- Indiana Office of Medicaid Policy and Planning
- New Mexico Human Services Department
- North Carolina Division of Medical Assistance

D. Revenue Maximization

Myers and Stauffer has assisted several states with Medicare upper payment limit calculations. Our work has encompassed preparing detailed analyses, developing alternative findings methodologies, and helping our clients address issues or questions raised by CMS. We have assisted our clients in maximizing federal leveraging opportunities, representing millions in budgetary offsets and expansions of health care services. Our findings (studies and analyses) have been presented in federal court on two occasions, where each state successfully defended itself from Boren Amendment challenges to its payment system. Although these challenges did not directly attack our Medicare upper limit findings, we consider the fact that both states were successful in their defense against these lawsuits attests to the quality of our analyses and the related recommendations we made to our clients.

Through our work with other states, we have developed an extensive understanding of Medicare reimbursement principles. Medicare reimbursement issues are frequently encountered in conjunction with the performance of Medicaid cost report audits, which is a substantial portion of our business. We have also demonstrated our understanding of Medicare reimbursement through previous Medicare upper limit and payment system development projects.

Since the enactment of the Medicare Prospective Payment System (PPS), we have worked with Medicare PPS rates in developing upper payment limits. We have performed upper payment limit services for the following states:

- Colorado Department of Healthcare Policy and Finance
- Georgia Department of Community Health
- Idaho Division of Medicaid, Department of Health and Welfare
- Indiana Office of Medicaid Policy and Planning
- Iowa Department of Human Services
- Kansas Department of Social and Rehabilitative Services
- Kentucky Department for Medicaid Services
- Louisiana Bureau of Health Services Financing
- Montana Department of Health and Human Services
- Nevada Department of Human Resources
- New Jersey Department of Health and Human Services
- New Mexico Human Services Department
- Pennsylvania Department of Public Welfare
- Washington Medical Assistance Administration
- Wisconsin Department of Administration

Myers and Stauffer has assisted our state Medicaid agency clients with provider tax projects since enactment of the provider tax and donation regulations. For many years following enactment of these regulations, there was relatively little activity in this area. Recently, we have seen a flurry of provider tax plans pursued by our Medicaid agency clients.

We have seen and assisted several states with their pursuit of automatic waivers of the broad-based and uniformity requirements of the provider tax regulations. States have demonstrated an increased willingness to use this funding mechanism in light of increased budget pressures.

Our provider tax experience includes the following Medicaid agencies:

- Colorado Department of Healthcare Policy and Finance
- Indiana Office of Medicaid Policy and Planning
- Iowa Department of Human Services
- Montana Department of Health and Human Services
- North Carolina Division of Medical Assistance
- Pennsylvania Department of Public Welfare

E. Reimbursement Technical Assistance and Support

Myers and Stauffer specializes in reimbursement system design and rate setting for Medicaid programs. Over the past five years, we have designed reimbursement systems and set rates for Medicaid programs in 15 states. Areas of expertise include:

- ICF/MR: prospective price and cost-based reimbursement systems.
- Nursing facility and other LTC facilities: prospective cost and price-based reimbursement systems.
- Level of care (acuity) systems for long term care facilities.
- Home health services: prospective reimbursement systems.
- Inpatient hospital: DRG, per diem and TEFRA-like systems.
- Outpatient hospital services (cost and price-based systems).
- Physician relative value systems.
- Pharmacy dispensing fee and ingredient reimbursement systems.
- Dental, transportation and other ancillary medical services.

We are one of a few firms nationally that specialize in this area of health care finance. Our services include extensive statistical and fiscal impact modeling, comparison with national practices, setting weights and defining allowable costs, developing computerized rate setting systems for client use, database development, and drafting supporting regulations and state plan amendments. The firm has been a leader in the development of acuity-based reimbursement systems for long term care facilities.

F. Project Summaries

We have included five project summaries to demonstrate Myers and Stauffer's most relevant government experience with the areas identified in the RFP.

Project Summary pages 333-337 have been removed from sanitized version of proposal due to confidential nature of information.

11.3 Letters of Reference

(RFP Section 7.2.11.2)

Myers and Stauffer has the reputation of being professional, knowledgeable, courteous and timely with its projects. We pride ourselves in the fact that our integrity has never been questioned and we have never had a contract dispute with any client, nor a contract terminated for cause. Our success is built on providing exceptional service to government health care agencies.

We have included letters of reference from three state agency clients on the following pages. These reference letters are not intended to serve as a substitute for independent inquiry. We encourage the evaluation committee to review these letters and contact the individuals for verification of the professionalism and competence of Myers and Stauffer. We have included additional letters of reference in Appendix G.

11.4 Disclosure of Felony Convictions

(RFP Section 7.2.11.3)

Neither Myers and Stauffer, nor any of its owners, officers or primary partners, have ever been convicted of a felony. We understand this is a continuing disclosure requirement. We agree that any such matter, which occurs after submission of the Bid Proposal and/or execution of a contract, will be disclosed in a timely manner in a written statement to the Department.

INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION
FSSA
"People helping people help themselves"

Frank O'Bannon, Governor
State of Indiana

Office of Medicaid Policy and Planning
402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

Katherine L. Davis, Secretary

April 29, 1998

To Whom It May Concern:

This letter is a professional reference for the firm of Myers and Stauffer, LC, which has performed services for the State of Indiana in a variety of Medicaid health care reimbursement areas since 1982. I personally have been involved in activities with Myers and Stauffer since 1995, when they were awarded the hospital audit and rate-setting contract.

The services currently provided to us by Myers and Stauffer on the hospital contract include the following:

1) Ensure receipt of and perform desk reviews of cost reports for all Medicaid-enrolled hospital providers, including acute care hospitals, private psychiatric and rehabilitation hospitals, community mental health centers and state-operated hospitals.

2) Perform desk reviews of cost reports filed by hospitals to verify completeness and accuracy; create and adjust to a Medicaid statistical report from electronic claims data. Maintain claims database for purpose of claims data analysis.

3) Perform field audits of hospitals upon request of OMPP. Such field audits are either full scope in nature, or shall be focused on specific issues that are identified.

4) Determine which Medicaid-enrolled hospital providers qualify for disproportionate share hospital (DSH) payments. The determinations include preparation of a database that includes all information necessary to determine eligibility and calculate payment amounts.

5) Ensure receipt of cost reports related to provider-based RHC and FQHC expenditures from all enrolled providers. Conduct desk audits of provider data to identify necessary audits in order to insure the integrity of the reimbursement program.

6) Perform field audits of provider-based RHC and FQHC providers to insure an equitable cost settlement. Develop Medicaid statistical reports based on claims data for use in final settlement calculations. Revise provider-submitted cost reports to reflect audit findings and issue a Title XIX Notice of Program Reimbursement (NPR) for each provider. Maintain an accounts receivable and accounts payable function associated with these settlement activities.

7) Perform periodic interim settlements to facilitate proper cost reimbursement for provider-based and free-standing RHCs and FQHCs, as appropriate.

8) Maintain staffing, data systems and other resources necessary to support rate setting under the DRG/LOC reimbursement systems, and perform tasks necessary to calculate updated DRG relative weights, hospital DRG base rates, hospital rates for the LOC, and other rates to support the State's inpatient prospective payment system.

9) Monitor the outpatient reimbursement system, and conduct fiscal analyses and rate setting activities related to the reimbursement of hospital outpatient services as deemed necessary by OMPP.

10) Conduct a study of APG outpatient reimbursement methodology including payment modeling and making recommendations to OMPP on changes to the payment methodologies.

11) Maintain current and appropriate rates for physician professional services reimbursed under the Resource-Based Relative Value Units (RBRVU) system and other professional and technical practitioner services; such as therapy, laboratory, and radiology services.

12) Develop revised dental reimbursement fee schedule as requested by OMPP and provide consultation services to evaluate OMPP dental reimbursement policies.

13) Provide additional analysis and support to evaluate Medicaid reimbursement levels in various non-institutional provider reimbursement categories, such as durable medical equipment, transportation, and other providers paid on a fee schedule basis.

14) Provide general consulting services on an as-needed basis to assist the OMPP with resolution of various program issues that arise.

15) Monitor Medicaid and Medicare legislation and federal rule making associated with all areas listed above and advise OMPP on those changes.

16) Prepare and provide supporting documentation and offer testimony at administrative and judicial hearings resulting from activities associated with all areas listed above.

The Office of Medicaid Policy and Planning, within the Indiana Family and Social Services Administration, has a staff of 70 persons and is responsible for administering Indiana's nearly $3 billion Medicaid Program. Because our staff is small, the Office places great reliance on its many contractors for providing the analytical and program support necessary to properly evaluate and enhance Medicaid policy and program delivery.

Myers and Stauffer currently has three contracts with our Office: nursing facility case mix development and implementation; long term care rate-setting; and hospital rate-setting and auditing. All three were competitively procured with Myers and Stauffer selected as the optimal bidder for the State.

In its contractual capacity with the Medicaid Office, Myers and Stauffer has provided a staff of resources that are exceptionally well-trained, knowledgeable, professional, and unflinchingly supportive. Staff turnover that affects work performed under our contracts is rare, if not altogether nonexistent. Management of time and resources is outstanding as well.

Myers and Stauffer's overall performance and service delivery is unmatched by other contractors. Deadlines are always met or exceeded, work products are always comprehensive and of exceptional quality, and collaboration with appropriate State staff is always initiated and pursued with good judgment.

I highly recommend Myers and Stauffer for the performance of health care related services. Without their assistance, the Indiana Medicaid Office would not have been able to accomplish many of our short and long-term program and policy objectives.

Please feel free to contact me at (317)232-4318 if you have any questions concerning this letter of recommendation. I would be more than happy to discuss Myers and Stauffer's performance in greater detail.

Sincerely,

Pat Nolting

Pat Nolting, Director
Medicaid Program Operations-Acute Care

PN:jb

INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION
FSSA
"People helping people help themselves"

Frank O'Bannon, Governor
State of Indiana

Office of Medicaid Policy and Planning
402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

Katherine Humphreys, Secretary

May 22, 2001

To Whom it May Concern:

This letter will serve as a professional reference for the firm of Myers and Stauffer. Myers and Stauffer has held several significant competitively procured contracts with the Indiana Office of Medicaid Policy and Planning (OMPP) for many years, and our office has consistently been very pleased with their performance. Myers and Stauffer has always exhibited the utmost professionalism and timeliness in providing services to our office.

In 1998, Myers and Stauffer, through a subcontract with our fiscal agent contractor, began providing management and support services to Indiana's Drug Rebate unit. Myers and Stauffer has provided overall management of the unit, as well as technical support and cash control responsibilities.

Over the following twelve months Indiana began to see the results of diligent, proactive dispute resolution. The OMPP was very pleased that disputes were being settled in a timely manner. In addition, the fiscal agent and Myers and Stauffer together developed instructional provider mailings to describe and clarify appropriate billing units of measure for certain pharmacy products that often resulted in disputes. Through this provider education, disputes were reduced at the inception by improving the accuracy of provider billing.

When Myers and Stauffer assumed management responsibilities of the drug rebate unit, there were approximately $53 million in drug rebate receivables, of which $23 million were in disputed NDCs. Myers and Stauffer worked diligently with the OMPP and our fiscal agent to ensure that dispute resolution remained a high priority. This was all done within the parameters of HCFA's dispute resolution guidelines. Today, disputes are at an all-time low and are effectively and efficiently managed on a timely basis. In addition, Myers and Stauffer performs the cash control activities in Indiana by working with a local bank in establishing a lockbox and collecting related documentation and updating the cash receipts systems. Cash receipts have always been posted timely and accurately. The leadership Myers and Stauffer brings to this activity in Indiana has been instrumental to its success and has also allowed OMPP an opportunity to focus on other important issues of policy within the pharmacy area.

The OMPP continues to be very pleased with the level of service provided by Myers and Stauffer in the drug rebate unit, and would not hesitate to recommend them to other state Medicaid agencies for similar projects. Please feel free to contact me if you have any questions; for that possibility, I am forwarding my business card.

Sincerely,

Marc Shirley, R.Ph.

Marc Shirley, R.Ph.
Pharmacy Program Director

State of Idaho
DEPARTMENT OF HEALTH AND WELFARE
Division of Medicaid

DIRK KEMPTHORNE
Governor
KARL B. KURTZ
Director
JOSEPH R. BRUNSON
Administrator

P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5747
Fax (208) 364-1811

June 28, 1999

To Whom It May Concern:

I am pleased to offer this letter as a professional reference for the firm of Myers and Stauffer LC. Myers and Stauffer has provided a variety of Medicaid audit and reimbursement services for the state of Idaho since February of 1992. I personally have worked with Myers and Stauffer since 1994 in my capacity as Medicaid Division Deputy Administrator.

In addition to ongoing duties as the contract auditor/rate setter for the state of Idaho, Myers and Stauffer provided consulting services to the Department of Health and Welfare for the development of a prospective case-mix reimbursement system for nursing facilities. During this process Myers and Stauffer personnel attended a series of meetings with the Department of Health and Welfare and provider representatives and their consultant.

Initially, Myers and Stauffer provided the group with overviews of case-mix reimbursement systems from several other states and presented both the positive and negative attributes associated with each. Myers and Stauffer constructively assisted the Department and the group in defining desired goals and objectives of the new reimbursement system while, at the same time, representing the Department's interests in discussions with the providers' consultant. Once goals and objectives were defined, Myers and Stauffer prepared multiple reimbursement models with built-in flexibility to provide "what-if" type analyses during the meetings. These models and analyses saved valuable time and helped expedite the decision making process.

In this and other assignments, the staff of Myers and Stauffer have been competent, accessible, and thorough. They have a comprehensive understanding of the Medicaid reimbursement field and conduct themselves in a professional manner when working with state agency personnel as well as with providers of health care services. They are sensitive to the budget restraints within which state agencies must operate. Myers and Stauffer personnel have proven to be a valuable and effective resource for the state of Idaho.

I highly recommend the firm of Myers and Stauffer to any state agency requiring assistance in the health care reimbursement area.

Sincerely,

Kathleen P. Allyn

KATHLEEN P. ALLYN
Deputy Administrator

Printed on recycled paper.

12. Certifications and Guarantees by the Bidder

Myers and Stauffer offers the following certifications and guarantees as required in the RFP.

12.1 Authorization to Release Information

(RFP Section 7.2.12.1)

Myers and Stauffer has signed the document included in the RFP as Attachment F authorizing the release of information to the Department. The signed document is located at the end of this section.

12.2 Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions

(RFP Section 7.2.12.2)

Myers and Stauffer has signed the document included in the RFP as Attachment G which certifies that the firm is not presently disbarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any federal, department or agency. The signed document is located at the end of this section.

12.3 Certification of Independence and No Conflict of Interest

(RFP Section 7.2.12.3)

Myers and Stauffer has signed the document included in the RFP as Attachment H which certifies that our proposal was developed independently. Myers and Stauffer certifies that no relationship exists or will exist during the contract period between our firm and the Department that interferes with fair

competition or is a conflict of interest. The signed document is located at the end of this section.

12.4 Proposal Certifications and Declarations

(RFP Section 7.2.12.4)

Myers and Stauffer has signed the document included in the RFP as Attachment I certifying that the contents of the Bid Proposal are true and accurate. The signed document is located at the end of this section.

12.5 Certification of Available Resources

(RFP Section 7.2.12.5)

Myers and Stauffer has signed the document included in the RFP as Attachment J certifying that Myers and Stauffer has sufficient personnel resources available to provide the services for all Bid Proposals submitted. The signed document is located at the end of this section.

12.6 Acceptance of Terms and Conditions

(RFP Section 7.2.12.6)

Myers and Stauffer accepts all terms and conditions stated in the RFP.

12.7 Firm Bid Proposal Terms

(RFP Section 7.2.12.7)

Myers and Stauffer guarantees the availability of the services offered in our proposal and that all proposal terms, including price, will remain firm for at least 120 days after the date set for completion of contract negotiations and execution of the contract.

AUTHORIZATION TO RELEASE INFORMATION

Myers and Stauffer LC (name of bidder) hereby authorizes any person or entity, public or private, having any information concerning the bidder's background, including but not limited to its performance history regarding its prior rendering of services similar to those detailed in this RFP, to release such information to the Department.

The bidder acknowledges that it may not agree with the information and opinions given by such person or entity in response to a reference request. The bidder acknowledges that the information and opinions given by such person or entity may hurt its chances to receive contract awards from the Department or may otherwise hurt its reputation or operations. The bidder is willing to take that risk. The bidder agrees to release all persons, entities, the Department, and the State of Iowa from any liability whatsoever that may be incurred in releasing this information or using this information.

Myers and Stauffer LC

Printed Name of Bidder Organization

Signature of Authorized Representative

3-9-04

Date

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 which 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 Non-procurement 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 AN 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.

Signature

3-9-04
Date

Kristopher J. Knerr

Name (Printed)

Member

Title

Myers and Stauffer LC

Name of Bidder Organization

CERTIFICATION OF INDEPENDENCE AND NO CONFLICT OF INTEREST

By submission of a Bid Proposal, the bidder certifies (and in the case of a joint proposal, each party thereto certifies) that:

- The Bid Proposal has been developed independently, without consultation, communication or agreement with any employee or consultant of the Department who has worked on the development of this RFP, or with any person serving as a member of the evaluation committee;
- The Bid Proposal has been developed independently, without consultation, communication or agreement with any other bidder or parties for the purpose of restricting competition;
- Unless otherwise required by law, the information in the Bid Proposal has not been knowingly disclosed by the bidder and will not knowingly be disclosed prior to the award of the contract, directly or indirectly, to any other bidder;
- No attempt has been made or will be made by the bidder to induce any other bidder to submit or not to submit a Bid Proposal for the purpose of restricting competition;
- No relationship exists or will exist during the contract period between the bidder and the Department that interferes with fair competition or is a conflict of interest.

Name _____ Date 3-9-04

Member _____

Title

Myers and Stauffer LC

Name of Bidder Organization

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 Proposals (RFP) and offered in the bidder's proposal. I understand that by submitting this Bid Proposal, the bidder indicated below agrees to provide Provider Cost Audits and Rate Setting services 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.

Kenneth J. Kim _____ 3-9-04

Name Date

Member _____

Title

Myers and Stauffer LC _____
Name of Bidder Organization

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, 2004.

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.

Kenneth J. Kym _____ 3-9-04 _____

Name Date

Member _____

Title

Myers and Stauffer LC _____

Name of Bidder Organization

13. Appendix

A. Sample NF/ICF/MR Desk Review Program

B. Sample Auditor's Report

C. Sample FQHC Cost Settlement Program

D. Sample NF/ICF/MR Audit Program

E. Sample Audit Questionnaire

F. Sample SMAC Reports

G. Additional Myers and Stauffer LC Client Reference Letters

Sample NF/ICF/MR Desk Review Program - CONFIDENTIAL

Sample Auditor's Report - CONFIDENTIAL

Sample FQHC Cost Settlement Program - CONFIDENTIAL

Sample NF/ICF/MR
Audit Program - CONFIDENTIAL

Sample Audit Questionnaire - CONFIDENTIAL

Sample SMAC Reports

Medicaid Prescription Drug Program

Estimated SMAC Savings

Total Claims January 1, 2002 - March 31, 2003, by Quarter

DRAFT - For Internal Deliberations Only

		Total Claims								
gcn	drug name	Q1, 2002	Q2, 2002	% change from previous qtr	Q3, 2002	% change from previous qtr	Q4, 2002	% change from previous qtr	Q1, 2003	% change from previous qtr
35742	IBUPROFEN 600MG TAB	277	286	3.15%	227	-25.99%	268	15.30%	243	-10.29%
14222	DIAZEPAM 5MG TABLET	6,189	6,009	-3.00%	5,822	-3.21%	5,792	-0.52%	5,535	-4.64%
14260	ALPRAZOLAM 0.25MG TABLET	14,352	14,292	-0.42%	14,008	-2.03%	13,683	-2.38%	12,639	-8.26%
39683	AMOXICILLIN 250MG/5ML SUSP	4,596	3,596	-27.81%	3,029	-18.72%	2,955	-2.50%	2,742	-7.77%
27172	PREDNISONE 10MG TABLET	70	59	-18.64%	56	-5.36%	86	34.88%	114	24.56%
34962	FUROSEMIDE 40MG	2,379	2,505	5.03%	2,277	-10.01%	2,088	-9.05%	1,855	-12.56%
20642	METOPROLOL 50MG TABLET	11,667	11,722	0.47%	10,966	-6.89%	10,603	-3.42%	10,903	2.75%
15401	TRAZODONE 50MG TABLET	1,866	1,609	-15.97%	1,438	-11.89%	1,354	-6.20%	1,312	-3.20%
34961	FUROSEMIDE 20MG	1,630	1,312	-24.24%	1,163	-12.81%	1,043	-11.51%	919	-13.49%
17470	CLONAZEPAM 0.5MG	9,603	9,779	1.80%	9,365	-4.42%	9,392	0.29%	8,866	-5.93%
14261	ALPRAZOLAM 0.5MG	3,686	2,769	-33.12%	2,398	-15.47%	2,388	-0.42%	2,223	-7.42%
35744	IBUPROFEN 800MG TABLET	3,468	3,469	0.03%	3,400	-2.03%	3,410	0.29%	3,280	-3.96%
20661	ATENOLOL 50MG TAB	32,599	33,113	1.55%	32,834	-0.85%	32,501	-1.02%	31,553	-3.00%
20662	ATENOLOL 25MG TABLET	2,710	2,744	1.24%	2,682	-2.31%	2,673	-0.34%	2,539	-5.28%
70331	HYDROCODONE/APAP 5MG/500MG T/	868	931	6.77%	949	1.90%	944	-0.53%	943	-0.11%
14262	ALPRAZOLAM 1MG	36,476	36,814	0.92%	36,041	-2.14%	34,269	-5.17%	33,026	-3.76%
41681	ALBUTEROL .83MG/ML SOLUTION	13,207	12,870	-2.62%	12,843	-0.21%	12,710	-1.05%	12,475	-1.88%
17471	CLONAZEPAM 1MG	2,775	3,000	7.50%	3,117	3.75%	3,145	0.89%	3,085	-1.94%
42235	IPRATROPIUM 0.0002 INH SOL VIAL	4,741	4,802	1.27%	4,816	0.29%	4,693	-2.62%	4,854	3.32%
70335	HYDROCODONE/APAP 7.5MG/750MG	1,713	1,763	2.84%	1,774	0.62%	1,753	-1.20%	1,622	-8.08%
01390	CLONIDINE 0.1MG TAB	1,073	982	-9.27%	961	-2.19%	991	3.03%	983	-0.81%
34963	FUROSEMIDE 80MG TAB	7,361	7,557	2.59%	7,506	-0.68%	7,931	5.36%	8,011	1.00%
70335	HYDROCODONE/APAP 7.5/500	639	803	20.42%	800	-0.38%	789	-1.39%	738	-6.91%
14160	LORAZEPAM 0.5MG TABLET	335	361	7.20%	317	-13.88%	334	5.09%	330	-1.21%
17450	CARBAMAZEPINE 200MG	9,639	9,967	3.29%	9,812	-1.58%	10,182	3.63%	10,099	-0.82%

Claims

	Q1, 2002	Q2, 2002	% change from previous qtr	Q3, 2002	% change from previous qtr	Q4, 2002	% change from previous qtr	Q1, 2003	% change from previous qtr
	173,919	**173,114**	**-0.47%**	**168,601**	**-2.68%**	**165,977**	**-1.58%**	**160,889**	**-3.16%**

Medicaid Prescription Drug Program

Estimated SMAC Savings

Total Savings January 1, 2002 - March 31, 2003, by Quarter

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		Savings															
gcn	drug name	Q1, 2002	Q1, 2003	[1]Q1 Savings	% change from previous year	Q2, 2002	Q2, 2003	Q2 Savings	% change from previous year	Q3, 2002	Q3, 2003	Q3 Savings	% change from previous year	Q4, 2002	Q4, 2003	Q4 Savings	% change from previous year
35742	IBUPROFEN 600MG TAB	$48	$23	$6,075	-108.70%	$31	--	--	--	$32	--	--	--	$47	--	--	--
14222	DIAZEPAM 5MG TABLET	$29	$27	$11,070	-7.41%	$30	--	--	--	$27	--	--	--	$27	--	--	--
14260	ALPRAZOLAM 0.25MG TABLET	$8	$7	$12,639	-14.29%	$8	--	--	--	$7	--	--	--	$7	--	--	--
39683	AMOXICILLIN 250MG/5ML SUSP	$33	$23	$27,420	-43.48%	$32	--	--	--	$24	--	--	--	$23	--	--	--
27172	PREDNISONE 10MG TABLET	$37	$16	$2,394	-131.25%	$32	--	--	--	$17	--	--	--	$21	--	--	--
34962	FUROSEMIDE 40MG	$107	$99	$14,840	-8.08%	$106	--	--	--	$97	--	--	--	$101	--	--	--
20642	METOPROLOL 50MG TABLET	$9	$9	$0	0.00%	$9	--	--	--	$8	--	--	--	$9	--	--	--
15401	TRAZODONE 50MG TABLET	$50	$36	$18,368	-38.89%	$48	--	--	--	$37	--	--	--	$37	--	--	--
34961	FUROSEMIDE 20MG	$46	$36	$9,190	-27.78%	$44	--	--	--	$36	--	--	--	$36	--	--	--
17470	CLONAZEPAM 0.5MG	$28	$20	$70,928	-40.00%	$26	--	--	--	$15	--	--	--	$20	--	--	--
14261	ALPRAZOLAM 0.5MG	$24	$16	$17,784	-50.00%	$23	--	--	--	$17	--	--	--	$17	--	--	--
35744	IBUPROFEN 800MG TABLET	$49	$29	$65,600	-68.97%	$46	--	--	--	$29	--	--	--	$29	--	--	--
20661	ATENOLOL 50MG TAB	$7	$7	$0	0.00%	$7	--	--	--	$7	--	--	--	$7	--	--	--
20662	ATENOLOL 25MG TABLET	$47	$45	$5,078	-4.44%	$45	--	--	--	$42	--	--	--	$49	--	--	--
70331	HYDROCODONE/APAP 5MG/500MG TAB	$35	$31	$3,772	-12.90%	$35	--	--	--	$31	--	--	--	$32	--	--	--
14262	ALPRAZOLAM 1MG	$15	$11	$132,104	-36.36%	$14	--	--	--	$11	--	--	--	$11	--	--	--
41681	ALBUTEROL .83MG/ML SOLUTION	$8	$7	$12,475	-14.29%	$8	--	--	--	$7	--	--	--	$7	--	--	--
17471	CLONAZEPAM 1MG	$74	$36	$117,230	-105.56%	$69	--	--	--	$38	--	--	--	$38	--	--	--
42235	IPRATROPIUM 0.0002 INH SOL VIAL	$8	$7	$4,854	-14.29%	$8	--	--	--	$7	--	--	--	$7	--	--	--
70335	HYDROCODONE/APAP 7.5MG/750MG TAB	$37	$34	$4,866	-8.82%	$36	--	--	--	$34	--	--	--	$34	--	--	--
01390	CLONIDINE 0.1MG TAB	$73	$27	$45,218	-170.37%	$67	--	--	--	$26	--	--	--	$26	--	--	--
34963	FUROSEMIDE 80MG TAB	$23	$13	$80,110	-76.92%	$22	--	--	--	$14	--	--	--	$14	--	--	--
70335	HYDROCODONE/APAP 7.5/500	$26	$21	$3,690	-23.81%	$22	--	--	--	$21	--	--	--	$21	--	--	--
14160	LORAZEPAM 0.5MG TABLET	$64	$31	$10,890	-106.45%	$59	--	--	--	$31	--	--	--	$33	--	--	--
17450	CARBAMAZEPINE 200MG	$19	$11	$80,792	-72.73%	$18	--	--	--	$11	--	--	--	$11	--	--	--
		$21	**$16**	**$4,611,602**	**-35.29%**	**$21.03**				**$16.09**				**$16.32**			
				$2,857,810													
				$1,753,792													

Medicaid Prescription Drug Program

Estimated SMAC Savings

Total Claims January 1, 2002 - March 31, 2003, by Quarter

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gcn	drug name	Payment per Claim				
		Q1, 2002	Q2, 2002	Q3, 2002	Q4, 2002	Q1, 2003
35742	IBUPROFEN 600MG TAB	$48	$31	$32	$47	$23
14222	DIAZEPAM 5MG TABLET	$29	$30	$27	$27	$27
14260	ALPRAZOLAM 0.25MG TABLET	$8	$8	$7	$7	$7
39683	AMOXICILLIN 250MG/5ML SUSP	$33	$32	$24	$23	$23
27172	PREDNISONE 10MG TABLET	$37	$32	$17	$21	$16
34962	FUROSEMIDE 40MG	$107	$106	$97	$101	$99
20642	METOPROLOL 50MG TABLET	$9	$9	$8	$9	$9
15401	TRAZODONE 50MG TABLET	$50	$48	$37	$37	$36
34961	FUROSEMIDE 20MG	$46	$44	$36	$36	$36
17470	CLONAZEPAM 0.5MG	$28	$26	$15	$20	$20
14261	ALPRAZOLAM 0.5MG	$24	$23	$17	$17	$16
35744	IBUPROFEN 800MG TABLET	$49	$46	$29	$29	$29
20661	ATENOLOL 50MG TAB	$7	$7	$7	$7	$7
20662	ATENOLOL 25MG TABLET	$47	$45	$42	$49	$45
70331	HYDROCODONE/APAP 5MG/500MG TAB	$35	$35	$31	$32	$31
14262	ALPRAZOLAM 1MG	$15	$14	$11	$11	$11
41681	ALBUTEROL .83MG/ML SOLUTION	$8	$8	$7	$7	$7
17471	CLONAZEPAM 1MG	$74	$69	$38	$38	$36
42235	IPRATROPIUM 0.0002 INH SOL VIAL	$8	$8	$7	$7	$7
70335	HYDROCODONE/APAP 7.5MG/750MG TAB	$37	$36	$34	$34	$34
01390	CLONIDINE 0.1MG TAB	$73	$67	$26	$26	$27
34963	FUROSEMIDE 80MG TAB	$23	$22	$14	$14	$13
70335	HYDROCODONE/APAP 7.5/500	$26	$22	$21	$21	$21
14160	LORAZEPAM 0.5MG TABLET	$64	$59	$31	$33	$31
17450	CARBAMAZEPINE 200MG					

	Payment per Claim				
	Q1, 2002	Q2, 2002	Q3, 2002	Q4, 2002	Q1, 2003
Totals	$13.37	$12.85	$9.74	$9.80	$9.87

Medicaid
State MAC Rate Analysis
Estimated Annual Fiscal Savings

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GCN	Smart Key	Drug Group Name	Units (a)	State MAC (b)	EAC (c)	FUL (d)	Difference (e)	Estimated Annual Savings (f = e x a)
35742	11043903723079060001	IBUPROFEN 600MG TAB						
14222	80025801615020560001	DIAZEPAM 5MG TABLET						
14260	80025801617006560001	ALPRAZOLAM 0.25MG TABLET						
39683	20047603963810115001	AMOXICILLIN 250MG/5ML SUSP						
27172	68036002879024060001	PREDNISONE 10MG TABLET						
34962	56750203660037560001	FUROSEMIDE 40MG						
20642	32029802102039060001	METOPROLOL 50MG TABLET						
15401	80889301652039060001	TRAZODONE 50MG TABLET						
34961	56750203660030060001	FUROSEMIDE 20MG						
17470	44027501894010060001	CLONAZEPAM 0.5MG						
14261	80025801617010060001	ALPRAZOLAM 0.5MG						
35744	11043903723084060001	IBUPROFEN 800MG TABLET						
20661	32029802104039060001	ATENOLOL 50MG TAB						
20662	32029802104032060001	ATENOLOL 25MG TABLET						
70331	02026801730517060001	HYDROCODONE/APAP 5MG/500MG TAB						
14262	80025801617013560001	ALPRAZOLAM 1MG						
41681	14029402073566808015	ALBUTEROL .83MG/ML SOLUTION						
17471	44027501894013560001	CLONAZEPAM 1MG						
42235	14014200057550608015	IPRATROPIUM 0.0002 INH SOL VIAL						
70335	02026801730467260001	HYDROCODONE/APAP 7.5MG/750MG TAB						
01390	41014500113003060001	CLONIDINE 0.1MG TAB						
34963	56750203660043060001	FUROSEMIDE 80MG TAB						
70335	02026801730466960001	HYDROCODONE/APAP 7.5/500						
14160	80025804846010060001	LORAZEPAM 0.5MG TABLET						
17450	44027501893056060001	CARBAMAZEPINE 200MG						
39661	20047603963076050001	AMOXICILLIN 500MG CAPSULE						
21020	65030002148024060001	METOCLOPRAMIDE 10MG TABLET						
94781	95020301062013560001	FOLIC ACID 1MG TAB						
14161	80025804846013560001	LORAZEPAM 1MG TAB						
16354	80887501655030050001	FLUOXETINE HCL 20MG CAPSULE						
90163	20049104071531760001	SULFAMETHOXAZOLE/TMP DS TAB						
48104	38015206341033561301	ISOSORBIDE MN 30MG TAB SA						
46430	65766804521030060001	FAMOTIDINE 20MG TABLET						

Medicaid
State MAC Rate Analysis
Estimated Annual Fiscal Savings

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GCN	Smart Key	Drug Group Name	Units (a)	State MAC (b)	EAC (c)	FUL (d)	Difference (e)	Estimated Annual Savings (f = e x a)
70931	02026801768516460001	PROPOXY-N/APAP 100-650						
18020	77028101950024060001	CYCLOBENZAPRINE 10MG TAB						
17912	77028101944069060001	CARISOPRODOL 350MG						
10200	65766804520051560001	RANITIDINE 150MG						
70134	02026801717515260001	ACETAMINOPHEN/COD #3 TABLET						
35793	11043903727076060001	NAPROXEN 500MG TABLET						
47261	41014700132024060001	LISINOPRIL 10MG TABLET						
10810	71017904763076060001	METFORMIN HCL 500MG TABLET						
47262	41014700132030060001	LISINOPRIL 20MG TABLET						
39802	20925613908076050001	CEPHALEXIN 500MG						
70334	02026801730047360001	HYDROCODONE/APAP 10/500 TAB						
20110	14029402074784940215	ALBUTEROL 90MCG						
25793	35033802812020560001	WARFARIN 5MG TAB						
03513	59016700549711161601	POTASSIUM CL 20MEQ TAB SA						
18142	80915804834047560001	CLOZAPINE 100MG TAB						
17700	44027501877047550001	PHENYTOIN SOD EXT 100MG CAP						
34824	56042403649032060001	HYDROCHLOROTHIAZIDE 25MG TB						

Group	GCN	Smart Key	Drug Group Name	IN base rate	ID base rate	higher	Difference
617	26461	32029802107071050001	ACEBUTOLOL 400MG CAPSULE	$0.3006	$0.2875	IN	-$0.0131
143	70134	02026801717515260001	ACETAMINOPHEN/COD #3 TABLET	$0.0895	$0.1917	ID	$0.1022
410	13721	23051004183084060001	ACYCLOVIR 800MG TABLET	$0.3621	$0.3463	IN	-$0.0157
138	41680	14029402073633408015	ALBUTEROL 5MG/ML SOLUTION	$0.5303	$0.7401	ID	$0.2098
34	20110	14029402074784940215	ALBUTEROL 90MCG	$0.2639	$0.5213	ID	$0.2574
21	14261	80025801617010060001	ALPRAZOLAM 0.5MG	$0.0287	$0.0838	ID	$0.0551
11	14262	80025801617013560001	ALPRAZOLAM 1MG	$0.0424	$0.1050	ID	$0.0625
73	14263	80025801617016060001	ALPRAZOLAM 2MG TAB	$0.1068	$0.1022	IN	-$0.0046
579	17530	29027701898767509901	AMANTADINE 50MG/5ML SYRUP	$0.0253	$0.0242	IN	-$0.0011
22	10920	38014300083056060001	AMIODARONE HCL 200MG	$0.4488	$0.8485	ID	$0.3996
496	15272	80887701643051560001	AMITRIPTYLINE HCL 150MG TAB	$0.1141	$0.1091	IN	-$0.0050
227	39681	20047603962500160001	AMOX TR-K CLV 500-125MG TAB	$3.5466	$6.8184	ID	$3.2718
214	67076	20047603962238560001	AMOX TR-K CLV 875-125MG TAB	$5.0644	$9.4439	ID	$4.3795
142	39661	20047603963076050001	AMOXICILLIN 500MG CAPSULE	$0.0792	$0.1556	ID	$0.0764
224	56971	32029213449024060001	AMPHETAMINE SALTS 10MG TAB	$0.8616	$1.8812	ID	$1.0196
233	56973	32029213449030060001	AMPHETAMINE SALTS 20MG TAB	$0.8233	$1.8297	ID	$1.0064
258	56972	32029213449033560001	AMPHETAMINE SALTS 30MG TAB	$0.8456	$0.8088	IN	-$0.0368
234	56970	32029213449020560001	AMPHETAMINE SALTS 5MG TAB	$0.8928	$1.9107	ID	$1.0179
268	69500	02026801699033550001	ASA/BUTALBITAL/CAFFEINE with CODEINE	$1.0149	$0.9708	IN	-$0.0441
147	46771	72058304523039060001	AZATHIOPRINE 50MG TABLET	$0.3917	$0.7746	ID	$0.3829
489	87589	62040203383000006306	BACIT/POLYMYXIN EYE OINT	$1.1935	$1.1416	IN	-$0.0519
165	18010	77028101949024060001	BACLOFEN 10MG TABLET	$0.1764	$0.1687	IN	-$0.0077
173	18011	77028101949030060001	BACLOFEN 20MG TABLET	$0.3633	$0.3475	IN	-$0.0158
186	29840	50027901929047550001	BENZONATATE 100MG SOFTGEL	$0.2575	$0.5785	ID	$0.3210
270	17622	29027801905016060001	BENZTROPINE MES 2MG TABLET	$0.1134	$0.1085	IN	-$0.0049
541	31101	86038402883107005805	BETAMETHASONE VA 0.1% CREAM	$0.0558	$0.0534	IN	-$0.0024
52	16385	80889101653047560001	BUPROPION 100MG TAB	$0.2686	$0.5313	ID	$0.2627
49	16384	80889101653042060001	BUPROPION 75MG TAB	$0.1759	$0.3807	ID	$0.2048
221	28891	80025801620024060001	BUSPIRONE HCL 10MG TABLET	$0.1083	$0.1036	IN	-$0.0047
216	28892	80025801620027060001	BUSPIRONE HCL 15MG TABLET	$0.1995	$0.3973	ID	$0.1978
241	20641	80025801620020560001	BUSPIRONE HCL 5MG TABLET	$0.0918	$0.0878	IN	-$0.0040
452	71150	02027001790158150001	BUTALBITAL COMPOUND CAPSULE	$0.7457	$0.7133	IN	-$0.0324
444	71160	02027001790158160001	BUTALBITAL COMPOUND TABLET	$0.1414	$0.1353	IN	-$0.0061
341	72531	02027101854492560001	BUTALBITAL/APAP/CAFFEINE TB	$0.2331	$0.2230	IN	-$0.0101
118	72530	02027101854158160001	BUTALBITAL/CAFFEINE/APAP 50MG/40MG/325MG TAB	$0.1802	$0.3576	ID	$0.1774
666	01480	41014700128047560001	CAPTOPRIL 100MG TABLET	$0.0755	$0.0722	IN	-$0.0033
414	01483	41014700128025560001	CAPTOPRIL 12.5MG TABLET	$0.0174	$0.0167	IN	-$0.0008
433	01481	41014700128032060001	CAPTOPRIL 25MG TABLET	$0.0256	$0.0245	IN	-$0.0011
476	01482	41014700128039060001	CAPTOPRIL 50MG TABLET	$0.0328	$0.0313	IN	-$0.0014
117	54940	41014700127482860001	CAPTOPRIL/HCTZ 25MG/15MG TAB	$0.0788	$0.0754	IN	-$0.0034
19	17460	44027501893047560301	CARBAMAZEPINE 100MG CHW	$0.1364	$0.1305	IN	-$0.0059
5	17450	44027501893056060001	CARBAMAZEPINE 200MG	$0.0817	$0.1526	ID	$0.0709
18	62741	29027713894488260001	CARBIDOPA/LEVO 25/100	$0.2386	$0.4992	ID	$0.2606
278	62742	29027713894448360001	CARBIDOPA/LEVO 25/250 TAB	$0.2979	$0.6138	ID	$0.3159

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1	11043903723079060001	00591401101	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	100	6.70	0.067	1	0.067	
1	11043903723079060001	00904518661	IBUPROFEN 600MG TABLET	EA	BLIST PACK	MG	1	100	5.91	0.0591	1	0.0591	
1	11043903723079060001	59762737902	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	500	20.57	0.0411	2	0.0822	
1	11043903723079060001	59762737902	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	500	18.60	0.0372	1	0.0372	
1	11043903723079060001	49884077801	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	100	3.51	0.0351	3	0.1053	
1	11043903723079060001	53746013201	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	100	3.15	0.0315	1	0.0315	
1	11043903723079060001	00603401928	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	500	15.47	0.0309	1	0.0309	
1	11043903723079060001	59762737902	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	500	15.39	0.0307	1	0.0307	
1	11043903723079060001	49884077801	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	100	3.05	0.0305	2	0.061	
1	11043903723079060001	53746013201	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	100	3.02	0.0302	1	0.0302	
1	11043903723079060001	49884077801	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	100	3.01	0.0301	1	0.0301	
1	11043903723079060001	00603401921	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	100	2.98	0.0298	1	0.0298	
1	11043903723079060001	49884077801	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	100	2.98	0.0298	1	0.0298	
1	11043903723079060001	00677103205	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	500	14.87	0.0297	1	0.0297	
1	11043903723079060001	53746013201	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	100	2.96	0.0296	1	0.0296	
1	11043903723079060001	49884077801	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	100	2.80	0.028	1	0.028	
1	11043903723079060001	00677103205	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	500	13.80	0.0276	1	0.0276	
1	11043903723079060001	49884077801	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	100	2.74	0.0274	1	0.0274	
1	11043903723079060001	00603401928	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	500	13.48	0.0269	1	0.0269	
1	11043903723079060001	49884077801	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	100	2.66	0.0266	2	0.0532	
1	11043903723079060001	49884077805	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	500	13.18	0.0263	3	0.0789	
1	11043903723079060001	53746013205	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	500	13.11	0.0262	6	0.1572	
1	11043903723079060001	49884077805	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	500	13.09	0.0261	1	0.0261	
1	11043903723079060001	49884046805	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	500	12.53	0.025	3	0.075	
1	11043903723079060001	49884077805	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	500	12.53	0.025	16	0.4	
1	11043903723079060001	49884077805	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	500	12.26	0.0245	2	0.049	
1	11043903723079060001	49884046805	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	500	12.09	0.0241	1	0.0241	
1	11043903723079060001	49884077805	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	500	12.00	0.024	11	0.264	
1	11043903723079060001	49884077805	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	500	11.84	0.0236	1	0.0236	
1	11043903723079060001	49884077805	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	500	11.76	0.0235	2	0.047	
1	11043903723079060001	53746013205	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	500	11.39	0.0227	1	0.0227	
1	11043903723079060001	59762737902	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	500	11.35	0.0227	1	0.0227	
1	11043903723079060001	49884077805	IBUPROFEN 600MG TABLET	EA	BOTTLE	MG	1	500	10.94	0.0218	1	0.0218	
											74	2.0593	$0.0278
2	80025801615020560001	51079028520	DIAZEPAM 5MG TABLET	EA	BLIST PACK	MG	1	100	7.45	0.0745	1	0.0745	
2	80025801615020560001	00555036302	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	100	5.76	0.0576	1	0.0576	
2	80025801615020560001	00591561901	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	100	5.08	0.0508	1	0.0508	
2	80025801615020560001	00172392660	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	100	4.60	0.046	1	0.046	
2	80025801615020560001	00591561901	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	100	3.57	0.0357	1	0.0357	
2	80025801615020560001	00591561901	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	100	3.53	0.0353	1	0.0353	
2	80025801615020560001	00591561901	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	100	3.39	0.0339	1	0.0339	
2	80025801615020560001	00378034505	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	500	16.70	0.0334	2	0.0668	
2	80025801615020560001	00555036302	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	100	3.27	0.0327	1	0.0327	
2	80025801615020560001	00378034501	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	100	3.26	0.0326	2	0.0652	
2	80025801615020560001	00591561901	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	100	2.98	0.0298	8	0.2384	
2	80025801615020560001	00555036302	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	100	2.96	0.0296	1	0.0296	
2	80025801615020560001	00591561905	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	500	14.77	0.0295	2	0.059	
2	80025801615020560001	00591561901	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	100	2.92	0.0292	3	0.0876	
2	80025801615020560001	00172392660	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	100	2.86	0.0286	1	0.0286	
2	80025801615020560001	00555036302	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	100	2.86	0.0286	6	0.1716	

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2	80025801615020560001	00228205210	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	100	2.81	0.0281	1	0.0281	
2	80025801615020560001	00555036305	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	1000	27.93	0.0279	1	0.0279	
2	80025801615020560001	00555036305	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	1000	27.94	0.0279	9	0.2511	
2	80025801615020560001	00591561901	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	100	2.79	0.0279	2	0.0558	
2	80025801615020560001	00228205210	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	100	2.78	0.0278	2	0.0556	
2	80025801615020560001	00228205210	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	100	2.76	0.0276	1	0.0276	
2	80025801615020560001	00591561901	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	100	2.70	0.027	1	0.027	
2	80025801615020560001	00555036302	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	100	2.68	0.0268	1	0.0268	
2	80025801615020560001	00378034505	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	500	13.20	0.0264	1	0.0264	
2	80025801615020560001	00378034505	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	500	13.00	0.026	1	0.026	
2	80025801615020560001	00591561905	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	500	12.98	0.0259	1	0.0259	
2	80025801615020560001	00591561910	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	1000	25.20	0.0252	2	0.0504	
2	80025801615020560001	00591561910	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	1000	23.64	0.0236	1	0.0236	
2	80025801615020560001	00591561910	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	1000	23.26	0.0232	1	0.0232	
2	80025801615020560001	00228205250	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	500	11.55	0.0231	2	0.0462	
2	80025801615020560001	00228205250	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	500	11.11	0.0222	2	0.0444	
2	80025801615020560001	00591561905	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	500	11.00	0.022	8	0.176	
2	80025801615020560001	00228205250	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	500	10.88	0.0217	1	0.0217	
2	80025801615020560001	00591561905	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	500	10.78	0.0215	1	0.0215	
2	80025801615020560001	00228205250	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	500	10.40	0.0208	1	0.0208	
2	80025801615020560001	00591561910	DIAZEPAM 5MG TABLET	EA	BOTTLE	MG	1	1000	9.31	0.0093	1	0.0093	
											74	2.1286	$0.0288
3	80025801617006560001	00781106105	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	36.68	0.0733	1	0.0733	
3	80025801617006560001	59762371903	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	31.90	0.0638	1	0.0638	
3	80025801617006560001	59762371904	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	1000	44.20	0.0442	1	0.0442	
3	80025801617006560001	00781106105	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	21.86	0.0437	1	0.0437	
3	80025801617006560001	00781106101	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	100	4.35	0.0435	4	0.174	
3	80025801617006560001	00378400101	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	100	4.28	0.0428	1	0.0428	
3	80025801617006560001	00781106110	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	1000	42.60	0.0426	1	0.0426	
3	80025801617006560001	00781106101	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	100	4.23	0.0423	1	0.0423	
3	80025801617006560001	00781106105	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	20.89	0.0417	15	0.6255	
3	80025801617006560001	00781106105	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	20.51	0.041	1	0.041	
3	80025801617006560001	00378400101	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	100	4.08	0.0408	1	0.0408	
3	80025801617006560001	00378400105	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	19.95	0.0399	2	0.0798	
3	80025801617006560001	00781106110	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	1000	39.61	0.0396	2	0.0792	
3	80025801617006560001	00781106105	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	19.73	0.0394	1	0.0394	
3	80025801617006560001	00378400105	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	19.60	0.0392	1	0.0392	
3	80025801617006560001	00378400105	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	19.58	0.0391	14	0.5474	
3	80025801617006560001	00378400101	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	100	3.90	0.039	1	0.039	
3	80025801617006560001	00781106105	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	19.52	0.039	1	0.039	
3	80025801617006560001	00781106105	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	19.47	0.0389	3	0.1167	
3	80025801617006560001	00378400105	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	19.28	0.0385	1	0.0385	
3	80025801617006560001	00378400105	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	19.18	0.0383	2	0.0766	
3	80025801617006560001	00781106105	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	19.15	0.0383	1	0.0383	
3	80025801617006560001	00378400101	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	100	3.82	0.0382	1	0.0382	
3	80025801617006560001	00378400101	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	100	3.81	0.0381	1	0.0381	
3	80025801617006560001	00378400101	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	100	3.79	0.0379	1	0.0379	
3	80025801617006560001	00781106110	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	1000	37.90	0.0379	3	0.1137	
3	80025801617006560001	00228202796	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	1000	37.57	0.0375	2	0.075	

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3	80025801617006560001	00378400105	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	18.60	0.0372	1	0.0372	
3	80025801617006560001	00378400105	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	18.25	0.0365	1	0.0365	
3	80025801617006560001	00781106101	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	100	3.64	0.0364	1	0.0364	
3	80025801617006560001	00781106105	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	18.15	0.0363	1	0.0363	
3	80025801617006560001	00781106110	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	1000	36.01	0.036	1	0.036	
3	80025801617006560001	00781106110	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	1000	36.08	0.036	1	0.036	
3	80025801617006560001	00378400101	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	100	3.40	0.034	1	0.034	
3	80025801617006560001	59762371901	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	100	3.36	0.0336	2	0.0672	
3	80025801617006560001	00378400105	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	16.54	0.033	3	0.099	
3	80025801617006560001	00228202710	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	100	3.29	0.0329	2	0.0658	
3	80025801617006560001	00228202710	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	100	3.28	0.0328	1	0.0328	
3	80025801617006560001	00378400105	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	16.32	0.0326	1	0.0326	
3	80025801617006560001	59762371901	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	100	3.19	0.0319	1	0.0319	
3	80025801617006560001	59762371903	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	15.89	0.0317	1	0.0317	
3	80025801617006560001	59762371903	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	15.66	0.0313	1	0.0313	
3	80025801617006560001	59762371904	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	1000	31.31	0.0313	2	0.0626	
3	80025801617006560001	59762371904	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	1000	29.65	0.0296	1	0.0296	
3	80025801617006560001	59762371904	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	1000	28.16	0.0281	3	0.0843	
3	80025801617006560001	00228202796	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	1000	24.27	0.0242	1	0.0242	
3	80025801617006560001	59762371901	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	100	1.97	0.0197	2	0.0394	
3	80025801617006560001	00378400105	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	9.67	0.0193	1	0.0193	
3	80025801617006560001	00781106101	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	100	1.57	0.0157	1	0.0157	
3	80025801617006560001	59762371904	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	1000	14.28	0.0142	1	0.0142	
3	80025801617006560001	00781106105	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	7.08	0.0141	1	0.0141	
3	80025801617006560001	59762371903	ALPRAZOLAM 0.25MG TABLET	EA	BOTTLE	MG	1	500	6.93	0.0138	1	0.0138	
											98	3.6319	$0.0371

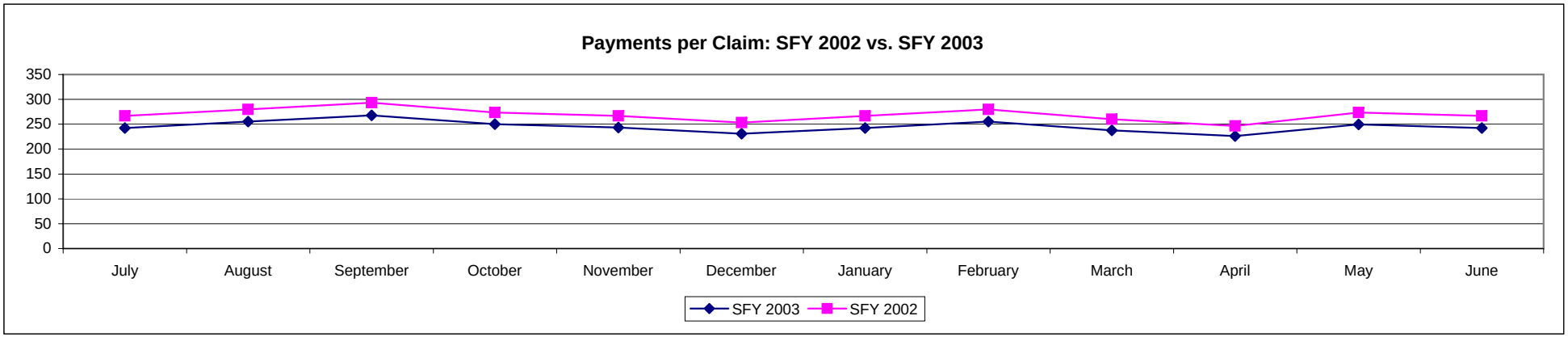
Medicaid: State Maximum Allowable Cost Fee Schedule Monitoring

Utilization Summary

DRAFT - For Internal Deliberations Only

SFY 2002	July	August	September	October	November	December	January	February	March	April	May	June	Total
MAC Payments	$2,000,000	$2,100,000	$2,200,000	$2,300,000	$2,200,000	$2,100,000	$2,000,000	$2,100,000	$2,200,000	$2,300,000	$2,200,000	$2,000,000	$25,700,000
MAC Claims	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	$180,000
MAC Recipients	1,000	1000	1000	1000	1000	1000	1000	1000	1000	1000	1000	1000	$12,000
Non-MAC Payments	$40,000,000	$42,000,000	$44,000,000	$41,000,000	$40,000,000	$38,000,000	$40,000,000	$42,000,000	$39,000,000	$37,000,000	$41,000,000	$40,000,000	$484,000,000
Non-MAC Claims	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	$1,800,000
Non-MAC Recipients	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	$60,000
Total Payments	$42,000,000	$44,100,000	$46,200,000	$43,300,000	$42,200,000	$40,100,000	$42,000,000	$44,100,000	$41,200,000	$39,300,000	$43,200,000	$42,000,000	$509,700,000
Total Claims	165,000	165,000	165,000	165,000	165,000	165,000	165,000	165,000	165,000	165,000	165,000	165,000	1,980,000
Total Recipients	6,000	6,000	6,000	6,000	6,000	6,000	6,000	6,000	6,000	6,000	6,000	6,000	72,000
Payment/Recip	$7,000	$7,350	$7,700	$7,217	$7,033	$6,683	$7,000	$7,350	$6,867	$6,550	$7,200	$7,000	$7,079
Payment/Claim	$255	$267	$280	$262	$256	$243	$255	$267	$250	$238	$262	$255	$257

SFY 2003	July	August	September	October	November	December	January	February	March	April	May	June	Total
MAC Payments	$2,000,000	$2,100,000	$2,200,000	$2,300,000	$2,200,000	$2,100,000	$2,000,000	$2,100,000	$2,200,000	$2,300,000	$2,200,000	$2,000,000	$25,700,000
MAC Claims	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	15,000	$180,000
MAC Recipients	1,000	1000	1000	1000	1000	1000	1000	1000	1000	1000	1000	1000	$12,000
Non-MAC Payments	$38,000,000	$40,000,000	$42,000,000	$39,000,000	$38,000,000	$36,000,000	$38,000,000	$40,000,000	$37,000,000	$35,000,000	$39,000,000	$38,000,000	$460,000,000
Non-MAC Claims	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	150,000	$1,800,000
Non-MAC Recipients	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	$60,000
Total Payments	$40,000,000	$42,100,000	$44,200,000	$41,300,000	$40,200,000	$38,100,000	$40,000,000	$42,100,000	$39,200,000	$37,300,000	$41,200,000	$40,000,000	$485,700,000
Total Claims	165,000	165,000	165,000	165,000	165,000	165,000	165,000	165,000	165,000	165,000	165,000	165,000	1,980,000
Total Recipients	6,000	6,000	6,000	6,000	6,000	6,000	6,000	6,000	6,000	6,000	6,000	6,000	72,000
Payment/Recip	$6,667	$7,017	$7,367	$6,883	$6,700	$6,350	$6,667	$7,017	$6,533	$6,217	$6,867	$6,667	$6,746
Payment/Claim	$242	$255	$268	$250	$244	$231	$242	$255	$238	$226	$250	$242	$245

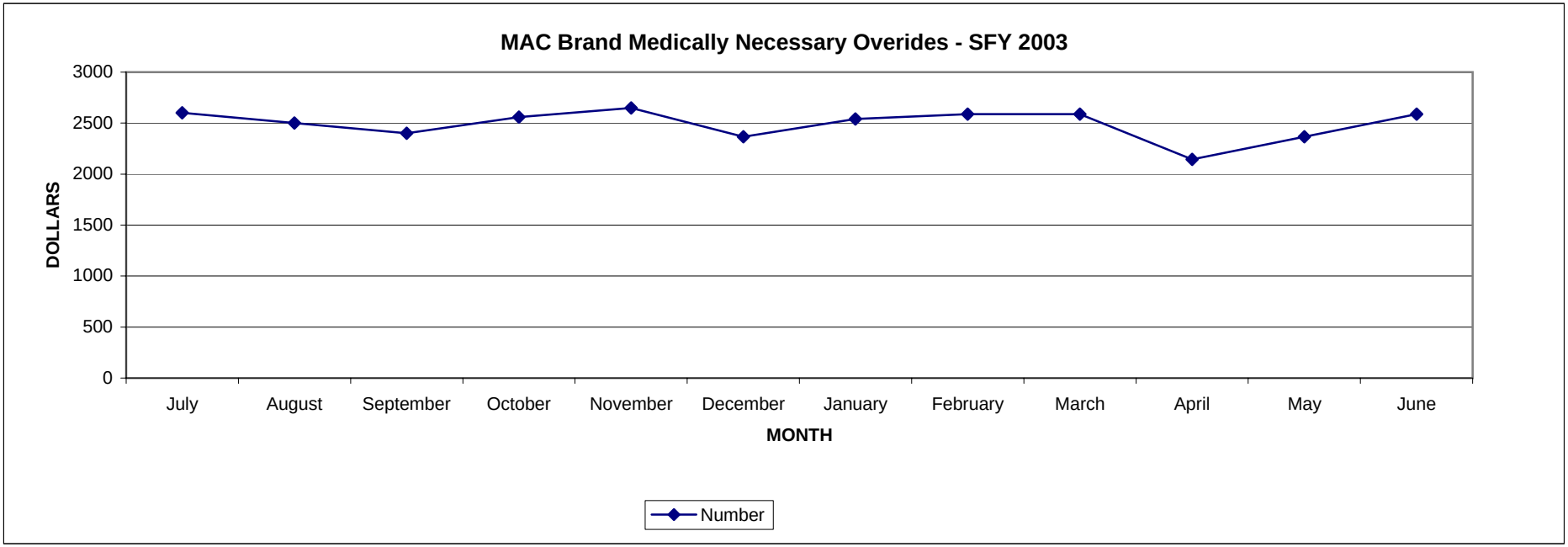


Medicaid: State Maximum Allowable Cost Fee Schedule Monitoring

Brand Medically Necessary Overrides-SFY 2003

DRAFT - For Internal Deliberations Only

	July	August	September	October	November	December	January	February	March	April	May	June	Totals
Number	2600	2500	2400	2560	2650	2365	2541	2589	2587	2145	2365	2589	29891
Payments	$512.00	$587.00	$593.00	$512.00	$532.00	$569.00	$587.00	$541.00	$523.00	$569.00	$587.00	$541.00	$6,653.00
Cost per Overide	$5.08	$4.26	$4.05	$5.00	$4.98	$4.16	$4.33	$4.79	$4.95	$3.77	$4.03	$4.79	$4.49



Medicaid: State Maximum Allowable Cost Fee Schedule Monitoring

Brand Medically Necessary Expenditures, by Drug-SFY 2003

DRAFT - For Internal Deliberations Only

gcn	drug name	Number of Overrides	Payments	Cost (Payments - Payments at MAC Rate)
35742	IBUPROFEN 600MG TAB	129	$25,326	$3,489
14222	DIAZEPAM 5MG TABLET	129	$25,326	$3,489
14260	ALPRAZOLAM 0.25MG TABLET	129	$25,326	$3,489
39683	AMOXICILLIN 250MG/5ML SUSP	129	$25,326	$3,489
27172	PREDNISONE 10MG TABLET	129	$25,326	$3,489
34962	FUROSEMIDE 40MG	129	$25,326	$3,489
20642	METOPROLOL 50MG TABLET	129	$25,326	$3,489
15401	TRAZODONE 50MG TABLET	129	$25,326	$3,489
34961	FUROSEMIDE 20MG	129	$25,326	$3,489
17470	CLONAZEPAM 0.5MG	129	$25,326	$3,489
14261	ALPRAZOLAM 0.5MG	129	$25,326	$3,489
35744	IBUPROFEN 800MG TABLET	129	$25,326	$3,489
20661	ATENOLOL 50MG TAB	129	$25,326	$3,489
20662	ATENOLOL 25MG TABLET	129	$25,326	$3,489
70331	HYDROCODONE/APAP 5MG/500MG TAB	129	$25,326	$3,489
14262	ALPRAZOLAM 1MG	129	$25,326	$3,489
41681	ALBUTEROL .83MG/ML SOLUTION	129	$25,326	$3,489
17471	CLONAZEPAM 1MG	129	$25,326	$3,489
42235	IPRATROPIUM 0.0002 INH SOL VIAL	129	$25,326	$3,489
70335	HYDROCODONE/APAP 7.5MG/750MG TAB	129	$25,326	$3,489
01390	CLONIDINE 0.1MG TAB	129	$25,326	$3,489
34963	FUROSEMIDE 80MG TAB	129	$25,326	$3,489
70335	HYDROCODONE/APAP 7.5/500	129	$25,326	$3,489
14160	LORAZEPAM 0.5MG TABLET	129	$25,326	$3,489
17450	CARBAMAZEPINE 200MG	129	$25,326	$3,489
		129	$25,326	$3,489

Medicaid: State Maximum Allowable Cost Fee Schedule Monitoring

Brand Medically Necessary Expenditures, by Pharmacy (Top 25) - SFY 2003

DRAFT - For Internal Deliberations Only

Rank	Provider Number	Pharmacy Name	Number of Overrides	Payments	Cost (Payments - Payments at MAC Rate)
1	112233445	CVS #1	153	$25,350	$3,513
2	112233446	CVS #2	152	$25,349	$3,512
3	112233447	CVS #3	151	$25,348	$3,511
4	112233448	CVS #4	150	$25,347	$3,510
5	112233449	CVS #5	149	$25,346	$3,509
6	112233450	CVS #6	148	$25,345	$3,508
7	112233451	CVS #7	147	$25,344	$3,507
8	112233452	CVS #8	146	$25,343	$3,506
9	112233453	CVS #9	145	$25,342	$3,505
10	112233454	CVS #10	144	$25,341	$3,504
11	112233455	CVS #11	143	$25,340	$3,503
12	112233456	CVS #12	142	$25,339	$3,502
13	112233457	CVS #13	141	$25,338	$3,501
14	112233458	CVS #14	140	$25,337	$3,500
15	112233459	CVS #15	139	$25,336	$3,499
16	112233460	CVS #16	138	$25,335	$3,498
17	112233461	CVS #17	137	$25,334	$3,497
18	112233462	CVS #18	136	$25,333	$3,496
19	112233463	CVS #19	135	$25,332	$3,495
20	112233464	CVS #20	134	$25,331	$3,494
21	112233465	CVS #21	133	$25,330	$3,493
22	112233466	CVS #22	132	$25,329	$3,492
23	112233467	CVS #23	131	$25,328	$3,491
24	112233468	CVS #24	130	$25,327	$3,490
25	112233469	CVS #25	129	$25,326	$3,489

Additional Myers and Stauffer LC Client Reference Letters

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAL ASSISTANCE

P.O. BOX 110660
JUNEAU, ALASKA 99811-0660
PHONE: (907) 465-3355
FAX: (907)465-2204

June 22, 1999

To Whom It May Concern:

I am pleased to offer this letter as a professional reference for the firm of Myers and Stauffer LC.

Myers and Stauffer contracted with the State of Alaska to compare physician reimbursement and utilization under Alaska's recently implemented RBRVS methodology to physician reimbursement under the prior system (usual, customary, and prevailing (UCP) charges). They also compared our level of reimbursement to that of other Region X states and Medicare.

Myers and Stauffer was able to develop a work plan which collapsed a large number of claims and data elements into a limited number of key elements for comparison purposes. From this information, they were able to identify overall changes in reimbursement and utilization as well as several areas of concern. Findings were conveyed to our Department in the form of a comprehensive project report.

Throughout the life of this project, Myers and Stauffer personnel were professional, courteous and well-informed on the intricacies of this highly technical reimbursement system. Always receptive to our concerns and recommendations, Myers and Stauffer expanded the project's original objectives to include a comparative study of Medicaid rate setting methodologies for mental health services.

It is without hesitation that I recommend the firm of Myers and Stauffer. Please feel free to contact me if you need additional information at (907) 465-3355.

Sincerely,

Dave Williams, Program Officer
Health Services Unit

06-F145LH

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INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION
"People helping people help themselves"

Joseph E. Kernan, Governor
State of Indiana

Office of Medicaid Policy and Planning
402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204-2739

To Whom it May Concern:

This letter shall serve as a professional reference for the firm of Myers and Stauffer LC. Myers and Stauffer has been engaged by the Indiana Medicaid agency for more than 20 years performing a wide array of rate setting, accounting, financial and claims analysis for the Indiana Medicaid program in virtually every provider category. Myers and Stauffer provides rate setting, data management and analysis, consulting, and other related services that are critical to the successful management of the Medicaid program.

The firm also provides extensive assistance in the development, implementation and operational aspects of Indiana's upper payment limit (UPL), intergovernmental transfer (IGT) and disproportionate share (DSH) programs. Some of these programs were established many years ago, while others were implemented more recently. We rely extensively on Myers and Stauffer to help us resolve numerous issues that Medicaid faces, including provider concerns, federal regulatory interpretation and overall budget constraints.

Myers and Stauffer staff are responsive to our needs in these areas, and work diligently to address technical and compliance issues in a timely and competent manner. It is without hesitation that I recommend Myers and Stauffer to provide similar services for other state Medicaid agencies. Without their assistance, the Indiana Medicaid office would not have been able to accomplish many of our short and long term program and policy objectives.

Please feel free to call me if I can answer any questions. I would be more than happy to discuss Myers and Stauffer's performance in greater detail.

Sincerely,

Melanie Bella

Melanie Bella,
Assistant Secretary

KANSAS
DEPARTMENT ON AGING

Docking State Office Building
915 S.W. Harrison, 150-S
Topeka, KS 66612-1500
Phone (913) 296-4986
Fax (913) 296-0256

Bill Graves
Governor

Thelma Hunter Gordon
Secretary of Aging

February 11, 1998

RE: Professional Reference for Myers and Stauffer, LC:

To Whom It May Concern:

It is a pleasure to offer this professional reference for Myers and Stauffer, LC. The firm has provided professional services related to health care reimbursement matters to the State of Kansas since the mid 1970s. They have worked under contract on the hospital, pharmacy, nursing facility and intermediate care facility for mentally retarded programs. Services are performed in a timely, professional manner, and meet the needs of the State.

My primary involvement with Myers and Stauffer personnel, first at the Kansas Department of Social and Rehabilitation Services (SRS) and now with the Department on Aging, is in the area of nursing facility (NF) reimbursement. The NF program and the related interaction with Myers and Stauffer were transferred from SRS to the Department on Aging, effective July 1, 1997. They have maintained the NF cost report and resident assessment data bases which are used to determine upper payment limits and rates. They provide consultation services and assist in preparing the Medicaid annual findings and State Plan exhibits.

Myers and Stauffer personnel assisted SRS staff in preparing an application to participate in the National Nursing Facility Case Mix Demonstration Project. The grant was awarded in 1989. The Kansas Medicaid Demonstration project evolved into the national Medicare demonstration project in which we continue to participate.

Myers and Stauffer, LC has served as the primary contractor for the Kansas case mix demonstration project. They have assisted SRS staff in the meetings with the Case Mix Advisory Committee and the Quality Assurance, Resident Classification, and Reimbursement work groups. They modeled various Medicaid case mix payment systems and were instrumental in the design, with input from the stakeholders, of the system which was implemented by Kansas in July, 1994.

Myers and Stauffer staff developed and have maintained the Kansas resident assessment data base and the resident classification system, using the federal Health Care Financing Administration (HCFA) protocols. Kansas uses the Minimum Data Set (MDS), Version 2.0, resident assessment, and the Resource Utilization Groups III (RUGS III), resident classifications. The MDS data base and resident classifications are used in determining the case mix adjusted payment rates.

Kansas electronically submits the resident assessments to HCFA. The MDS data base and RUGS III resident classifications have been used in the Medicare demonstration project for determining rates under the case mix adjusted, prospective payment system (PPS). The federal Balanced Budget Act of 1997 included the provision to implement Medicare's new case mix PPS for skilled nursing facilities for fiscal years beginning on or after July 1, 1998.

I would not hesitate to recommend the firm of Myers and Stauffer to state agencies looking for professional services related to health care rate setting and reimbursement.

Sincerely,

Bill McDaniel, Director
Nursing Facility Rate Setting
Administrative Services Commission

BRM

c Commissioner Alice Knatt

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

MARC RACICOT
GOVERNOR

LAURIE EKANGER
DIRECTOR

STATE OF MONTANA

PHONE: (406) 444-4077

SENIOR & LONG TERM CARE DIVISION
PO BOX 4210
HELENA, MT 59604-4210

June 28, 1999

RE: Professional Reference Letter for Myers and Stauffer LC

I am pleased to offer this letter of reference for the firm of Myers and Stauffer LC.

The state of Montana has had an ongoing contractual relationship with Myers and Stauffer since 1990. During that time they have provided a wide array of professional services to the state of Montana, including Medicaid cost report audit services and consultation on complex state plan and reimbursement issues.

Most recently Myers and Stauffer has been involved with the Department in the development of a RUG's III based case-mix reimbursement system. Senior management of the firm has played an active role in the development of the system through attendance at meetings, and through detailed modeling of alternative reimbursement approaches. They have participated in formal and informal meetings presenting case mix issues to state, nursing facility and patient advocacy representatives.

Myers and Stauffer staff perform audits of nursing facility, federally qualified heath center and rural health clinic Medicaid cost reports for Montana. These audits address cost report compliance with Medicare and Montana Medicaid reporting requirements. Their staff also assists in resolving appeal issues that arise through the audit process.

Throughout the course of our relationship with Myers and Stauffer they have demonstrated a thorough understanding of healthcare reimbursement issues through their knowledge of Medicare and Medicaid reimbursement principles. Myers and Stauffer staff are continuously accessible and timely in their response to requests for information and inquiries. The personnel assigned to our engagements have consistently conducted themselves in a friendly and professional manner.

I highly recommend the firm of Myers and Stauffer LC. Please feel free to contact me at (406) 444-4147 if you need any additional information.

Sincerely,

Kelly Williams

Kelly Williams, Chief
Nursing Facility Services Bureau

"An Equal Opportunity Employer"

NEW MEXICO HUMAN SERVICES DEPARTMENT
P.O. Box 2348
Santa Fe, New Mexico 87504-2348
MEDICAL ASSISTANCE DIVISION

July 3, 1997

To Whom It May Concern:

This letter is to provide a professional reference for the firm of Myers and Stauffer LC. Myers and Stauffer LC has been our audit agent and consultant for hospital, FQHC, HHA, and hospice reimbursement issues since March 1996. The knowledge and expertise they have provided to our agency have been invaluable to us in managing our current program and preparing for the future. They have brought professionalism and rigorous standards to the cost settlements of TEFRA hospitals, DRG hospital outpatient services, FQHCs, and other cost-reimbursed providers, and have provided consulting assistance to us in a number of key areas.

Myers and Stauffer LC has been responsible for determining disproportionate share hospital (DSH) eligibility, and payment amounts under the existing state plan and regulations for historical periods 1993 through June 30, 1997. In addition, they have been of considerable assistance to us in developing a DSH plan to be effective this July that will achieve the State's indigent care funding objectives under our new managed care delivery system.

In the area of DRG reimbursement, Myers and Stauffer LC assisted our Fiscal Agent in correctly recalibrating DRG weights for the Version 12 grouper, identifying and resolving a number of problems that had led to erroneous rates in the initial implementation. They have also recently completed computations for new DRG base rates that we will be implementing retroactive to October 1994. When providers have raised questions regarding DRG rate setting and other reimbursement issues, Myers and Stauffer has been able to supply solid answers, thereby increasing provider confidence in our program.

In the area of FQHC reimbursement, Myers and Stauffer has helped us increase our control over expenditures. They have accurately and fairly applied Medicare and Medicaid reimbursement principles to cost settlements, some dating back to 1991. They have developed an electronic Medicare/Medicaid cost reporting form and have provided training to facilities in proper cost reporting procedures. Recently, they have assisted us in developing policies and procedures for appropriately reimbursing FQHCs that provide services to Medicaid clients enrolled in managed care organizations (MCOs).

Senior management of the firm have been very accessible and have taken an active role in our projects. I would recommend Myers and Stauffer to any state requiring assistance with its Medicaid Program.

Sincerely,

Ramona Flores-Lopez
Deputy Director

New Mexico DRUG FREE

State of Wyoming

Department of Health

Division of Health Care Financing
James D. Shepard, Administrator

JIM GERINGER, GOVERNOR

June 22, 1999

To Whom It May Concern:

This letter is written for the purpose of providing a professional reference for the accounting firm of Myers and Stauffer LC. Myers and Stauffer has assisted the state of Wyoming with Medicaid related reimbursement issues since 1989.

Myers and Stauffer's primary function has been to serve as the contract rate setter for long term care facilities. This process involves performing desk reviews on Wyoming Medicaid cost reports, and establishing reimbursement rates in accordance with Wyoming's state plan. In addition to long term care rate setting, Myers and Stauffer has also provided Medicaid reimbursement services in the areas of acute care, pharmacies, rural health clinics, federally qualified health centers, and home health agencies.

Myers and Stauffer has assisted the state of Wyoming in all phases of developing alternative reimbursement methodologies. The personnel at Myers and Stauffer not only have a thorough understanding of Medicare and Medicaid reimbursement issues, but are also able to provide consultation on state plan amendments and administrative rule changes.

It is without hesitation that we recommend Myers and Stauffer to other state agencies requiring assistance with health care reimbursement issues.

Sincerely,

SHARON KUSTER
Financial Services Manager

6101 Yellowstone Road • Room 259B • Cheyenne WY 82002