

**TABLE OF CONTENTS**  
**of the**  
**REQUEST FOR PROPOSALS**  
**for**  
**THE IOWA PLAN FOR BEHAVIORAL HEALTH**

**SECTION 1: INTRODUCTION TO THE IOWA PLAN FOR BEHAVIORAL HEALTH (THE IOWA PLAN)**

- 1.1 The Iowa Plan
- 1.2 Priorities for the Next Iowa Plan Contract
- 1.3 Development of the Request for Proposals
- 1.4 Issuance of the Request for Proposals (RFP)
- 1.5 Administrative Overview
- 1.6 Comparison of Requirements
- 1.7 An Overview of Mental Health Services in Iowa
- 1.8 An Overview of Substance Abuse Services in Iowa
- 1.9 Coordinating with Other State Agencies and Programs

**SECTION 2: PROCUREMENT PROCESS**

- 2.1 Issuing the Request for Proposals
- 2.2 Restriction on Communication with the Departments' Employees
- 2.3 Procurement Timetable
- 2.4 Who Can Bid on the Iowa Plan
- 2.5 Resources Available On-Line
- 2.6 Letters of Intent to Bid
- 2.7 RFP Amendments
- 2.8 Submission of Proposals
- 2.9 Proposal Amendments and Rules for Withdrawal
- 2.10 Acceptance of Proposals and Clarifications
- 2.11 Firm Proposal Terms
- 2.12 Cost of Preparing Proposals
- 2.13 Acceptance of Terms and Conditions
- 2.14 Reference Checks
- 2.15 Information from Other Sources

- 2.16 Verification of Proposal Contents
- 2.17 Criminal History and Background Investigation
- 2.18 Rejection of Proposals
- 2.19 Disposition of Proposals
- 2.20 Public Records and Requests for Confidential Treatment
- 2.21 Copyrights
- 2.22 Release of Claims
- 2.23 Presentations
- 2.24 Evaluation of Proposals Submitted
- 2.25 Definition of Contract
- 2.26 CMS Contingency
- 2.27 Choice of Law and Forum
- 2.28 Restrictions on Gifts and Activities
- 2.29 No Minimum Guaranteed
- 2.30 Current Contractor

**SECTION 3: PERSONS TO BE SERVED THROUGH THE IOWA PLAN AND ELIGIBLE PERSON RIGHTS AND PROTECTIONS**

- 3.1 Persons to be Served Through the Iowa Plan
- 3.2 Medicaid Members Not Enrolled in the Iowa Plan
- 3.3 Marketing to Members
- 3.4 Disenrollments
- 3.5 Third Party Considerations
- 3.6 Eligible Person Rights
- 3.7 Eligible Person Protections

**SECTION 4: SERVICE REQUIREMENTS OF THE IOWA PLAN**

- 4.1 Framework for the Iowa Plan
- 4.2 General Requirements Pertaining to Service Provision

**SECTION 4A: SERVICE REQUIREMENTS RELATED TO THE MENTAL HEALTH NEED OF IOWA PLAN ENROLLEES**

- 4A.1 Philosophy in the Design and Delivery of Mental Health Services and Supports
- 4A.2 Rehabilitation, Recovery, and Strength-Based Approach to Services
- 4A.3 Covered Services for Mental Health Conditions
- 4A.4 Required Services for Mental Health Conditions
- 4A.5 Optional Services and Supports
- 4A.6 Covered Mental Health Diagnoses
- 4A.7 Evidence-Based Coverage
- 4A.8 Accessibility Requirements in the Provision of Mental Health Services

**SECTION 4B: SERVICE REQUIREMENTS RELATED TO THE SUBSTANCE ABUSE TREATMENT NEEDS OF ELIGIBLE PERSONS**

- 4B.1 Philosophy in the Design and Delivery of Substance Abuse Treatment Services and Supports
- 4B.2 Rehabilitation, Recovery and Strength-Based Approach to Services
- 4B.3 Covered Services for Substance Abuse Conditions
- 4B.4 Covered Substance Abuse Diagnoses
- 4B.5 Special Considerations Pertaining to Substance Abuse Treatment
- 4B.6 Accessibility Requirements for the Provider Network

**SECTION 4C: SERVICE REQUIREMENTS RELATED TO THE MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT NEEDS OF IOWA PLAN ENROLLEES**

- 4C.1 Services Requirements Related to Both Mental Health and Substance Abuse Service Needs
- 4C.2 Services for Children with Serious Behavioral Health Conditions
- 4C.3 Distinguishing Medical Services from mental Health and Substance Abuse Services

**SECTION 5: MANAGING SERVICE PROVISION**

- 5.1 Supporting the Philosophy of the Iowa Plan
- 5.2 Participating in Service System Development Efforts

**SECTION 5A: UTILIZATION MANAGEMENT**

- 5A.1 Organization of Utilization Management Staff (Enrollees Only)
- 5A.2 Service Authorization Review and Notification of Adverse Action (Enrollees Only)
- 5A.3 Developing, Adopting, Implementing and Updating Utilization Management Guidelines
- 5A.4 Administrative Authorization of Services (Enrollees Only)
- 5A.5 Administrative Crisis Services, Case Management, Service Coordination, and Intensive Clinical Management
- 5A.6 Special Service Considerations

**SECTION 5B: GRIEVANCE SYSTEM**

- 5B.1 Grievance System (Enrollees Only)
- 5B.2 Appeals Process (Enrollees Only)
- 5B.3 Grievance Process (Enrollees Only)
- 5B.4 Complaint Process (IDPH Participants)

**SECTION 5C: PROVIDER NETWORK**

- 5C.1 Provider Network Development and Composition
- 5C.2 Provider Reimbursement
- 5C.3 Relationship Between Contractor and Network Providers
- 5C.4 Prohibition on Restrictions on Provider-Eligible Person Communication
- 5C.5 Network Management

**SECTION 5D: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT**

- 5D.1 Quality Assessment and Performance Improvement Program
- 5D.2 Quality Improvement Goals
- 5D.3 Performance Indicators and the Iowa Plan Contractor
- 5D.4 Advisory Committees
- 5D.5 Other Mechanisms to Obtain and Utilize Public Input

**SECTION 5E: OUTREACH TO IOWA PLAN ELIGIBLE PERSONS**

- 5E.1 Outreach to Iowa Plan Enrollees
- 5E.2 Outreach to IDPH Participants
- 5E.3 Advance Directives (Enrollees Only)

**SECTION 6: REQUIRED ADMINISTRATIVE CAPABILITIES**

- 6.1 Supporting the Operation of the Iowa Plan
- 6.2 Transition Planning
- 6.3 Clinical Record Keeping (Enrollees Only)
- 6.4 Management Information System
- 6.5 Contract Monitoring and General Reporting Requirements
- 6.6 Financial Requirements
- 6.7 Claims Payment by the Contractor
- 6.8 Fraud and Abuse

**SECTION 7: FORMAT AND GENERAL REQUIREMENTS OF PROPOSALS**

- 7.1 Format of Proposals
- 7.2 Writing Style for Proposals
- 7.3 Transmittal Letter
- 7.4 Bid Bond Required
- 7.5 Required Addenda

**SECTION 7A: REQUIRED CONTENT OF PROPOSALS**

- 7A.1 Elements of the Proposal
- 7A.2 Programmatic Overview
- 7A.3 Corporate Organization and Experience
- 7A.4 Project Organization and Staffing
- 7A.5 Budget Worksheet and Description

## **SECTION 8: EVALUATION OF PROPOSALS**

- 8.1 Evaluation for Completeness and Compliance
- 8.2 Evaluation Panel
- 8.3 Design for the Evaluation Process
- 8.4 Evaluation Criteria
- 8.5 Oral Presentations
- 8.6 Evaluation Panel Recommendations
- 8.7 Bidder Acceptance of Evaluation Design

## **SECTION 9: CONTRACTUAL TERMS AND CONDITIONS**

- Contract Declarations and Execution Form
- 9.1 Special Contract Terms
  - 9.1(1) Nature of the Contract
  - 9.1(2) Scope of Work
  - 9.1(3) Contract Payment Clause
  - 9.1(4) Remedies in the Event of Contractor's Failure to Perform
  - 9.1(5) Fraud and Abuse
  - 9.1(6) Contract performance Disputes and Appeals
  - 9.1(7) Changes of Key Iowa Plan Personnel
  - 9.1(8) Maintenance of Local Funding for Substance Abuse Services (IDPH Participants only)
  - 9.1(9) Disallowable Expenses (IDPH Participants Only)
  - 9.1(10) Payment of Last Resort (IDPH Participants Only)
  - 9.1(11) Non-Supplanting Requirement (IDPH Participants Only)
  - 9.1(12) Publications, Copyrights and Rights in Data and Patents
  - 9.1(13) Legalized Aliens (IDPH Participants Only)
  - 9.1(14) Not-For-Profit/For-Profit Status
  - 9.1(15) Coordination of Services (IDPH Participants Only)
  - 9.1(16) Priority in Substance Abuse Treatment
  - 9.1(17) Substance Abuse Interim Services (IDPH Participants Only)
  - 9.1(18) Iowa Residence (IDPH Participants Only)
  - 9.1(19) Outreach Services--IV Drug (IDPH Participants Only)
  - 9.1(20) Tuberculosis (TB) Services (IDPH Participants Only)
  - 9.1(21) HIV/Services
  - 9.1(22) Coordination of Activities
  - 9.1(23) Services and Education to Employees
  - 9.1(24) Substance Abuse License Requirements
  - 9.1(25) Eligible Persons' Access to Substance Abuse Services
  - 9.1(26) Screening Instrument for Substance Abuse Services
  - 9.1(27) Certified Alcohol and Drug Counselor
  - 9.1(28) Subcontractors
- 9.2 General Terms for Services Contracts
  - 9.2(1) Definitions
  - 9.2(2) Duration of the Contract
  - 9.2(3) Scope of Work
  - 9.2(4) Compensation
  - 9.2(5) Termination
  - 9.2(6) Confidential Information

- 9.2(7) Indemnification
- 9.2(8) Insurance
- 9.2(9) Project Management and Reporting
- 9.2(10) Legislative Changes
- 9.2(11) Intellectual Property
- 9.2(12) Warranties
- 9.2(13) Acceptance Testing
- 9.2(14) Contract Administration
- Contract Certifications
- Business Associate Agreement

**SECTION 10: DEFINITION OF TERMS**

**ATTACHMENTS: SECTIONS 1, 1A, 1B, AND 1C**

- 1.2 Map of IDPH Regions

**ATTACHMENTS: SECTION 2**

- 2.5.1 List of Documents Available

**ATTACHMENTS: SECTION, 4A**

- 4.2 Covered Diagnoses

**ATTACHMENTS: SECTION 9**

- 9.3 Medicaid Capitation Rates for Iowa Plan Enrollees
- 9.3 Payment to the Contractor for IDPH Funded Services
- 9.4 Performance Indicators Carrying Medicaid Financial Incentives
- 9.4 Performance Indicators Carrying Medicaid Financial Disincentives
- 9.4 Performance Indicators Carrying IDPH Financial Disincentives

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34

**SECTION 1**  
**INTRODUCTION TO THE**  
**IOWA PLAN FOR BEHAVIORAL HEALTH**  
**(THE IOWA PLAN)**

*Vision:*  
*The Iowa Plan for Behavioral Health is part of a statewide recovery-oriented care system that supports Eligible Persons and their families in their personal recovery efforts related to mental health and substance abuse disorders. The Iowa Plan promotes a broad infrastructure of services and supports statewide and coordinates with other related service delivery systems and recovery supports.*

**1.1 THE IOWA PLAN**

The Iowa Department of Human Services (DHS) and the Iowa Department of Public Health (IDPH) jointly issue this Request for Proposals (RFP) for a single statewide Contractor to administer the Iowa Plan for Behavioral Health (the Iowa Plan). The Iowa Plan jointly manages specific, publicly funded treatment and related support services for mental health and substance abuse. The Contractor is at full risk for all Medicaid-funded mental health and substance abuse services and provides specified administrative services for the IDPH-funded substance abuse services. The contract is for an initial two and a half-year term, with three one-year extension options at the discretion of the Departments. The Iowa Plan is being rebid at this time because the current contract will expire on December 31, 2009.

Through this reprocurement of the Iowa Plan, the Departments (DHS and IDPH) are jointly striving to make continued improvements to the state’s behavioral health care system. DHS and IDPH are focused on ensuring that the Iowa Plan provides a recovery-oriented care system that matches each person’s strengths, needs and choices with appropriate and coordinated services and supports. Through this system, the Iowa Plan will strive to offer:

- prompt and welcoming access to services and supports;
- service and support planning and delivery led by and built on the Eligible Person’s, and where appropriate, family choices and needs;
- improved outcomes for Eligible Persons which span boundaries of programs and funding streams;

- 35 • quality services for Eligible Persons in their homes and communities and within the context  
36 of their natural support systems;
- 37 • clinical pathways that promote and support recovery;
- 38 • strong community involvement and investment, with the local delivery system contoured to  
39 community strengths and needs;
- 40 • coordination of planning and implementation between agencies;
- 41 • prevention and early intervention with those at risk, and
- 42 • minimal duplication between systems, permitting a smooth transition between funding  
43 streams and services.

44 The Departments hope to receive proposals from managed behavioral health organizations  
45 (MBHOs) that have a passion for innovation, system change and continued quality improvement.  
46

## 47 **1.2 PRIORITIES FOR THE NEXT IOWA PLAN CONTRACT**

48 The Departments envision the Iowa Plan supporting a more recovery-oriented care system over  
49 the next procurement period. To allow for the Iowa Plan to mature into a full recovery-oriented  
50 system, the Departments' intention is to have the Contractor give special focus to these areas  
51 under the next Iowa Plan contract:

- 52 • Provide Services to Enrollees aged 65 and older in the Iowa Plan – Under this  
53 reprocurement, the Iowa Plan will begin to provide behavioral health services for  
54 Enrollees who are aged 65 and older, including those who receive services through  
55 Medicare and other third party insurance. The Contractor will be responsible for  
56 reporting on the transition of this population to the Iowa Plan and impact of including  
57 them within the Iowa Plan. In 2008, the Iowa Medicaid program had approximately  
58 25,000 Members aged 65 and older. The Contractor will be responsible for serving this  
59 population in the Iowa Plan within six months of contract implementation date and must  
60 provide extensive outreach to the population prior to the transition to the Iowa Plan.
- 61 • Continue expansion of recovery and rehabilitation services – The Departments will  
62 require the Contractor to build additional capacity for, and linkage with, recovery and  
63 rehabilitation services where it does not exist today.
- 64 • Require services available statewide – The Contractor will be obligated to develop  
65 capacity for “required services” to Iowa Plan Enrollees on a statewide basis over the term  
66 of the contract. The Contractor will work with the Departments and stakeholders to  
67 determine the priority in which to engage in service capacity building across the state.
- 68 • Coordinate services for those with co-occurring conditions –The Departments believe it  
69 is essential to provide coordinated services that meet the complex needs of the “whole  
70 person.” To that end, the Departments seek aggressive new strategies that will generate  
71 significant improvement in coordination. Where appropriate, these strategies should  
72 include coordinating, and where appropriate, integrating services for mental health and/or  
73 substance abuse disorders with co-occurring conditions, including but not limited to,  
74 medical illness, mental retardation, developmental disability, and problem gambling.

- 75 • Reduce readmission rates – The Departments seek to reduce readmission rates,  
76 particularly for Enrollees who are children. To that end, the Departments seek the  
77 development of capacity for mental health sub-acute care across the state.
- 78 • Improve services for children and families – The Departments believe that there is a  
79 significant opportunity to improve services for Enrollee children with emotional and  
80 behavioral issues; particularly, the Departments believe that the Contractor can assist  
81 DHS in reducing the lengths of stay in mental health PMICs.
- 82 • Coordinate with other state and local agency efforts – Eligible Persons served by the  
83 Iowa Plan often utilize the services of other state and local entities. Therefore, efforts by  
84 the Contractor to meet the needs of Eligible Persons require close coordination with these  
85 entities and associated efforts.
- 86 • Expand measurement of outcomes – The Departments seek to expand upon past efforts to  
87 measure outcomes in functional terms and in life domains valued by Eligible Persons and  
88 their families. This includes, in part, aligning measurement with the SAMHSA National  
89 Outcomes Measures (NOMs) and supporting IDPH Treatment Encounter Data Set  
90 compliance.
- 91 • Continuous quality improvement – The Contractor will be required to expand data-driven  
92 improvements in all areas of its operations, including in provider service delivery, in  
93 Eligible Person and family empowerment and learning, and in linkages to associated  
94 services and supports.

### 95 **1.3 DEVELOPMENT OF THE REQUEST FOR PROPOSALS**

96 Prior to the release of the Request for Proposals (RFP) the public was invited to attend three open  
97 meetings in September 2008 and provide oral or written comments on specific areas of interest to  
98 the Departments.

99 Pursuant to the CMS services regulation for service cost-effectiveness, DHS has consulted on an  
100 ongoing basis with Milliman USA, which has set and validated the capitation rates.

101

### 102 **1.4 ISSUANCE OF THE REQUEST FOR PROPOSALS (RFP)**

103 This RFP is issued by the Iowa Department of Human Services (DHS) and the Iowa Department  
104 of Public Health (IDPH). The Director of DHS is the final authority on all decisions related to  
105 the DHS components of the Iowa Plan; and the Director of the IDPH Division of Behavioral  
106 Health is the final authority on all decisions related to the IDPH components of the Iowa Plan.

### 107 **1.5 ADMINISTRATIVE OVERVIEW**

108 Primary responsibility for the procurement of the Contractor for the Iowa Plan, negotiation of the  
109 contract, and ongoing monitoring of contract implementation rests within the DHS Iowa  
110 Medicaid Enterprise (IME) Bureau of Managed Care and Clinical Services and with the IDPH  
111 Division of Behavioral Health, the state substance abuse authority. Programmatic consultation is  
112 provided to the Iowa Medicaid Enterprise (IME) and IDPH by the DHS Division of Mental  
113 Health and Disability Services, the state mental health authority.

114

114 **1.5a DHS IME Bureau of Managed Care and Clinical Services**

115 The Medical Assistance program provides health care coverage to more than 11% of Iowa  
116 residents. In state fiscal year 2008, total expenditures in Medical Assistance were just over \$2.6  
117 billion dollars. Spending on the Iowa Plan was just shy of \$110 million in state fiscal year 2008.  
118 The costs of the program are shared between the State of Iowa and the federal government. The  
119 Iowa Plan is available to nearly all Medicaid members. Iowa Plan Enrollees receive their medical  
120 services through one of three delivery systems: 4,764 Iowa Plan Enrollees receive care through  
121 the health maintenance organization (HMO) under the contract with the state; 147,094 Iowa Plan  
122 Enrollees receive care through the state's Primary Care Clinician Management program known as  
123 Medicaid Patient Access to Services System (MediPASS); and the remaining 144,029 Iowa Plan  
124 Enrollees receive care through the state's Fee-for-Services (FFS) reimbursement system. In  
125 addition to providing medical care, the FFS reimbursement system also provides payment for  
126 mental health services for those persons who receive Medicaid but are ineligible for the Iowa  
127 Plan, including inpatient care, outpatient care, and care provided by physicians and other  
128 community-based professionals. The methodology for the calculation of rates for the  
129 reimbursement methodologies for FFS services can be found in the Iowa Administrative Code  
130 (IAC) 441 Chapter 79. Iowa Plan Enrollees receive all pharmaceuticals outside of the Iowa Plan.  
131 Certain Iowa Plan Enrollees may be enrolled in the IME lock-in program. Under this program, a  
132 Member may only fill prescriptions at one pharmacy in an effort to prevent abuse of prescription  
133 drugs by a Member.

134 Some Iowa Plan Enrollees also receive additional mental health services through DHS on a FFS  
135 basis, as described below.

136 Children's Mental Health Waiver: DHS administers, outside of the Iowa Plan, a children's mental  
137 health waiver that provides additional funding and individualized supports above those provided  
138 through the Iowa Plan for up to 600 eligible children and youth with a diagnosis of "serious  
139 emotional disorder" up to age 18 to live in their own homes who are assessed to meet a hospital  
140 level of care. All children within the waiver receive service coordination and monitoring through  
141 the FFS Targeted Case Management program.

142 Remedial Services: DHS provides remedial services for children, adolescents and adults on a fee-  
143 for-service basis. The services are designed to meet the multiple and changing needs of the  
144 person with a mental health diagnosis by assisting the person to regain self-control and teach  
145 appropriate behaviors. Iowa Plan Enrollees may receive medically necessary remedial services  
146 through DHS on a fee-for-service basis.

147 Habilitation Services: DHS also provides habilitation services on a fee-for-service basis to  
148 Members who have functional deficits typically seen in persons with chronic mental illness.  
149 Provided as a home and community-based service, habilitation services assist a member in  
150 acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to  
151 reside successfully in the community. Services include case management, home-based  
152 habilitation, day habilitation, prevocational services and supported employment. Iowa Plan  
153 Enrollees may receive medically necessary habilitation services through DHS on a fee-for-service  
154 basis.

155

155 **1.5b IDPH Division of Behavioral Health**

156 The IDPH is an independent state agency with a director and policy-making State Board of  
157 Health. IDPH has primary responsibility for supervision of all public health programs, including  
158 prevention and treatment of substance abuse and problem gambling. The Division of Behavioral  
159 Health is the Single State Authority for substance abuse and, as such, administers the U.S.  
160 Department of Health and Human Services Substance Abuse and Mental Health Services  
161 Administration (SAMHSA) Substance Abuse Prevention and Treatment (SAPT) Block Grant,  
162 and associated state appropriations. The IDPH Division of Behavioral Health also licenses and  
163 regulates substance abuse and problem gambling treatment programs.

164 **1.6 COMPARISON OF REQUIREMENTS**

165 *The following terms are used in this RFP:*  
166

167 **Medicaid Member (“Member”):** *an individual who has been determined eligible*  
168 *for the Iowa Medicaid program*

169 **Iowa Plan Enrollee (“Enrollee”):** *a Member enrolled in the Iowa Plan*

170 **Participant (“IDPH Participant”):** *a person meeting the eligibility criteria to*  
171 *receive IDPH-funded Iowa Plan substance abuse services*

172 **Eligible Persons (“Eligibles”):** *Enrollees and IDPH Participants*

173  
174 The Iowa Plan provides services to Eligible Persons, including Iowa Plan Enrollees and IDPH  
175 Participants. The following chart compares requirements for services for both types of Eligible  
176 Persons. The requirements are separated by service in this chart for clarity and not to indicate that  
177 similar or duplicate requirements should not be integrated to the fullest extent. The chart  
178 summarizes requirements set forth elsewhere in this RFP; however, in case of conflict, the  
179 requirements established in other sections shall control.

1  
2  
3  
4  
5

**COMPARISON OF COMPONENTS  
OF THE IOWA PLAN FOR BEHAVIORAL HEALTH  
(The Iowa Plan)**

<b>Program Feature</b>	<b>Mental Health Services</b>	<b>Substance Abuse Services</b>	
	<b>DHS</b>	<b>DHS</b>	<b>IDPH</b>
<b>Population Served</b>	Almost all Medicaid Members	Almost all Medicaid Members	Iowa residents at or below 200% of the federal poverty level who are not Medicaid Members
<b>Treatment Services to be Reimbursed through Contractor</b>	All mental health services covered in fee-for-service plus services designated as “required”; optional services may be implemented after DHS approval	Full continuum of services including detoxification, inpatient, residential, halfway house and outpatient	Continuum of services including residential, halfway house and outpatient
<b>Coverage of Psychiatric Medical Institutions for Children (PMICs)</b>	Services provided by mental health PMICs not covered; remain FFS system responsibility <sup>1</sup>	Services provided by substance abuse PMICs covered	Services provided by PMICs not covered

---

<sup>1</sup> While mental health PMIC services are outside of the Iowa Plan, DHS expects the Contractor to facilitate the return to the community of children served in PMICs, thereby reducing the number of days when children are served in mental health PMICs when they could be supported in the community.

Program Feature	Mental Health Services	Substance Abuse Services	
	DHS	DHS	IDPH
<b>Coverage of Services in a Mental Health Institute (MHI) (details at 4A.3.6)</b>	Services to persons under age 21 and 65 and older based on application of UM Guidelines: Services to voluntary admissions age 21 and over and under 65 based on application of UM Guidelines; Services to involuntary admissions over age 21 and under 65 not covered; additional requirements in Section 4A	Services to voluntary admissions age 21 and over based on ASAM PPC-2R; Services to involuntary admissions over age 21 covered	Services not covered
<b>Coverage of Court-Ordered Evaluations (details at 4A.3.5 and 4A.3.6)</b>	Court-ordered evaluation in a community hospital covered for up to five days; For persons under age 21 and 65 and over, court-ordered evaluations in an MHI covered for up to five days; For persons age 21 and over, court-ordered inpatient evaluations at MHI not covered	Court-ordered evaluations at a contracted network provider covered for one day; court-ordered inpatient evaluations at MHI not covered	Court-ordered evaluations at contracted IDPH providers covered by the provider

<b>Program Feature</b>	<b>Mental Health Services</b>		<b>Substance Abuse Services</b>	
	<b>DHS</b>	<b>DHS</b>	<b>DHS</b>	<b>IDPH</b>
<b>Other Services to be Provided by Contractor</b>	Full range of management services: 24-hour crisis counseling & referral, management information system, network development, claims payment, eligible person communications	Full range of management services: 24-hour crisis counseling & referral, management information system, network development, claims payment, eligible person communications	Full range of management services: 24-hour crisis counseling & referral, management information system, network development, claims payment, eligible person communications	Specific management services: 24-hour crisis counseling & referral, retrospective utilization monitoring, management information system, network development, provider contract payment
<b>Utilization Management</b>	Done by Contractor staff; Contractor has option to require prior authorization of all or some services except emergency services	Done by Contractor staff at higher and more intensive levels of care; retrospective review at all levels of care by Contractor staff	Done by Contractor staff at higher and more intensive levels of care; retrospective review at all levels of care by Contractor staff	Done by contracted IDPH-funded providers for all levels of service; retrospective review at all levels of care by Contractor staff
<b>Utilization Management Guidelines</b>	Proposed by Contractor; approved by Departments; reviewed annually with stakeholder input	ASAM PPC-2R: PMIC Substance Abuse criteria	ASAM PPC-2R	ASAM PPC-2R
<b>Eligible Persons Involvement</b>	Forums and client satisfaction surveys required; Enrollee participation in joint treatment planning encouraged; Enrollees and family members on Recovery Advisory Committee	Forums and client satisfaction surveys required; Enrollee participation in joint treatment planning encouraged; Enrollees and family members on Recovery Advisory Committee	Forums and client satisfaction surveys required; Enrollee participation in joint treatment planning encouraged; Enrollees and family members on Recovery Advisory Committee	Forums and client satisfaction surveys required; IDPH Participants and family members on Recovery Advisory Committee
<b>Community Involvement</b>	Meet regularly with local, county and state planning groups	Meet regularly with local, county and state planning groups	Meet regularly with local, county and state planning groups	Meet regularly with local, county and state planning groups

<b>Program Feature</b>	<b>Mental Health Services</b>		<b>Substance Abuse Services</b>	
	<b>DHS</b>		<b>DHS</b>	<b>IDPH</b>
<b>System Planning</b>	Cooperatively with local planning groups; assist in building local management capacity		Cooperatively with local planning groups; assist in building local management capacity	Cooperatively with local planning groups; assist in building local management capacity
<b>Provider Involvement</b>	Forums required; participation in review of UM Guidelines; satisfaction surveys required		Forums required; satisfaction surveys required	Forums required; satisfaction surveys required
<b>Quality Assessment and Performance Improvement</b>	Comprehensive plan which meets NCQA accreditation standards and be accredited by NCQA; Development and implementation of QA Plan		Comprehensive plan which meets NCQA accreditation standards and be accredited by NCQA; Development and implementation of QA Plan	Comprehensive plan which meets NCQA accreditation standards and be accredited by NCQA; Development and implementation of QA Plan
<b>Training &amp; Technical Assistance</b>	Training and technical assistance to providers, including a website		Training and technical assistance to providers, including a website	Training and technical assistance to providers, including a website.
<b>Deployment of Contractor Staff</b>	Geographical organization of UM staff; staff available to consult on-site at a ratio of at least 1 per region		Geographical organization of UM staff; staff available to consult on-site at a ratio of at least 1 per region	Staff available to consult on-site

<b>Program Feature</b>	<b>Mental Health Services</b>		<b>Substance Abuse Services</b>	
	<b>DHS</b>	<b>DHS</b>	<b>DHS</b>	<b>IDPH</b>
<b>Payment to Contractor</b>	Single Medicaid capitation payment per Enrollee per month covering all Medicaid services; Contractor is at full risk; administrative cost including profit not to exceed 13.5% of capitation payment; Contractor must return any interest earned from premium payments to the state	Single Medicaid capitation payment per Enrollee per month covering all Medicaid services; Contractor is at full risk; administrative cost including profit not to exceed 13.5% of capitation payment. Contractor must return any interest earned from premium payments to the state	Single Medicaid capitation payment per Enrollee per month covering all Medicaid services; Contractor is at full risk; administrative cost including profit not to exceed 13.5% of capitation payment. Contractor must return any interest earned from premium payments to the state	Payment for administrative services performed; risk borne at provider level; administrative cost including profit not to exceed 3.5% of IDPH Iowa Plan funding
<b>Provider Network</b>	Panel open to any mental health provider who is appropriately licensed and credentialed and meets contract requirements	Panel open to any substance abuse treatment program licensed or exempt as outlined in 125.13A(2) of the Iowa Code	Panel open to any substance abuse treatment program licensed or exempt as outlined in 125.13A(2) of the Iowa Code	Competitively procured substance abuse treatment programs licensed according to Iowa Code Chapter 125
<b>Contractor Options in Development of Provider Network</b>	Contractor may propose for Departments approval standards by which to open provider panel to provider categories not accredited or licensed as mental health providers	Not applicable	Not applicable	Not applicable
<b>Network Contracting</b>	Rates negotiated by providers and Contractor	Rates negotiated by providers and Contractor	Rates negotiated by providers and Contractor	Contract amount and number of IDPH Participants to be served determined by IDPH and Contractor and providers based on prevalence information and historical utilization

1 **1.7 AN OVERVIEW OF MENTAL HEALTH SERVICES IN IOWA**

2 In 1995, DHS implemented the Mental Health Access Plan (MHAP), the state’s first managed  
3 care program for mental health services funded by Medicaid. In 1999, MHAP was joined with  
4 IMSACP, the state’s corollary substance abuse managed care program, to form the Iowa Plan for  
5 Behavioral Health. The Iowa Plan is a capitated, at-risk plan to provide managed mental health  
6 and substance abuse treatment to Enrollees under a Medicaid 1915(b) waiver, under the authority  
7 of DHS, as well as an administrative services only plan for substance abuse treatment services  
8 funded by federal block grant and state appropriations under the authority of IDPH. Specific to  
9 mental health services, the Iowa Plan provides:

- 10 • Utilization Management Guidelines and the authorization of mental health services based  
11 on psychosocial necessity, which is an expansion of the concept of medical necessity;
- 12 • an array of mental health services and supports that is significantly broader than that  
13 reimbursable through the Iowa Medicaid fee-for-service system;
- 14 • coordinated services for Iowa Plan Enrollees with complex issues, including co-occurring  
15 mental health and substance abuse concerns; and
- 16 • resources to assist the state in building of infrastructure and capacity to expand recovery-  
17 oriented care services to Iowa Plan Enrollees.

18  
19 **1.7.1 ROLE OF COUNTY GOVERNMENT**

20 Iowa counties have historically been responsible for meeting the needs of their elderly, poor, sick  
21 and disabled residents. Required county services are set forth in the Code of Iowa (Section  
22 331.381). For a full description of county responsibilities as well as options available to counties  
23 see the resource room for the RFP. In part, those responsibilities include the following:

- 24 • counties must pay for the “necessary and legal” costs and expenses for “taking into  
25 custody, care, investigation, admission, commitment and support” of mentally ill persons  
26 in the state mental health institutes;
- 27 • counties are required to provide Targeted Case Management (TCM) services to persons  
28 who have chronic mental illness as well as certain other stipulated conditions. They may  
29 do this directly, through sub-contract, or by contracting with DHS. For Iowa Plan  
30 Enrollees with chronic mental illness, the full cost of TCM is paid by the Contractor; for  
31 others who receive TCM, the counties pay one-half of the non-federal share of the cost;
- 32 • counties are required to submit an annual county management plan to MHDS that  
33 identifies how the county will implement various requirements related to managing their  
34 service delivery system. Each county also is required to establish a Central Point of  
35 Coordination (CPC) process (or single point of entry process) and employ a qualified  
36 CPC administrator, and
- 37 • counties are required to contract with a community mental health center or “other mental  
38 health provider” (i.e., an agency that is accredited by DHS and meets community mental  
39 health center criteria).

40 If a county requests that the Contractor enter into a business relationship to assist that county in  
41 the management of mental health services for the county’s residents, the Contractor must  
42 negotiate with that county’s representatives and make a good faith effort to enter into a  
43 reasonable contract with the county.

44 **1.7.2 PROVIDING MENTAL HEALTH SERVICES IN IOWA**

45 Mental health services are provided through a mental health care delivery system that is funded  
46 through a variety of sources and incorporates a number of different services as described below.

47 **1.7.2.1 Specialized Psychiatric Units in General Hospitals**

48 Thirty-five general hospitals in Iowa, and ten in surrounding states, have licensed psychiatric  
49 units that participate in the Iowa Medicaid program. Of these, twelve in-state hospitals and three  
50 out-of-state hospitals have separate child/adolescent programs. Other than the four state mental  
51 health institutes described below, no specialty psychiatric hospitals participate in the Iowa  
52 Medicaid program.

53 **1.7.2.2 State Mental Health Institutes**

54 DHS operates four specialty psychiatric hospitals known as state mental health institutes (MHIs).  
55 Iowa's MHIs are located in the four corners of the state: Cherokee, Independence, Clarinda and  
56 Mt. Pleasant. All four are licensed as hospitals and provide inpatient psychiatric services to  
57 adults. In addition to providing services to adults, the MHIs provide the following:

- 58
- 59 • Cherokee also serves children and adolescents;
  - 60 • Independence also serve children and adolescents, and has a mental health PMIC;
  - 61 • Clarinda also provides long-term gero-psychiatric care and
  - 62 • Mt. Pleasant also provides substance abuse treatment, including residential, and has a unit  
63 for persons with both mental health and substance abuse diagnoses.

64

65 **1.7.2.3 Psychiatric Medical Institutions for Children**

66

67 Thirteen Psychiatric Medical Institutions for Children (PMICs) participate in the Iowa Medicaid  
68 program in addition to 16 out of state facilities. In Iowa Code Section 135H.1(8), PMICs are  
69 defined as facilities that provide longer term treatment for children. PMIC services for substance  
70 abuse treatment (35 beds in two facilities, Alegent in Council Bluffs and Gordon Recovery in  
71 Sioux City) are part of the Iowa Plan. While mental health PMIC services to children are not  
72 covered by the Iowa Plan, but paid for on a fee-for-service basis by the state, all children  
73 receiving PMIC services are enrolled in the Iowa Plan. The Contractor is responsible for  
74 participating in discharge planning from PMICs and providing follow-up services to assist in the  
75 transition to the child's next living arrangement.

76

76 **1.7.2.4 Community Mental Health Centers and Other Mental Health Providers**

77 Thirty-five Iowa agencies are accredited by the Division of Mental Health and Disability Services  
78 as Community Mental Health Centers (CMHCs). Twenty-seven additional agencies are  
79 accredited as Other Providers in three categories – Mental Health Service Provider, Case  
80 Management, and Supported Community Living.

81 CMHCs serve a defined catchment area, ranging from one county to nine counties. Other Mental  
82 Health Service Providers generally serve a specific geographic area. These agencies may be  
83 accredited to provide any of the following services: partial hospitalization, day  
84 treatment/intensive outpatient, psychiatric rehabilitation, supported community living, outpatient,  
85 emergency, and evaluation. Rules for the accreditations are found in 441 Iowa Administrative  
86 Code Chapter 24.

87 **1.7.2.5 Private Practitioners and Clinics**

88 IDPH licenses psychiatrists, psychologists, social workers, mental health counselors and marital  
89 and family therapists. These individuals practice in institutional, agency and private practice  
90 settings.

91 1.7.2.5.1 Psychiatrists

92 Approximately 227 psychiatrists practice in Iowa. Thirty-one are child psychiatrists and 193 are  
93 adult psychiatrists. Their distribution is concentrated, with most psychiatrists practicing in  
94 metropolitan or urban counties. A secondary concentration is found in or near those counties  
95 with a psychiatric institution (MHI or VA hospital). It is widely perceived that Iowa has a  
96 shortage of psychiatrists, particularly for children and in rural areas of the state.

97 1.7.2.5.2 Psychologists

98 A current Iowa license is held by 498 psychologists. While not as concentrated as psychiatrists,  
99 there are no psychologists practicing in approximately one-half of Iowa's 99 counties.

100 1.7.2.5.3 Social Workers

101 Approximately 4288 social workers hold a current Iowa license. 1580 are independent social  
102 workers. This level of licensure requires a master's degree in social work and additional  
103 experience. Additionally, there are 1623 bachelor level and 1185 master level social workers.

104 1.7.2.5.4 Mental Health Counselors

105 Iowa has 634 individuals who are currently licensed as certified mental health counselors. These  
106 individuals have a master's degree in mental health counseling or a related field.

107 1.7.2.5.5 Marital and Family Therapists

108 Approximately 159 individuals are currently licensed as marital and family therapists. These  
109 individuals have a master's degree in marital and family therapy or a related field.

110

110 **1.7.2.6 Residential Care Facilities for Persons with a Mental Illness**

111 The Iowa Department of Inspections and Appeals (DIA) licenses Residential Care Facilities for  
112 Persons with a Mental Illness (RCF/PMI). Fourteen programs with 331 beds are currently  
113 licensed. These programs provide care in residential facilities to persons with severe psychiatric  
114 disabilities who require specialized psychiatric care. While they are scattered around the state,  
115 these programs are not readily available in every locale.

116 **1.7.2.7 Intermediate Care Facilities for Persons with a Mental Illness**

117 DIA also licenses Intermediate Care Facilities for persons with a mental illness (ICF/PMI). These  
118 programs provide care at the intermediate nursing level to persons who also have specialized  
119 psychiatric care needs. They may participate in Medicaid, if they wish, as a Nursing Facility for  
120 Persons with a Mental Illness (NF/PMI). Medicaid will only fund persons 65 and over in this  
121 setting. Currently only one Iowa program holds this licensure.

122 **1.7.2.8 Targeted Case Managers**

123 Iowa Code requires that each county board of supervisors designate a Targeted Case Management  
124 (TCM) provider for persons with a chronic mental illness, mental retardation or developmental  
125 disability. These providers are accredited by the Division of Mental Health and Disability  
126 Services and counties may choose to provide this service with county employees, to contract with  
127 the state's Targeted Case Management program, or to sub-contract with private agencies.  
128 Targeted Case Managers (TCMs) provide assessment, service planning, monitoring, and  
129 advocacy services to Eligible Persons. TCM for persons with a chronic mental illness is  
130 reimbursed through the Iowa Plan.

131 TCM will be reimbursement based on 15-minute increments. As federal Medicaid rules continue  
132 to evolve in this area, the Contractor will be required to make any requisite changes to comply  
133 with changes to DHS' TCM requirements.

134 **1.7.2.9 Other Providers**

135 A variety of other practitioners including nurse practitioners, physician assistants, pharmacists,  
136 public health nurses, and developmental pediatricians may be appropriate providers of specific  
137 mental health services through the Iowa Plan.

138 **1.7.3 EXPERIENCE DATA FROM THE IOWA PLAN**

139 A brief summary of information of the Iowa Plan shows:

140

140

	Fiscal Year 2005	Fiscal Year 2006	Fiscal Year 2007	Fiscal Year 2008
Average monthly enrollment	247,048	257,566	257,104	304,579
Unduplicated Enrollees	345,181	358,794	360,182	419,100
Unduplicated Enrollees authorized for one or more services <sup>2</sup>	56,696	57,582	60,198	61,394
Percent of Enrollees authorized to receive services each month <sup>2</sup>	16.43%	16.05%	16.71%	14.65%

141

142 For detailed Iowa Plan enrollment, utilization and expenditure data visit the RFP's on-line  
143 resource room <http://www.ime.state.ia.us/ManagedCare/IowaPlanReprocurement.html>. Reference  
144 RFP #MED-09-010.

145 **1.8 AN OVERVIEW OF SUBSTANCE ABUSE SERVICES IN IOWA**

1 In 1995, DHS and IDPH implemented the Iowa Managed Substance Abuse Care Plan (IMSACP),  
2 the state's first managed care program for substance abuse services funded by Medicaid and by  
3 the Substance Abuse Prevention and Treatment Block Grant and associated state appropriations.  
4 In 1999, IMSACP was joined with MHAP, the state's corollary mental health managed care  
5 program, to form the Iowa Plan for Behavioral Health. The Iowa Plan is a capitated, at-risk plan  
6 to provide managed mental health and substance abuse treatment to Enrollees under a Medicaid  
7 1915(b) waiver, under the authority of DHS, as well as an administrative services only plan for  
8 substance abuse treatment services funded by federal block grant and state appropriations under  
9 the authority of IDPH. The Contractor receives separate funding from DHS and IDPH and must  
10 meet distinct funding and service requirements while assuring close coordination of all services  
11 and supports. Specific to substance abuse services, the Iowa Plan provides:

- 12 • utilization management and retrospective utilization monitoring using the American  
13 Society of Addiction Medicine Patient Placement Criteria, Second Edition-Revised  
14 (ASAM PPC-2R) and the PMIC Admission and Continued Stay Criteria, and based in  
15 service necessity, an expansion of the concept of medical necessity;
- 16 • an array of substance abuse services and supports that is significantly broader than that  
17 reimbursable through the Iowa Medicaid fee-for-service system and that complements the  
18 IDPH-funded services infrastructure;
- 19 • coordinated services for Iowa Plan Eligible Persons with complex issues, including co-  
20-occurring mental health and substance abuse concerns;
- 21 • linkages to other recovery-oriented services and supports that benefit Eligible Persons in  
22 their personal recovery efforts;
- 23 • data analysis and reporting, and

---

<sup>2</sup> The current Contractor eliminated prior authorization requirements for certain services, resulting in a decrease in overall authorizations. The decrease in authorizations does not indicate a decrease in the number or percent of Enrollees who received services.

- 24 • resources to assist the state in building infrastructure and capacity to expand recovery-  
25 oriented care services to Iowa Plan Eligible Persons.
- 26 See the RFP’s resource room for the historical number of Medicaid Members and Iowa Plan  
27 Enrollees, expenditure and utilization information.
- 28 Substance abuse treatment services are provided by substance abuse licensed treatment programs,  
29 not by individual practitioners.
- 30 For IDPH-funded services, the Contractor provides certain administrative services and contracts  
31 with providers for at-risk, provider-managed services, with providers required to serve a  
32 minimum number of IDPH Participants. Authorization is not required at any level of service for  
33 the IDPH population.
- 34 For Iowa Plan Enrollees, authorization is required for Level IV Inpatient, Level III Residential  
35 and PMIC services. Authorization may be required by the Contractor for other services or levels  
36 of care for quality improvement or contract compliance purposes, as approved by the  
37 Departments.
- 38 Retrospective utilization monitoring is performed for both Enrollees and IDPH Participants at all  
39 levels of service to ensure appropriate application of clinical criteria.
- 40 The Iowa Plan uses the American Society of Addiction Medicine’s Patient Placement Criteria for  
41 the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R) as the  
42 clinical criteria for all levels of substance abuse services and uses PMIC Admission and  
43 Continued Stay Criteria for PMIC services.

44

45 **1.8.1 PROVIDING SUBSTANCE ABUSE TREATMENT SERVICES IN IOWA**

46 **1.8.1.1 Specialized Substance Abuse Treatment in General Hospitals**

47 A limited number of Iowa general hospitals have inpatient substance abuse treatment units and/or  
48 outpatient substance abuse treatment programs. Many of these hospitals participate in the Iowa  
49 Plan as network providers and provide a continuum of services.

50 **1.8.1.2 Detoxification Services in Hospitals**

51 General hospitals may provide inpatient medical detoxification services.

52 **1.8.1.3 Mental Health Institutes**

53 Mount Pleasant Mental Health Institute operates a licensed substance abuse treatment program  
54 for adults.

55 The Iowa Plan explicitly provides for coverage of dual diagnosis mental health and substance  
56 abuse treatment provided at Mount Pleasant when the following criteria are met:

- 57 • the person is an Enrollee in the Iowa Plan;
- 58 • the Enrollee is admitted on a voluntary basis;
- 59 • the clinical needs of the Enrollee meet the ASAM PPC-2R criteria, and
- 60 • the Enrollee meets all other terms and conditions of the Iowa Plan contract.

61

62 **1.8.1.4 Psychiatric Medical Institutions for Children**

63

64 As described above in Section 1.7.2.3, the mental health Psychiatric Medical Institutions for  
65 Children (PMIC) do not provide mental health services as part of the Iowa Plan but do participate

66 in the fee-for-service Medicaid program as hospitals. Two of the eleven PMICs in Iowa -  
67 Alegent Behavioral Health Services in Council Bluffs and Jackson Recovery Center in Sioux City  
68 - are licensed substance abuse treatment programs which provide residential substance abuse  
69 treatment services to persons under age twenty-one, with a primary substance abuse diagnosis and  
70 a mental health diagnosis requiring management concurrent with substance abuse treatment. The  
71 two PMIC programs have a 56-bed capacity within their substance abuse PMIC treatment  
72 programs and participate in the Iowa Plan for the purpose of the substance abuse services.

73 **1.8.1.5 Community-Based Substance Abuse Treatment Programs**

74 Iowa has a statewide establishment of community-based, licensed substance abuse treatment  
75 programs that provide a continuum of substance abuse treatment.

76 **1.9 COORDINATING WITH OTHER STATE AGENCIES AND PROGRAMS**

1 To ensure that the Iowa Plan meets its vision of supporting a recovery-oriented care system, it is  
2 essential that DHS, IDPH, and the Contractor work closely with other state agencies and  
3 programs that interact with the behavioral health system in Iowa.  
4

5 **1.9.1 THE DHS DIVISION OF MENTAL HEALTH AND DISABILITY SERVICES**  
6 **(MHDS)**  
7

8 The DHS Division of Mental Health and Disability Services (MHDS) is the designated Mental  
9 Health Authority for the State of Iowa. MHDS is responsible for setting mental health policy for  
10 the state and is currently focusing on two major initiatives – the implementation of an emergency  
11 mental health crisis services system on a statewide basis and the development of a coordinated  
12 system of care for children with serious emotional disturbance. In addition to these initiatives,  
13 the Division administers several federal and state funding streams and provides oversight in the  
14 form of monitoring and technical assistance to the 99 county mental health services plans. The  
15 Division also is responsible for accrediting the provision of various mental health services by  
16 Community Mental Health Centers (CMHCs), Other Community Mental Health Providers,  
17 Supported Community Living Providers and Targeted Case Management providers.

18 The emergency mental health crisis services system will begin on a pilot basis in 2009. The  
19 purpose of the system is to provide a time-limited intervention service to reduce escalation of  
20 mental health crisis situations, relieve immediate distress, reduce risk of persons in crisis harming  
21 themselves or others, and promoting timely access to appropriate services for those requiring  
22 ongoing care.

23 MHDS is legislatively mandated to establish a comprehensive community-based mental health  
24 services system for children and youth. The system must provide care in the least restrictive  
25 setting possible and will be focused on community-based systems of care with a local lead agency  
26 responsible for providing or coordinating necessary services and collaborating with local  
27 educational entities.

28 The Contractor will be required to work closely with MHDS throughout the term of the contract.  
29 The Departments foresee the Contractor assisting MHDS in the advancement of the availability  
30 of emergency services system and the development of a statewide coordinated system of care for  
31 children. MHDS may focus on additional initiatives during the term of the contract in which the  
32 Contractor will also be required to participate.

33 To ensure that the Iowa Plan and the state-only funded mental health system work together for  
34 patients in the most integrated way, the Contractor must:

- 35 • participate on steering committees and in workgroups as requested by MHDS, and  
36 approved by DHS, to forward MHDS initiatives, such as the Emergency Services Pilot  
37 and improvements to the children’s mental health system, and
- 38 • share best practices and lessons learned, across counties, MHDS and the Contractor to  
39 ensure mutual learning and benefits from pilots and other initiatives.  
40

41 **1.9.2 DHS CHILD WELFARE AND JUVENILE JUSTICE SERVICES (CW/JJ)**

42 The DHS Bureau of Protective Services (DBPS) has responsibility for program standards and the  
43 budget for most child welfare and juvenile justice services and for child care, licensing and  
44 approval standards for various types of public and private facilities and agencies, and  
45 administration of the child abuse and dependent adult abuse registries, child abuse and teen  
46 pregnancy prevention. The children served include children who have been or are at risk of abuse  
47 or neglect, children in need of assistance as defined by the Juvenile Justice Act (Chapter 232 of  
48 the Iowa Code), children adjudicated delinquent, and children with physical, emotional or mental  
49 disabilities.

50 A number of children enrolled in the Iowa Plan also receive child welfare/juvenile justice services  
51 or are within the state’s foster care or subsidized adoption program. The Contractor is responsible  
52 for coordinating with DBPS to meet goals for safety, permanency and well-being of the child and  
53 is responsible for authorizing appropriate mental health or substance abuse services to  
54 complement CW/JJ services upon request from DHS field workers or juvenile court officers.  
55 As children in foster care and those in subsidized adoptions will be enrolled in the Iowa Plan, the  
56 Contractor must work to improve the integration of services to these particularly vulnerable  
57 children. Additionally, the Contractor is responsible for partnering with all those involved in the  
58 life of a child or family to assure that children in the CW/JJ system receive the mental health  
59 services that they need, and that services are coordinated and integrated.  
60

61 **1.9.2.1 Services for Children in the Foster Care Program**

62 The Contractor is responsible for coordinating and integrating behavioral health services to  
63 address the identified needs of children in foster care. The Contractor, where appropriate, must  
64 include providers in family team meetings for foster children to facilitate treatment planning.  
65

66 **1.9.2.2 Services for Children in Subsidized Adoption**

67 Children whose adoptive families receive an adoption subsidy from DHS are eligible for  
68 Medicaid and enrolled in the Iowa Plan. A significant number of these children have mental  
69 health needs or are at risk of having mental health needs. As an integral part of the system which  
70 provides services and supports to adopted children and their families, the Contractor shall be  
71 required to collaborate with DHS and with the Iowa Foster and Adoptive Parents Association to  
72 develop services and supports to meet the specialized behavioral health needs of children who  
73 have been adopted from Iowa’s foster care system.

74 **1.9.3 IDPH BUREAU OF ADMINISTRATION, REGULATION AND LICENSURE**

75 The Contractor may be required to support the Bureau of Administration, Regulation and  
76 Licensure in specific efforts, as directed by IDPH. Such efforts may include, but are not limited  
77 to, coordination on: contract and licensure compliance, quality assurance and improvement, and  
78 technical assistance.

79 Such support may require coordination with other entities, such as local public health, provider  
80 associations, and the State Board of Health.

81 **1.9.4 IDPH BUREAU OF SUBSTANCE ABUSE PREVENTION AND TREATMENT**

82 The Contractor may be required to support the Bureau of Substance Abuse Prevention and  
83 Treatment in specific efforts as directed by IDPH. Such efforts may include, but are not limited  
84 to, coordination on: Access To Recovery (ATR); Culturally Competent Substance Abuse  
85 Treatment; Family Drug Court; Jail-Based Treatment; Methamphetamine Summit; NIATx  
86 (Network for Improvement of Addiction Treatment) projects, including STAR-SI and Whole  
87 Systems Change; and prevention activities.

88 Such support may require coordination with other State agencies such as the Department of  
89 Correctional Services, the Department of Education, the Department of Human Rights Criminal  
90 and Juvenile Justice Planning, the Judicial Branch, and the Office of Drug Control Policy, and  
91 with other entities such as community coalitions and provider associations.

92 **1.9.5 IDPH Office of Gambling Treatment and Prevention**

93 The Contractor may be required to support the Office of Gambling Treatment and Prevention in  
94 specific efforts, as directed by IDPH. Such efforts may include, but are not limited to,  
95 coordination on: contract and licensure compliance; distance treatment options; licensure  
96 alignment; quality assurance and improvement, and technical assistance.

97 Such support may require coordination with other entities, such as advisory groups, local public  
98 health, and provider associations.

99

100

101

## SECTION 2

102

## PROCUREMENT PROCESS

103

104

### 2.1 ISSUING THE REQUEST FOR PROPOSALS

106

107 This RFP is issued jointly by DHS and IDPH. The DHS Bureau of Managed Care and Clinical  
108 Services is the sole point of contact regarding the RFP from the date of issuance of the RFP until  
109 the contract is signed with the selected Bidder. This RFP is designed to provide Bidders with the  
110 information necessary for the preparation of competitive Bid Proposals. The RFP process is for  
111 the Departments' benefit and is intended to provide the Departments with competitive  
112 information to assist in the selection process. It is not intended to be comprehensive. Each Bidder  
113 is responsible for determining all factors necessary for submission of a comprehensive Bid  
114 Proposal. The Departments adhere to all applicable federal and state laws, rules, and regulations  
115 when entering into a contract for services. Any contract resulting from the RFP shall not be an  
116 exclusive contract.

117

### 2.2 RESTRICTION ON COMMUNICATION WITH THE DEPARTMENTS' EMPLOYEES

119

120 From the issue date of this RFP until announcement of the successful Bidder, Bidders shall  
121 contact only the Issuing Officer. The issuing officer is:

122

Cynthia Tracy, Iowa Plan Program Manager

123

Bureau of Managed Care & Clinical Services

124

Iowa Department of Human Services

125

100 Army Post Road

126

Des Moines, IA 50315

127

[ctracy@dhs.state.ia.us](mailto:ctracy@dhs.state.ia.us)

128

Telephone: (515) 725-1145

129

Fax: (515) 725-1360

130

131 The Issuing Officer will respond only to questions regarding the procurement process. Questions  
132 related to interpretation of the requirements of the RFP must be submitted in writing with the  
133 Letter of Intent to Bid, as set forth in Section 2.6.

134

135 Bidders are not permitted to communicate with any other DHS or IDPH staff concerning the RFP  
136 or about issues relating to this RFP from the issue date of this RFP until announcement of the  
successful Bidder. Such inappropriate conduct will disqualify the Bidder.

137

138 DHS and IDPH assume no responsibility for representations made by its officers or employees  
prior to the execution of a contract, unless such representations are in writing and are

139 incorporated into this RFP through a formal amendment. Verbal discussions pertaining to  
140 modifications or clarifications of this RFP shall not be considered part of the RFP unless the RFP  
141 is amended.

142 Any information provided verbally by a Bidder shall not be considered part of the Bidder's  
143 proposal. Only written communications from the Bidder that are received by DHS within the  
144 required timeframes will be considered.

### 145 **2.3 PROCUREMENT TIMETABLE**

146  
147 The following dates are set forth for informational and planning purposes. The Departments  
148 reserve the right to change the dates (hereafter referred to as "Procurement Timetable").

149

150 RFP posted to Targeted Small Business website.....	December 29, 2008
151	
152 Issue RFP.....	December 31, 2008
153	
154 Letters of Intent and Questions Due .....	January 21, 2009 (4:30 p.m. Central time)
155	
156 Responses to Questions Issued.....	February 4, 2009
157	
158 Closing date for receipt of bids .....	March 20, 2009
159	
160 Notice of Intent to Award issued.....	April 22, 2009
161	
162 Contract Fully Executed.....	May 1, 2009
163	
164 Implementation Period Begins .....	May 2, 2009
165	
166 Operations Begins .....	January 1, 2010
167	

### 168 **2.4 WHO CAN BID ON THE IOWA PLAN**

169 The Departments welcome any entity that considers itself capable of meeting the requirements of  
170 this Request for Proposals to submit a bid. No Bidder, however, can be a direct provider of any  
171 treatment services that are to be reimbursed through the Iowa Plan. In other words, no entity will  
172 be considered for a contract for the Iowa Plan if that entity expects to be reimbursed for mental  
173 health or substance abuse treatment services or supports through any of the Medicaid capitation  
174 payments (see Section 9.1(3)), or through IDPH funds allocated to service provision. Any entity  
175 submitting a bid for the Iowa Plan must disclose any financial or related party interest in any  
176 provider or group of providers that expects to be reimbursed through any of the capitation  
177 payments which are designated for the Claims Fund.

### 178 **2.5. RESOURCES AVAILABLE ON-LINE**

179 The Departments will make available to potential Bidders reports and other information generated  
180 during the operation of the Iowa Plan. Resources are available on-line at  
181 <http://www.ime.state.ia.us/ManagedCare/IowaPlanReprocurement.html>. A list of information to  
182 be available is included in the **Attachments to Section 2**.

### 183 **Downloading the RFP from the Internet**

184  
185 The RFP, all amendments and responses to questions will be posted at  
186 <http://bidopportunities.iowa.gov/>. The Bidder is advised to check the web page periodically for  
187 any amendments to this RFP. Only Bidders who have responded with an intent to bid will be  
188 electronically notified of amendments. This does not guarantee that electronic notices will be  
189 received.

## 190 **2.6 LETTERS OF INTENT TO BID**

191 Submitting a Letter of Intent to Bid is a mandatory requirement for submitting a proposal. A  
192 Letter of Intent to Bid must be received by the date and time set forth in Section 2.3 (Procurement  
193 Timetable). Facsimiles and e-mail submissions will be accepted. Only those who submit a Letter  
194 of Intent to Bid will receive the Responses to Questions and any amendments to the RFP.

195 The Letter of Intent to Bid must state the Bidder's name, mailing address, e-mail address,  
196 telephone number, and statement of intent to compete for the Iowa Plan contract. If two or more  
197 legal entities plan to collaborate and form a partnership or some other legal or financial  
198 arrangement to submit a bid jointly, each collaborating entity and its executive officer must be  
199 named. The Letter of Intent to Bid must include an authorizing signature.

200 Letters of Intent to Bid must be received at DHS no later than the date and time identified in  
201 Section 2.3 (Procurement Timetable). Any Letter of Intent to Bid received after this time and date  
202 will not be accepted, will be deemed non-responsive, and will be returned to the Bidder. It is the  
203 responsibility of the Bidder to ensure that the Letter of Intent to Bid is timely received.  
204 Postmarking by the due date will not substitute for actual receipt of the Letter of Intent to Bid.

205 Letters of Intent to Bid must be directed to:

206  
207 Cynthia Tracy, Iowa Plan Program Manager  
208 Bureau of Managed Care & Clinical Services  
209 Iowa Department of Human Services  
210 100 Army Post Road  
211 Des Moines, IA 50315  
212 [ctracy@dhs.state.ia.us](mailto:ctracy@dhs.state.ia.us)  
213 Telephone: (515) 725-1145  
214 Fax: (515) 725-1360  
215

216 The Departments may publish a list of Bidders who have submitted Letters of Intent to Bid. The  
217 list may be included with the Response to Questions.  
218

### 219 **2.6.1 Submission of Questions**

220 Potential Bidders may include with their Letter of Intent to Bid an addendum with questions  
221 requesting clarification of terms of the RFP. Each question submitted must reference the specific  
222 page(s) and line(s) of the RFP to which it refers. Bidders are directed to e-mail a copy of all  
223 questions to the Issuing Officer (Section 2.2). Questions may be set forth in the body of the e-  
224 mail or attached to the e-mail in one of the following formats: Microsoft Word, RTF, or Text.

225 Responses will be limited to those questions that seek clarification of terms of the RFP. Questions  
226 will not be accepted if they are from organizations that do not submit a Letter of Intent to Bid in  
227 accordance with Section 2.6.

228 Any ambiguity regarding this RFP shall be addressed through the question and answer process.  
229 Submissions in response to this section may include suggestions for changes to the requirements  
230 of this RFP or contract language.

### 231 **2.6.2 Responses to Questions**

232 The Departments will respond to Bidders' questions by the date set forth in Section 2.3  
233 (Procurement Timetable). The Departments assume no responsibility for verbal representations  
234 made by its officers or employees unless such representations are confirmed in writing and  
235 incorporated into the RFP. In addition, the Departments' written responses to questions will not  
236 be considered part of the RFP. If the Departments decide to change the RFP, the Departments will  
237 issue an amendment.

238

### 239 **2.7 RFP AMENDMENTS**

240 The Departments reserve the right to amend the RFP at any time. The Bidder shall acknowledge  
241 receipt of any RFP amendments in its Bid Proposal. If the amendment occurs after the closing  
242 date for receipt of Bid Proposals, the Departments may, in their sole discretion, allow Bidders to  
243 amend their Bid Proposals if necessary.

244

### 245 **2.8 SUBMISSION OF PROPOSALS**

246 One (1) original and 10 copies of the Bid Proposal shall be submitted in separately sealed  
247 envelopes. The envelope containing the original Bid Proposal shall be labeled "original" and each  
248 envelope containing a copy of the Bid Proposal shall be labeled "copy." All copies shall contain  
249 the same attachments and be an exact copy of the original.

250

251 Bidders shall also submit the Bid Proposal electronically on a CD in either Microsoft Word 2000  
252 compatible or PDF format. If the Bidder designates any information in its Bid Proposal as  
253 confidential, the Bidder shall also submit one (1) copy of the Bid Proposal from which  
254 confidential information has been redacted. This copy shall be clearly labeled "Copy with  
255 Confidential Material Redacted".

256

257 Proposals must be received at DHS no later than the date and time identified in Section 2.3  
258 (Procurement Timetable). Any Proposals received after this time and date will not be accepted,  
259 will be deemed non-responsive, and will be returned to the Bidder unopened. It is the  
260 responsibility of the Bidder to ensure that the proposal(s) submitted are date and time-stamped to  
261 verify the time of delivery. Postmarking by the due date will not substitute for actual receipt of  
262 the proposal.

263 Proposals must be mailed or delivered to:

264 Cynthia Tracy, Iowa Plan Program Manager  
265 Bureau of Managed Care & Clinical Services  
266 Iowa Department of Human Services  
267 100 Army Post Road  
268 Des Moines, IA 50315

### 269 **2.9 PROPOSAL AMENDMENTS AND RULES FOR WITHDRAWAL**

270 Prior to the date by which proposals must be received, a proposal that has been submitted may be  
271 amended or withdrawn by submitting the amendment or the request to withdraw in writing to the  
272 address noted in Section 2.8. An authorized representative of the Bidder must sign the  
273 amendment or request to withdraw. If the Departments require the proposal to be submitted on a  
274 CD, the amendment must be also be submitted on a CD. The Bidder shall provide the same  
275 number of copies of the amendment as is required for the original proposal. The Issuing Officer  
276 shall receive the amendment by the deadline for submitting Bid Proposals. The Departments will  
277 not waive this mandatory requirement. Electronic mail and faxed amendments will not be  
278 accepted.

279 The Departments will not accept any amendments, revisions or alterations to proposals after the  
280 proposal due date unless such are requested in writing by the Departments.  
281

## 282 **2.10 ACCEPTANCE OF PROPOSALS AND CLARIFICATIONS**

283 The Departments will accept all proposals submitted in accordance with requirements of this  
284 RFP. The Departments reserve the right to request clarifications to the proposals at any time.  
285

286 Clarifications shall be submitted in writing and may not alter information in the proposal other  
287 than the section(s) being clarified. A proposal may not be orally clarified by a Bidder.

288 The Departments reserve the right to waive irregularities or technicalities in any proposal. In the  
289 event the Departments waive irregularities or technicalities, such waiver will not modify the RFP  
290 requirements or excuse the Bidder from full compliance with RFP specifications or other contract  
291 requirements if the Bidder is awarded the contract.

## 292 **2.11 FIRM PROPOSAL TERMS**

293 All bid proposal terms shall remain firm for a period of 90 days following the date the contract is  
294 awarded.

## 295 **2.12 COST OF PREPARING PROPOSALS**

296 Costs for developing a proposal are the sole responsibility of the Bidder, whether or not any  
297 award results from this Request for Proposals. The Departments will provide no reimbursement  
298 for such costs.

## 299 **2.13 ACCEPTANCE OF TERMS AND CONDITIONS**

300 The Bidder shall specifically stipulate in the Transmittal Letter that the Bid Proposal is predicated  
301 upon the acceptance of all terms, conditions and contract language provided in the RFP.

## 302 **2.14 REFERENCE CHECKS**

303 The Departments reserve the right to contact any reference to assist in the evaluation of the  
304 proposal, to verify information contained in the proposal and to discuss the Bidder's  
305 qualifications and the qualifications of any subcontractor identified in the proposal.  
306

## 307 **2.15 INFORMATION FROM OTHER SOURCES**

308

309 The Departments reserve the right to obtain and consider information from other sources  
310 concerning a Bidder, such as the Bidder's capability and performance under other contracts, or  
311 the Bidder's authority and ability to conduct business in the state.

312 **2.16 VERIFICATON OF PROPOSAL CONTENTS**

313 The content of a proposal submitted by a Bidder is subject to verification. Submission of  
314 misleading or inaccurate responses shall result in disqualification.

315 **2.17 CRIMINAL HISTORY AND BACKGROUND INVESTIGATION**

316 The Departments reserve the right to conduct criminal history and other background investigation  
317 of the Bidder, its officers, directors, shareholders, or partners and managerial and supervisory  
318 personnel retained by the Bidder for the performance of the contract. The Departments reserve  
319 the right to conduct criminal history and other background investigation of the Bidder's staff and  
320 subcontractors providing services under this contract.

321 **2.18 REJECTION OF PROPOSALS**

322 The Departments reserve the right to reject for full review any or all proposals, in whole and in  
323 part, or to cancel the RFP if it is in the Departments' best interest to do so at any time prior to the  
324 execution of a written contract. Issuance of this RFP in no way constitutes a commitment by the  
325 Departments to award a contract.

326 **2.19 DISPOSITION OF PROPOSALS**

327 All proposals become the property of the Departments and shall not be returned to the Bidder. At  
328 the conclusion of the selection process, the contents of all proposals will be in the public domain  
329 and be open to inspection by interested parties subject to exceptions provided in Iowa Code  
330 Chapter 22 or other applicable law.

331 **2.20 PUBLIC RECORDS AND REQUESTS FOR CONFIDENTIAL TREATMENT**

332 Original information submitted by a Bidder may be treated as public information by the  
333 Departments following the conclusion of the selection process unless the Bidder properly requests  
334 that information be treated as confidential at the time of submitting the Bid Proposal. The  
335 Departments' release of information is governed by Iowa Code Chapter 22. Bidders are  
336 encouraged to familiarize themselves with Chapter 22 before submitting a Proposal. The  
337 Departments will copy public records as required to comply with the public records laws.

338 Any request for confidential treatment of information must be included in the transmittal letter  
339 with the Bidder's Bid Proposal. In addition, the Bidder shall enumerate the specific grounds in  
340 Iowa Code chapter 22 or other applicable law, which support treatment of the material as  
341 confidential and explain why disclosure is not in the best interest of the public. The request for  
342 confidential treatment of information shall also include the name, address, electronic address, and  
343 telephone number of the person authorized by the Bidder to respond to any inquiries by the  
344 Departments concerning the confidential status of the materials.

345

346 Any Bid Proposal submitted which contains confidential information shall be conspicuously  
347 marked on the outside as containing confidential information, and each page upon which  
348 confidential information appears shall be conspicuously marked as containing confidential

349 information. The confidential material shall be redacted in such a way as to allow the public to  
350 determine the general nature of the material removed and to retain as much of the Bid Proposal as  
351 possible. To the extent possible, pages should be redacted sentence by sentence unless all material  
352 on a page is clearly confidential under the law. Identification of the entire Bid Proposal as  
353 confidential shall be deemed non-responsive and disqualify the Bidder.

354 If the Bidder requests confidential treatment of any portion of the Bid Proposal, the Bidder shall  
355 follow the instructions in Section 2.8 of the RFP concerning how to submit the material to the  
356 Departments.

357  
358 The Departments will treat the information marked confidential as confidential information to the  
359 extent such information is determined confidential under Iowa Code chapter 22 or other  
360 applicable law by a court of competent jurisdiction.

361  
362 In the event the Departments receive a request for information marked confidential, written notice  
363 shall be given to the Bidder seventy-two (72) hours prior to the release of the information to  
364 allow the Bidder to seek injunctive relief pursuant to Section 22.8 of the Iowa Code.

365  
366 The Bidder's failure to request confidential treatment of material pursuant to this section and the  
367 relevant law will be deemed by the Departments as a waiver of any right to confidentiality that  
368 the Bidder may have had.

## 369 **2.21 COPYRIGHTS**

370 By submitting a Bid Proposal, the Bidder agrees that the Departments may copy the Bid Proposal  
371 for purposes of facilitating the evaluation of the Bid Proposal or to respond to requests for public  
372 records. By submitting a Bid Proposal, the Bidder acknowledges that additional copies may be  
373 produced and distributed, and represents and warrants that such copying does not violate the  
374 rights of any third party. The Departments shall have the right to use ideas or adaptations of ideas  
375 that are presented in the Bid Proposals.

## 376 377 **2.22 RELEASE OF CLAIMS**

378  
379 By submitting a proposal, the Bidder agrees that it will not bring any claim or cause of action  
380 against the Departments based on any misunderstanding concerning the information provided  
381 herein or concerning the Departments' failure, negligent or otherwise, to provide the Bidder with  
382 pertinent information as intended by this RFP.

## 383 384 **2.23 PRESENTATIONS**

385  
386 Bidders may be required to make a presentation of the Bid Proposal. The presentation may occur  
387 at the Departments' offices, the offices of the Bidder, or other specified location. The  
388 determination as to need for presentations, the location, order, and schedule of the presentations is  
389 at the sole discretion of the Departments. The presentation may include slides, graphics and other  
390 media selected by the Bidder to illustrate the Bidder's Bid Proposal. The presentation shall not  
391 materially change the information contained in the Bid Proposal.

## 392 393 **2.24 EVALUATION OF PROPOSALS SUBMITTED**

394  
395 Bid Proposals that meet the mandatory requirements and are not subject to disqualification will be  
396 evaluated by a committee in accordance with Section 8 of the RFP.

397

398 **2.24.1 Notice of Intent to Award**

399 Notice of Intent to Award will be sent to all Bidders submitting a timely Bid Proposal. The Notice  
400 of Intent to Award does not constitute the formation of a contract between the Departments and  
401 the apparent successful Bidder.

402

403 **2.24.2 Acceptance Period**

404 The Departments shall make a good faith effort to negotiate and execute the contract no later than  
405 the date specified in Section 2.3 (Procurement Timetable). If the apparent successful Bidder fails  
406 to negotiate and execute a contract, the Departments may, in their sole discretion, revoke the  
407 Notice of Intent to Award and negotiate a contract with another Bidder or withdraw the RFP. The  
408 Departments further reserve the right to cancel the Notice of Intent to Award at any time prior to  
409 the execution of a written contract.

410

411 **2.24.3 Review of the Notice of Intent to Award Decision**

412

413 The Directors' joint decision to award the contract to a particular bidder shall constitute final  
414 agency action. Review of that decision may be had pursuant to Iowa Code § 17A.19.

415

416 **2.25 DEFINITION OF CONTRACT**

417 The full execution of a written contract shall constitute the making of a contract for services and  
418 no Bidder shall acquire any legal or equitable rights relative to the contract services until the  
419 contract has been fully executed by the successful Bidder and the Departments.

420 **2.26 CMS CONTINGENCY**

421 Award of the contract and implementation of the Iowa Plan is contingent upon approval by the  
422 Centers for Medicare and Medicaid Services (CMS) of the RFP and any amendments thereto, the  
423 contract with the selected Bidder, and the request for a renewal of its 1915(b) waiver. In the event  
424 changes are required to gain approval, DHS reserves the right to modify the RFP or the contract  
425 accordingly. DHS also reserves the right to mandate the Contractor to make any changes that may  
426 be required by CMS that would impact the ongoing operation of the Iowa Plan before or during  
427 its implementation. Any such modifications or changes will be done in consultation with IDPH.

428 **2.27 CHOICE OF LAW AND FORUM**

429 This RFP and the resulting contract are to be governed by the laws of the State of Iowa, without  
430 regard to the conflicts of law provisions thereof. Changes in applicable laws and rules may affect  
431 the award process or the resulting contract. Bidders are responsible for ascertaining pertinent  
432 legal requirements and restrictions. Any and all litigation or actions commenced in connection  
433 with this RFP shall be brought and maintained in the appropriate Iowa forum.

434 **2.28 RESTRICTIONS ON GIFTS AND ACTIVITIES**

435 Iowa Code Chapter 68B restricts gifts which may be given or received by state employees and  
436 requires certain individuals to disclose information concerning their activities with state  
437 government. Bidders are responsible to determine the applicability of this Chapter to their  
438 activities and to comply with the requirements. In addition, pursuant to Iowa Code section 722.1,  
439 it is a felony offense to bribe or attempt to bribe a public official.

440

441 **2.29 NO MINIMUM GUARANTEED**

442 The Departments anticipate that the selected Bidder will provide services as requested by the  
443 Departments. The Departments will not guarantee any minimum compensation will be paid to the  
444 Bidder or any minimum usage of the Bidder's services.

445 **2.30 CURRENT CONTRACTOR**

446 The current Contractor for the Iowa Plan is Magellan Behavioral Care of Iowa, Magellan Health  
447 Services. The Departments have had no contact with Magellan concerning the development of  
448 this RFP other than to obtain necessary utilization and expenditure data and other current  
449 program information, included in the on-line resource room. The Departments will give the  
450 current Contractor no preference in this or any other procurement process.

451

451

1  
2  
3  
4  
5  
6  
7

**SECTION 3**

**PERSONS TO BE SERVED THROUGH**

**THE IOWA PLAN**

**AND**

**ELIGIBLE PERSON RIGHTS AND PROTECTIONS**

8  
9

**3.1 PERSONS TO BE SERVED THROUGH THE IOWA PLAN**

10

**3.1.1 Medicaid Members Enrolled in the Iowa Plan**

11  
12  
13  
14  
15

The Iowa Medicaid program covers both categorically and medically needy individuals. All categories of members are required to receive mental health and substance abuse services through the Iowa Plan unless specifically excluded. Information on Iowa Medicaid eligibility may be found in the RFP's resource room. Changes in an Enrollee's Medicaid coverage group may result in the automatic disenrollment of the Enrollee from the Iowa Plan by DHS.

16  
17  
18  
19  
20  
21  
22

The Contractor will be responsible for ensuring the provision of appropriate mental health and substance abuse services and supports to Iowa Plan Enrollees for all months of eligibility beginning with the month in which the Enrollee signed an application for Medicaid. The Contractor will not be responsible for services provided in months in which retroactive eligibility was granted, except as described below. For those eligible for Medicaid based on a determination of SSI eligibility, Iowa Plan enrollment will not begin until the month of DHS' receipt of notice from the State Data Exchange of the person's new SSI eligibility, except as described below.

23  
24  
25  
26  
27  
28  
29  
30  
31  
32

The Contractor will be responsible for paying for all appropriate mental health and substance abuse treatment services for Iowa Plan Enrollees, even if the services occurred earlier in the month of application than enrollment in the Iowa Plan. The Contractor may establish requirements for authorization or retrospective review of the psychosocial necessity or service necessity of the services. Those requirements, however, may be no more stringent than the requirements for services reviewed at the time they are provided. If authorization is required at the time service is delivered to those whose enrollment is not yet determined, the Contractor also shall allow for retrospective review in situations in which it would have been unreasonable to expect that the provider could have determined that a person had, or was planning to apply for,

33 Medicaid coverage. In the development and implementation of policies and procedures, the  
34 Contractor is required to work with providers to find ways to minimize the burden on providers in  
35 dealing with those whose eligibility has not yet been determined, or whose eligibility is not  
36 readily apparent, at the time service is provided.

37  
38 At the end of each working day and of each calendar month, DHS will electronically provide a  
39 HIPAA-compliant 834 enrollment file to the Contractor. The file will contain Medicaid  
40 information for members who are enrolled in the Iowa Plan. At the end of each calendar month  
41 DHS will also electronically provide to the Contractor a list of Medicaid members for the  
42 following month and new Enrollees for current and prior months. Additionally, each working  
43 day and each calendar month, along with the 834 enrollment file, DHS will provide the  
44 Contractor with a Family and Child Services (FACS) file. The FACS file contains specialized  
45 data that are not included in the 834, such as caseworkers, supervisors, etc. Both the 834 and the  
46 FACS files contain the State Identification number and the date and time to make it easier to  
47 match between them. The Contractor will work with DHS to develop and implement a routine  
48 discrepancy reconciliation process to ensure that the Contractor's and DHS' eligibility and  
49 enrollment files are consistent.

50

51 **3.1.1.1 Retroactive enrollment for children in substance abuse PMICs and MHI**  
52 **child/adolescent treatment programs**

53 Children admitted to a PMIC, or to a child/adolescent treatment unit at Cherokee Mental Health  
54 Institute or Independence Mental Health Institute, often apply for and gain Medicaid eligibility in  
55 aid type 377 due to their out-of-home placement, upon or after admission. The Contractor must  
56 manage all admissions to these settings as if that person had been a Medicaid Enrollee at the date  
57 of admission.

58 If a child is admitted to a substance abuse licensed PMIC or, to a child/adolescent treatment  
59 unit at Cherokee Mental Health Institute or Independence Mental Health Institute, and is a  
60 Medicaid member or later becomes a Medicaid member under 377 aid type (including  
61 gaining retroactive Medicaid eligibility which typically includes up to three months of  
62 eligibility prior to application) for all or any of the months that the person resides in the  
63 PMIC, the member will be considered an Iowa Plan Enrollee regardless of whether the child  
64 is designated an Enrollee (by inclusion on the Contractor's enrollment tape or inclusion in the  
65 regular capitation payment). DHS will make a manual capitation payment quarterly for those  
66 Enrollees and months of enrollment not otherwise paid. The Contractor will provide a list, at  
67 least quarterly, of PMIC/ Mental Health Institute residents under the age of 18 and months of  
68 service not included in the regular capitation payment. The Contractor will work with the  
69 PMICs to ensure that all Medicaid Members have Iowa Plan eligibility from the month of  
70 entry to the substance abuse PMIC.

71

72 **3.1.1.2 Medicaid for Employed People with Disabilities (MEPD)**

73

74 Medicaid for Employed People with Disabilities (MEPD) is an optional Medicaid coverage  
75 group. To qualify the person must:

76

77 • be disabled by Social Security criteria for disability, with the exception that earnings are  
78 disregarded in determining if the person is disabled;

79

• be under age 65;

80

• have earned income from employment or self-employment, and

- 81           • meet all other financial and non-financial eligibility criteria.

82

83 A sliding scale premium is assessed when gross income of the disabled individual exceeds  
84 150% of poverty. When an applicant is not already receiving Social Security Disability  
85 Insurance, DHS must determine disability.

86

87 When an applicant is not already receiving Social Security Disability Insurance, DHS must  
88 determine disability. A disability determination usually takes at least three months but may  
89 take six or more. To avoid creating a problem for coverage under the Iowa Plan, the  
90 Contractor must agree to assume responsibility for MEPD applicants for up to three months  
91 prior to the date the application is approved.

92

### 93 **3.1.2 IDPH Participants Served through IDPH Substance Abuse Treatment Funding**

94

95 Chapter 125 of the Iowa Code states that all Iowans, regardless of ability to pay, should have  
96 access to substance abuse treatment services. IDPH provides substance abuse treatment services  
97 based on a sliding scale fee to Iowa residents with an income at or below 200% of the federal  
98 poverty level. Medicaid Members and Iowa Plan Enrollees may not be considered IDPH  
99 Participants during any month of enrollment in Medicaid or the Iowa Plan. Sliding fees are  
100 determined on the basis of income and family size and are standardized for all IDPH-funded  
101 treatment service providers. In all IDPH eligible transactions, IDPH funds shall be the payment of  
102 last resort for IDPH Participants.

103 An inmate of a non-medical public institution such as a public jail or other type of public penal  
104 institute is not eligible for IDPH-funded Iowa Plan services, except for IDPH designated jail-  
105 based services.

### 106 **3.1.3 Non-discrimination of Eligible Persons**

107

108 The Contractor will not discriminate against Eligible Persons on the basis of race, color, or  
109 national origin, and will not use any policy or practice that has the effect of discriminating on the  
110 basis of race, color, or national origin.

111

112 The Contractor must comply with all federal and state laws and regulations including Title VI of  
113 the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding  
114 education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of  
115 1973; and the Americans with Disabilities Act.

116

### 117 **3.2 MEDICAID MEMBERS NOT ENROLLED IN THE IOWA PLAN**

118 The following Medicaid Members are not enrolled in the Iowa Plan:

- 119           • persons who are eligible for Medicaid as a result of spending down excess income  
120           (medically needy with a cash spend down);
- 121           • persons enrolled in the PACE program;
- 122           • persons living in the Woodward State Hospital-School or the Glenwood State Hospital-  
123           School, and
- 124           • persons whose Medicaid benefit package is limited, such as Qualified Medicare Members  
125           (QMB), persons who are presumptively Medicaid eligible, illegal aliens and others not

126 entitled to the full range mental health and substance abuse treatment included in the  
127 Iowa Medicaid fee-for-service program.

128 All other Medicaid members are also Iowa Plan Enrollees and will receive their mental health and  
129 substance abuse services through the Contractor.

130 **3.2.1 When Iowa Plan Enrollees Who are Medicaid Members are Not Eligible for Iowa**  
131 **Plan Services Because they are Inmates of Non-medical Public Institutions**

132 An inmate of a non-medical public institution such as a public jail or other type of public penal  
133 institution is not eligible for Medical Assistance and thus is not eligible for services through the  
134 Iowa Plan. If a person enters such an institution in the middle of a month for which Medicaid  
135 eligibility was already granted prior to the person entering the institution, any medical services  
136 received in the portion of that month while he or she was an inmate are not Medicaid covered.

137 **3.3 MARKETING TO MEMBERS**

138 The marketing of Iowa Plan services to potential Enrollees is prohibited. “Potential Enrollee”  
139 means a Medicaid member who is subject to mandatory enrollment but is not yet an Enrollee of  
140 the Iowa Plan.

141  
142 **3.4 DISENROLLMENTS**

143  
144 **3.4.1 Disenrollments of Iowa Plan Enrollees**

145 The Contractor may not disenroll an Iowa Plan Enrollee. Automatic disenrollment of an Enrollee  
146 from the Iowa Plan may occur based on changes in circumstance, including:

- 147
- 148 • ineligibility for Medicaid;
  - 149 • shift to a Medicaid category not covered by the Iowa Plan;
  - 150 • change of place of residence to another state, and
  - 151 • death.

152 **3.4.2 Denial of Eligibility of IDPH Participants**

153 To ensure that individuals seeking treatment can access treatment, IDPH Participants may not be  
154 denied eligibility for cause. Denial of eligibility of IDPH Participants will only occur upon  
155 increased income or death. If an IDPH Participant becomes eligible for Medicaid, he or she will  
156 become an Iowa Plan Enrollee.

157 **3.5 THIRD PARTY CONSIDERATIONS**

158 Medicaid Members with other insurance, including Medicare, will be enrolled in the Iowa Plan  
159 unless otherwise excluded as noted in Section 3.2. The Medicaid capitation rate has been  
160 developed excluding those third party collections that have previously been identified and  
161 recovered. The Contractor is required to instruct providers to bill such third party payers, except  
162 for services designated by DHS as payable prior to pursuit of third party payment as specified in  
163 42 CFR 433.139(b)(2) (also known as “pay and chase” rules). With respect to the services subject  
164 to “pay and chase” rules, the Contractor shall actively pursue, collect and retain any moneys from  
165 third party payers for services to Enrollees, except where the amount of reimbursement the  
166 Contractor can reasonably expect to recover is less than the estimated cost of recovery.

167 The Contractor also is required to report annually on the collections from other insurers on a form  
168 provided by DHS. Third party recoveries are retained by the Contractor. The Contractor must  
169 report newly identified third party coverage to DHS as soon as such coverage is known.

170 Calculations of the Contractor's cost for providing mental health and substance abuse services  
171 shall include only the actual expenditures for those services after all third-party recoveries have  
172 been accounted for. For example, if an Enrollee with third party health insurance received \$250  
173 of mental health care, and the third party paid for \$200 of that care, leaving the Contractor to  
174 reimburse the remaining \$50, the total the Contractor may claim as its cost is \$50.

175 The Contractor is not responsible for payment of Medicare deductibles and co-insurance for  
176 persons who are dually eligible for Medicaid and Medicare.

### 177 **3.5.1 Utilization of Other Insurance Coverage for Substance Abuse Treatment**

178 In providing Iowa Plan substance abuse services to IDPH Participants, IDPH funds shall be the  
179 payment of last resort. Persons with other insurance, including insurance with coverage for  
180 substance abuse treatment, may be eligible for Iowa Plan IDPH-funded services, depended on  
181 insurance co-payment(s) and the relationship to the sliding fee scale. The Contractor will work  
182 with IDPH and providers in developing a policy regarding IDPH eligibility for persons with  
183 insurance coverage. Third party recoveries are retained by the provider.

## 184 **3.6 ELIGIBLE PERSON RIGHTS**

185 The Contractor must have written policies regarding the rights of Eligible Persons specified in  
186 this section.

- 187 • The Contractor must comply with any applicable federal and state laws that pertain to the  
188 rights of Eligible Persons and ensure that its staff and affiliated providers take those  
189 rights into account when furnishing services to Eligible Persons.
- 190 • Each Eligible Person is guaranteed the right to be treated with respect and with due  
191 consideration for his or her dignity and privacy.
- 192 • Each Eligible Person is guaranteed the right to receive information on available treatment  
193 options and alternatives, presented in a manner appropriate to the person's condition and  
194 ability to understand.
- 195 • Each Eligible Person is guaranteed the right to participate in decisions regarding his or  
196 her health care, including the right to refuse treatment.
- 197 • Each Eligible Person is guaranteed the right to be free from any form of restraint or  
198 seclusion used as a means of coercion, discipline, convenience, or retaliation.
- 199 • Each Eligible Person is guaranteed the right to treatment in the least restrictive setting,  
200 and right to fully participate in the community and to work, live and learn to the fullest  
201 extent possible.
- 202 • Each Enrollee is guaranteed the right to request and receive a copy of his or her medical  
203 records, and to request that they be amended or corrected, as specified in 45 CFR part  
204 164.
- 205 • Each Eligible Person is free to exercise his or her rights, and that the exercise of those  
206 rights does not adversely affect the way the Contractor, Iowa Plan providers or the  
207 Departments treat the Eligible Person.

- 208       • The Contractor must comply with any other applicable federal and state laws (such as  
209       Title VI of the Civil Rights Act of 1964, etc.) and other laws regarding privacy and  
210       confidentiality.
- 211       • DHS imposes no limitation on Enrollees' freedom to choose Iowa Plan providers.  
212

213       **3.7 ELIGIBLE PERSON PROTECTIONS**

214       Eligible Persons may not be held liable for:

- 215
- 216       • payments, including the Contractor's debts, in the event of the Contractor's insolvency;
- 217       • payments in the event DHS or IDPH does not pay the Contractor, or DHS or IDPH or the  
218       Contractor does not pay the individual or health care provider, and
- 219       • for payments for covered services furnished under a contract, referral, or other  
220       arrangement, to the extent that those payments are in excess of the amount the Enrollee  
221       would owe if the Contractor provided the service directly (i.e., no balance billing by  
222       providers).  
223

224       The Contractor shall implement policies to ensure that no participating or nonparticipating  
225       provider bills an Enrollee for all or any part of the cost of a covered, required, or optional service.  
226

226

1

2

3

4

5

6

7

8

**SECTION 4**

**SERVICE REQUIREMENTS**

**OF THE IOWA PLAN**

**4.1 FRAMEWORK FOR THE IOWA PLAN**

9

The Contractor will be responsible for ensuring, arranging, monitoring and reimbursing the delivery of appropriate mental health and substance abuse services and supports for Eligible Persons and for ensuring compliance with service requirements herein.

10

11

12

Within the Iowa Plan there are three distinct categories of mental health services – covered, required and optional. Covered services are those services that are part of the Iowa’s Medicaid State Plan. Required services are provided only to Iowa Plan Enrollees. Under this procurement the Departments are committed to required services being provided statewide and requiring the Contractor to develop capacity for such services. Optional services are those developed by the Contractor to provide more effective and efficient care to Iowa Plan Enrollees, but can be provided to Enrollees on an ad hoc basis depending on an individual’s need. A number of services that assist in improving the system of care generally, and in some cases, care provided to individuals, are considered administrative responsibilities. Those services include crisis counseling on the 24-hour hotline, joint treatment planning conferences and staffing, and case coordination.

13

14

15

16

17

18

19

20

21

22

23

If the Contractor wishes to delegate either clinical or administrative responsibilities required in this RFP to a direct service provider, the Departments reserve the right to limit the direct clinical services for which that provider can be reimbursed. The approval of the Departments also must be granted in writing prior to implementation of such a contractual arrangement.

24

25

26

27

As administrator of the Iowa Plan, the Contractor accepts responsibility for a variety of management functions that are set forth throughout this RFP. The Contractor also is expected to support community-based efforts to build better interfaces with those agencies and funders that are not included in the Plan. These include, but are not limited to, school districts and area education agencies, Decategorization Boards, counties and central points of coordination (CPCs), local public health entities (e.g. Board of Health), job training, placement and vocational service agencies, judicial districts and the Iowa Department of Corrections. The Departments will work with the Contractor to prioritize community-based efforts to support.

28

29

30

31

32

33

34

35

35 **4.2 GENERAL REQUIREMENTS PERTAINING TO SERVICE PROVISION**

36 4.2.1 Iowa Administrative Code 441 88.65(2) requires that Iowa Plan Enrollees receive all  
37 Medicaid-funded, covered, required and optional mental health and substance abuse  
38 services through the Iowa Plan. The Enrollee shall use only network providers unless the  
39 Contractor has authorized a referral to a nonparticipating provider for provision of a  
40 service or treatment plan or the Enrollee uses emergency services. Payment shall be  
41 denied under Medicaid fee-for-service on claims for covered, required and optional  
42 mental health and substance abuse services provided to Enrollees outside of the Iowa  
43 Plan.

44 4.2.2 A Contractor is not required to provide, reimburse, or provide coverage for, a counseling  
45 or referral service to Enrollees if that Contractor objects on moral or religious grounds. If  
46 the Contractor elects not to provide, reimburse, or provide coverage under this provision,  
47 it must furnish information to the State about the services it does not cover in its  
48 proposal, at the time contract is signed, or whenever it adopts the policy during the term  
49 of the contract as follows:

- 50
- 51 • it must be consistent with the provisions of 42 CFR 438.10;
- 52 • information regarding denial of reimbursement of the service must be provided to
- 53 new Enrollees within 10 days after enrollment, and
- 54 • information regarding denial of reimbursement of the service must be provided to on-
- 55 going Enrollees within 90 days after adopting the policy with respect to any
- 56 particular service.
- 57

58 4.2.3 The Contractor must assure that Iowa Plan services are sufficient in amount, duration,  
59 and scope to reasonably be expected to achieve the purpose for which the services are  
60 furnished when it is determined that there is a psychosocial necessity for mental health  
61 services or a service necessity for substance abuse services.

62

63 4.2.4 The Contractor may not impose limitations on the amount, duration, or scope of services  
64 provided to Enrollees which are not allowable under the Medicaid state plan. The  
65 Contractor may, however, require use of network providers, require prior authorization  
66 for services other than emergency services, and direct Enrollees to the appropriate level  
67 of care for receipt of those services which are the responsibility of the Contractor.

68

69 4.2.5 The Contractor may not arbitrarily deny or reduce the amount, duration, or scope of  
70 services solely because of the diagnosis, type of illness, or condition. Covered diagnoses  
71 are listed in the **Attachment to Section 4**.

72

73 4.2.6 The Contractor may place appropriate limits on a service on the basis of criteria approved  
74 by the Departments, provided the amount of services furnished can reasonably be  
75 expected to achieve their purpose.

76

77 4.2.7 The Contractor shall continue the telehealth mode of providing services put in place by  
78 the current contractor.

1  
2  
3  
4  
5  
6  
7  
8  
9

**SECTION 4A**

**SERVICE REQUIREMENTS RELATED TO THE  
MENTAL HEALTH NEEDS  
OF IOWA PLAN ENROLLEES**

10 **4A.1 PHILOSOPHY IN THE DESIGN AND DELIVERY OF MENTAL HEALTH**  
11 **SERVICES AND SUPPORTS**

12 The Departments believe that the most effective and appropriate mental health services are best  
13 delivered as part of a recovery-oriented care system that welcomes and engages Enrollees at any  
14 point and at all points in their personal recovery efforts. A major benefit of the Iowa Plan is the  
15 ability to provide flexibility in the design and funding of mental health services to Enrollees. As  
16 the Iowa Plan evolves, the focus of mental health services delivery will continue to grow beyond  
17 expanding the array of services and supports and coordinating service and support delivery,  
18 including for Enrollees involved in other service delivery systems or with other funders. This  
19 means the Contractor will be expected to embrace and incorporate into its policies and practices  
20 the following values:

- 21 • hope based in the knowledge that personally-valued recovery is possible;
- 22 • self-determination;
- 23 • empowering relationships;
- 24 • meaningful roles in society, and
- 25 • eliminating stigma and discrimination.

26  
27 The Iowa Plan philosophy contains the following principles related to the delivery of mental  
28 health services and supports, and to which the Contractor is expected to adhere:

- 29 • The Contractor must allow each Enrollee to choose his or her health professional to the  
30 fullest extent possible and appropriate.
- 31 • The Contractor will establish policies that support the involvement of the Enrollee, and  
32 those significant in the Enrollee's life as appropriate, in decisions about services provided  
33 to meet the Enrollee's mental health needs. Policies will relate to the Enrollee's  
34 interaction with the Contractor as well as the Enrollee's interaction with providers of  
35 direct service and those, such as targeted case managers, DHS/JCS workers, and others  
36 participating in an Enrollee's services and service planning.

- 37 • To the fullest extent possible, the Contractor will work with all providers and other  
38 entities serving an Enrollee to coordinate services for the purpose of eliminating both  
39 gaps in service and duplication of services.
- 40 • The Contractor will establish and promote strategies to engage Enrollees who may have  
41 histories of inconsistent involvement in treatment.
- 42 • To the fullest extent possible, adults with serious mental illness should live and work in  
43 normal community environments and be able to fully participate in the life of the  
44 community. Therefore services for Enrollees who have a serious and persistent mental  
45 illness should focus on helping the Enrollee to maintain their home environment and on  
46 promoting their recovery.
- 47 • Mental health services for children are most appropriately directed toward helping a child  
48 and the child's family to develop and maintain a stable and safe family environment for  
49 the child.
- 50 • In the delivery of services and supports offered under the Iowa Plan, the Contractor is  
51 encouraged to explore the use of emerging technology (e.g., telehealth) as a way to  
52 expand access to services and extend the reach of mental health and substance abuse  
53 service professionals, particularly into rural areas of the state.

54 **4A.2 REHABILITATION, RECOVERY AND STRENGTH-BASED APPROACH TO**  
55 **SERVICES**

56 The Contractor must provide the following core activities as part of its effort to provide recovery-  
57 based services to Enrollees:

- 58 • identification and implementation of the preferences of individuals and families in the  
59 design of services and supports;
- 60 • facilitation of the development of consumer-operated programs and use of peer support,  
61 including consumer/family teams for persons of all ages and behavioral health  
62 conditions;
- 63 • facilitation of the utilization of natural supports;
- 64 • facilitation of the development of resources to support self-management and relapse  
65 prevention skills, and
- 66 • activities to support the development and maintenance of healthy social networks and  
67 skills, employment, school performance or retirement activities.

68  
69 **4A.2.1 Peer Counseling**

70 The Contractor shall implement a certified peer counseling program to empower Enrollees to take  
71 an active role in their recovery from mental illness and return to active roles in their community,  
72 where possible. Certified peer specialists will work to establish recovery self-help groups, peer  
73 counseling, Recovery Centers where Enrollees can learn coping skills for all aspects of life,  
74 including employment skills, and warm line counseling to assist Enrollees in distress.

75 **4A.2.2 Active Engagement Strategy for Families**

76 The Contractor will engage families to actively participate in treatment planning and development  
77 of successful interventions. The Contractor shall develop protocols for team meetings in which  
78 families' opinions are respected, their strengths are explored and validated, and families are given  
79 opportunities to choose the course of care for their loved one.

80 **4A.2.3 Individual Service Coordination and Treatment Planning Requirements**

81 The Contractor must work with providers to emphasize the importance of exploring Enrollee  
82 strengths in the process of service planning and including the Enrollee in the design of a crisis  
83 plan that addresses the Enrollee's self-identified triggers.

84 **4A.2.4 Study Use of Flexible Funds**

85  
86 The Contractor shall study the possibility of, and present to the Departments for approval a  
87 proposal for, funding required services through flexible funds. The flexible funds proposal  
88 should include the empowerment of Enrollees to direct their own care by allowing Enrollees and  
89 their families to design their own menu of appropriate services and supports. The Departments  
90 believe that flexible funds may be most advantageous in cases where children and families are  
91 engaged in multiple systems including child welfare, schools, and public housing.

92  
93 **4A.3 COVERED SERVICES FOR MENTAL HEALTH CONDITIONS**

94  
95 **4A.3.1 Covered services are those which are included in Iowa's Medicaid State Plan**

96 The Contractor must provide at least as much access to medically necessary mental health care as  
97 was provided in the Medicaid fee-for-service delivery system prior to the implementation of  
98 managed care. The Contractor shall use the criteria for psychosocial necessity for determining the  
99 medical necessity of a mental health services.

100  
101 The Contractor may not propose a continuum of care which sets limits on the amount, scope or  
102 duration of these services which are not imposed in the fee-for-service program as reflected in the  
103 Iowa Administrative Code 441 Chapter 78 and the Iowa Medicaid State Plan.

104  
105 The Contractor must develop a network of appropriately credentialed mental health service  
106 providers, that is supported by written agreements, to assure availability of the following services  
107 to address the mental health needs of both adults and children:

- 108 • ambulance services for psychiatric conditions;
- 109 • emergency services for psychiatric conditions, available 24 hours per day, 365 days per  
110 year;
- 111 • inpatient hospital care for psychiatric conditions;
- 112 • dual diagnosis mental health and substance abuse treatment provided at the state mental  
113 health institute at Mount Pleasant;
- 114 • outpatient hospital care for psychiatric conditions, including:
  - 115 • intensive outpatient services;
  - 116 • individual and group therapy;
  - 117 • medication administration;
  - 118 • activity therapies (within the milieu of placement, not as a stand-alone service);
  - 119 • family counseling;
  - 120 • partial hospitalization;
  - 121 • day treatment;

- 122 • psychiatric physician, advanced registered nurse practitioner services, and physician  
123 assistant services including consultations requested for Enrollees receiving treatment for  
124 other medical conditions;
- 125 • specified mental health services provided by non-psychiatric physicians, advanced  
126 registered nurse practitioners, and physician assistants (see Section 4A.4.4);
- 127 • services of a licensed psychologist for testing/evaluation and treatment of mental illness;
- 128 • services in state mental health institutes for Enrollees under the age of 21 or through the  
129 age of 22 if the Enrollee is hospitalized prior to the Enrollee's 21<sup>st</sup> birthday;
- 130 • services in state mental health institutes for Enrollees 65 and over;
- 131 • services provided through a community mental health center, including:
  - 132 • services of a psychiatrist;
  - 133 • services of a clinical psychologist;
  - 134 • services of a licensed social worker;
  - 135 • services of a psychiatric nurse;
  - 136 • day treatment;
- 137 • home health services;
- 138 • Targeted Case Management services to Enrollees with chronic mental illness;
- 139 • medication management and counseling by appropriately credentialed professionals such  
140 as pharmacists, or physician assistants;
- 141 • medication compliance management;
- 142 • psychiatric nursing services by a home health agency;
- 143 • psychiatric or psychological screenings required subsequent to evaluations for persons  
144 applying for admission to nursing homes;
- 145 • services of a licensed social worker for treatment of mental illness and serious emotional  
146 disturbance;
- 147 • mobile crisis services;
- 148 • mobile counseling services;
- 149 • programs of Assertive Community Treatment;
- 150 • mental health services determined necessary subsequent to an Early and Periodic  
151 Screening, Diagnosis and Treatment (EPSDT) program screening, and
- 152 • second opinion as medically necessary and appropriate for the Enrollee's condition and  
153 identified needs from a qualified health care professional within the network or arranged  
154 for outside the network at no cost to the Enrollee.

156 With the exception of those services provided in an inpatient setting, the cost of prescription  
157 drugs and laboratory testing for Iowa Plan Enrollees receiving mental health services are not  
158 included in the Iowa Plan. Cost of prescription drugs and laboratory testing outside an inpatient  
159 care setting will be paid for all Enrollees through the Medicaid fee-for-service program.  
160

161 **4A.4 REQUIRED SERVICES FOR MENTAL HEALTH CONDITIONS**  
162

163 The Contractor also must make required services available to Enrollees. These services are not  
164 covered in the Iowa Medicaid fee-for-service program, but are appropriate and desirable services  
165 for adequately addressing the needs of individuals with mental health diagnoses. When these  
166 services do not exist in a defined geographic area, the Contractor is obligated to develop the  
167 capacity for the services within the first 18 months of the Contract, and expand their availability  
168 to Enrollees. Such services include, but are not limited to:

- 169
- 170 • services for those diagnosed with both chronic substance abuse and chronic mental illness  
171 (services for the dually diagnosed) (see Section 4A.4.3);
- 172 • Level I Sub-acute Facilities delivering 24-hour stabilization services;
- 173 • 23-hour observation in a 24-hour treatment facility;
- 174 • case consultation by a psychiatric physician to a non-psychiatric physician;
- 175 • integrated mental health services and supports (see Section 4A.4.1);
- 176 • intensive psychiatric rehabilitation services;
- 177 • focused case management;
- 178 • peer support services for persons with chronic mental illness;
- 179 • community support services; Community support services include:
  - 180 • monitoring of mental health symptoms and functioning/reality orientation
  - 181 • transportation
  - 182 • supportive relationship
  - 183 • communication with other providers
  - 184 • ensuring Enrollee attends appointments and obtains medications
  - 185 • crisis intervention and developing of a crisis plan
  - 186 • coordination and development of natural support systems for mental health support;
- 187 • stabilization services;
- 188 • in-home behavioral management services;
- 189 • behavioral interventions with child and with family;
- 190 • respite services
- 191 • family therapy to family members of a child in order to address the mental health needs  
192 of that child;
- 193 • reimbursement to appropriately credentialed/trained clinicians for administration of an  
194 appropriate level of functioning assessment to each Iowa Plan Enrollee who meets the  
195 criteria of either a child with a serious emotional disability or a person with serious and  
196 persistent mental illness; the scale shall be repeated at intervals recommended by the  
197 selected scale; the final determination of the scales shall be made by DHS following  
198 negotiation with the selected Contractor and the Iowa Plan Clinical Advisory Committee;

- 199 • specified services to adults admitted to a state mental health institute (see Section  
200 4A.4.6);
- 201 • court-ordered mental health services (see Section 4A.4.5), and
- 202 • services to address the mental health needs of children in the adoption subsidy program  
203 (see Section 1.9.2.2).

#### 204 205 **4A.4.1 Integrated Mental Health Services and Supports**

206 “Integrated mental health services and supports” are comprised of informal support services  
207 provided by family members and friends and community-based support services that are not part  
208 of the Contractor’s standing provider network.

209 The Contractor must integrate these services into the Enrollees treatment plan, especially for  
210 those with serious and persistent mental illness or serious emotional disabilities who can benefit  
211 from services and supports designed to assist Enrollees to remain in or return to their home and  
212 limit the need for more intensive out-of-home mental health treatment. Integrated services and  
213 supports are specifically tailored to an individual Enrollee’s needs at a particular point in time,  
214 and are not a set menu of services offered by the Contractor. The Contractor shall integrate these  
215 services into the Enrollee’s treatment plan and may provide compensation for such services if the  
216 Contractor deems it necessary.

217 In the design and authorization of integrated mental health services and supports, the Contractor  
218 must plan jointly with Enrollees, family members, decategorization projects, and representatives  
219 of other service delivery systems. The concept of integrating services and supports does not  
220 require the Contractor to assume clinical oversight or financial responsibility for services  
221 regularly funded through other funding streams. Rather, it allows the Contractor flexibility to  
222 provide Enrollees unique services to address the Enrollees’ mental health needs to augment and  
223 complement those provided through other funders and systems. Integrated mental health services  
224 and supports are closely tied to the concept of psychosocial necessity which is set forth in Section  
225 5A.3.1.

226 As one component of integrated mental health services and supports, the Contractor shall  
227 encourage the involvement of natural support systems, including providing compensation, if  
228 appropriate, to support their involvement. The Contractor shall also draw upon self-help systems  
229 when appropriate. The Contractor also is required to work with consumer and family advocacy  
230 organizations, providers, other funders, and appropriate groups and individuals to help promote  
231 the understanding and acceptance of integrated mental health services and supports. The  
232 Contractor shall provide a proven method of integrating service based on documented success in  
233 other states or counties. The Contractor will show how this method will be implemented with the  
234 contracted provider network.

#### 235 **4A.4.2 Prevention and Early Intervention in Mental Health**

236  
237 In implementing the Iowa Plan, the Contractor is required to provide services for prevention and  
238 early intervention. Primary prevention of mental health problems is accomplished by providing  
239 social and emotional support and education, promoting sensitive child-rearing for the pediatric  
240 population, or screening for risk factors and focusing efforts on specific groups. Secondary  
241 prevention is based on case finding strategies, screening populations to identify early signs of  
242 mental health problems, and then providing targeted interventions for those who have been

243 identified. The intention of this approach is to prevent further deterioration of function and to  
244 avoid the need for more intensive services in the future.

245

#### 246 **4A.4.3 Services for Co-Occurring Conditions**

247

248 As directed by the Departments, the Contractor is required to work with the Departments and  
249 other agencies in the development of appropriate programs and protocols for those with co-  
250 occurring conditions, such as mental health and substance abuse, medical conditions, mental  
251 illness, mental retardation and developmental disability.

252

#### 253 **4A.4.4 Mental Health Services Provided through Physicians Other than Psychiatric** 254 **Physicians**

255

256 General practitioners and other non-psychiatric physicians often provide mental health services to  
257 Iowa Plan Enrollees. The Contractor will be responsible for reimbursement for office visits to  
258 non-psychiatric physicians in the following circumstances:

259

260 • physical examinations performed for a patient being admitted for mental health services  
261 to an inpatient setting, providing such inpatient admission was authorized according to  
262 policies established by the Contractor, and

263 • to assure Enrollees access to mental health services, the Medicaid FFS program provides  
264 reimbursement to non-psychiatric physicians for 12 office visits for mental health  
265 services per Enrollee per state fiscal year. The Contractor will be responsible for  
266 reimbursement for office visits to physicians for mental health services that are in excess  
267 of the 12 non-psychiatric office visits available through FFS per calendar year. The  
268 Contractor may require prior authorizations for such office visits.

269

270 The Contractor may implement policies and procedures which limit both the credentialing  
271 required for non-psychiatric physicians and the scope of services for which they may be  
272 reimbursed. Further, the Contractor may implement a pilot program, through use of  
273 administrative funds, to provide consultation to primary care physicians by psychiatrists or other  
274 mental health professionals on mental health issues and medications to determine its effectiveness  
275 in easing access issues across Iowa.

276

#### 277 **4A.4.5 Court-Ordered Mental Health Services**

278 The Contractor is responsible for the provision of all covered and required mental health services  
279 ordered for Enrollees through a court action which fall within the Contractor's Utilization  
280 Management Guidelines and are to be provided by a provider which is part of the Contractor's  
281 provider network. Special requirements apply when those services are ordered for Enrollees over  
282 the age of 21 and under the age of 65 at a state mental health institute (see Section 4A.4.6).

283 The Contractor shall implement policies to assure reimbursement for up to five days, regardless  
284 of whether the Contractor's Utilization Management Guidelines are met, when an Iowa Plan  
285 Enrollee is court-ordered for an inpatient mental health evaluation at a community hospital which  
286 is in the Contractor's provider network and has appropriately credentialed staff available to  
287 conduct the evaluation.

288 If the Enrollee's clinical condition falls within the Contractor's Utilization Management  
289 Guidelines for inpatient evaluation or treatment, inpatient services shall be authorized so long as  
290 Guidelines are met.

291 The Contractor may establish policies to limit reimbursement to no more than one evaluation per  
292 inpatient episode. The Contractor has the right to establish policies which require providers of  
293 court-ordered mental health services to provide notification and documentation of court-ordered  
294 treatment.

#### 295 **4A.4.6 Services at a State Mental Health Institute**

296 State mental health institutes shall be part of the Contractor's provider network.

##### 297 For Enrollees under the age of 21 and age 65 and older

298 The Contractor shall authorize all inpatient treatment for persons under the age of 21 and age 65  
299 and older at state mental health institutes which falls within the Contractor's Utilization  
300 Management Guidelines.

301 The Contractor also shall implement policies to assure reimbursement for up to five days,  
302 regardless of whether the Contractor's Utilization Management Guidelines are met, when an Iowa  
303 Plan Enrollee under the age of 21 or age 65 and older is court-ordered for an inpatient mental  
304 health evaluation at a state mental health institute. If an Enrollee's clinical condition falls within  
305 the Contractor's Utilization Management Guidelines for inpatient care, inpatient services shall be  
306 authorized so long as Guidelines are met. The Contractor may establish policies to limit  
307 reimbursement to no more than one evaluation per inpatient episode.

##### 308 For Enrollees over the age of 21 and under the age of 65

309 The Contractor must authorize inpatient care at state mental health institutes for persons who are  
310 admitted on a voluntary basis and meet the Contractor's Utilization Management Guidelines for  
311 inpatient services. These are considered required services under the Iowa Plan.

312  
313 Services to Enrollees who are involuntarily admitted for evaluation or treatment at a state mental  
314 health institute are not reimbursed by Medicaid, and are not the responsibility of the Iowa Plan  
315 Contractor except as covered by Section 4A.4.5.

316  
317 At the request of an Enrollee, the state mental health institute and/or a representative of the  
318 Enrollee's county of legal settlement (and with appropriate releases), the Contractor is  
319 responsible for providing appropriate mental health services to support an Enrollee upon the  
320 Enrollee's discharge from the state mental health institute.

#### 321 **4A.4.7 Coverage and Payment for Emergency Services**

322

323 The Contractor is responsible for coverage and payment of emergency services and post -  
324 stabilization services where required in 42 CFR 438.114.

325

326 1) An Enrollee who has an emergency medical condition may not be held liable for payment of  
327 subsequent screening and treatment needed to diagnose the specific condition or stabilize the  
328 Enrollee.

- 329 2) The attending emergency physician, or the provider actually treating the Enrollee, is  
330 responsible for determining when the Enrollee is sufficiently stabilized from an emergency  
331 medical condition for transfer or discharge from an emergency room, and that determination  
332 is binding on the Contractor.
- 333 3) The Contractor may not deny payment for treatment obtained when an Enrollee had an  
334 emergency medical condition, including cases in which the absence of immediate medical  
335 attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition  
336 of emergency medical condition.
- 337 4) The Contractor may not deny payment for treatment obtained when a Contractor  
338 representative instructs the Enrollee to seek emergency services.
- 339 5) The Contractor may not limit what constitutes an emergency medical condition on the basis  
340 of lists of diagnoses or symptoms. However, the diagnoses and/or the symptoms relating to  
341 the reason the individual seeks emergency services must be related to a mental health or  
342 substance abuse condition.
- 343 6) The Contractor will cover emergency services when the provider notifies the Contractor  
344 within 10 calendar days of presentation for emergency services.
- 345 7) Emergency services for covered conditions must be reimbursed for Enrollees regardless of  
346 whether authorized in advance or whether the provider of the service is a part of the service  
347 network.
- 348 8) For emergency services provided to an Iowa Plan Enrollee by a network or non-network  
349 provider when psychiatric or substance abuse diagnoses are the primary condition, the  
350 Contractor may:
- 351 • provide a minimum triage fee to the hospital regardless of whether the facility  
352 notifies the Contractor; the triage fee shall be no less than is paid through the FFS  
353 Medicaid program;
  - 354 • reimburse the facility for emergency services provided, contingent upon the facility's  
355 compliance with notification policies;
  - 356 • reimburse non-network providers an emergency room fee which is no less than the  
357 minimum payment which would be made to a network provider, and
  - 358 • ensure follow-up contact within 72 hours of the provider's notification with at least  
359 85% of Enrollees served in an emergency room for whom inpatient treatment was  
360 requested, and no 24-hour level of care was authorized.
- 361 9) Any provider of emergency services that does not have in effect a contract with a Medicaid  
362 managed care entity that establishes payment amounts for services furnished to a member  
363 enrolled in the entity's Medicaid managed care plan, must accept as payment in full no more  
364 than the amounts (less any payments for indirect costs of medical education and direct costs  
365 of graduate medical education) that it could collect if the member received medical assistance  
366 under Title XIX other than through enrollment in such an entity.

367  
368 **4A.5 OPTIONAL SERVICES AND SUPPORTS**  
369

370 The Contractor may develop alternative ways to address the mental health needs of Enrollees.  
371 Such optional services and supports may be implemented only after approval by DHS. Optional  
372 services and supports, like all mental health services offered through the Iowa Plan, should be

373 provided by or under the supervision of qualified mental health professionals or appropriately  
374 accredited agencies. Examples of optional services include, but are not limited to:

- 375
- 376 • respite services and support;
  - 377 • clubhouse;
  - 378 • consumer-operated telephone “warm line”, and
  - 379 • creation of local systems of care for integrated screening, assessment, and care planning.
- 380

#### 381 **4A.6 COVERED MENTAL HEALTH DIAGNOSES**

382

383 The Contractor will be required to apply Utilization Management Guidelines described in Section  
384 5A and is responsible for authorizing appropriate short- and long-term services for the mental  
385 health needs of persons who have the following diagnoses as defined in the ICD-9-CM:

386

387	290-290.9	Senile and presenile organic psychotic conditions
388	293-293.9	Transient organic psychotic conditions
389	294-294.9	Other organic psychotic conditions (chronic)
390	295-295.9	Schizophrenic disorders
391	296-296.9	Affective psychoses
392	297-297.9	Paranoid states
393	298-298.9	Other non-organic psychoses
394	299-299.9	Psychoses with origin specific to childhood
395	300-300.9	Anxiety states
396	301-301.9	Personality disorders
397	302-302.9	Sexual deviations and disorders
398	306-306.9	Physiological malfunction arising from mental factors
399	307-307.9	Special symptoms or syndromes, not elsewhere classified
400	308-308.9	Acute reaction to stress
401	309-309.9	Adjustment reaction
402	311	Depressive disorder not elsewhere classified
403	312-312.9	Disturbance of conduct, not elsewhere classified
404	313-313.9	Disturbance of emotions specific to childhood and adolescence
405	314-314.9	Attention deficit disorder

406

407 The Contractor will be responsible for any new diagnoses added to ICD-9-CM. Services for a  
408 covered diagnosis cannot be denied solely on the basis of an individual also having a non-covered  
409 diagnosis. Mental health services, including inpatient care, cannot be denied solely on the basis  
410 of an individual having no Axis I diagnosis. The Contractor will be responsible for providing  
411 services necessary in the behavioral care and treatment of the covered diagnoses for Iowa Plan  
412 Enrollees who are dually diagnosed with a covered diagnosis and a non-covered diagnosis.

413

414 The following ICD-9 diagnosis codes are excluded because they represent a mental condition not  
415 attributed to a psychiatric illness. However, Enrollees with these diagnoses may also experience a  
416 need for mental health services and the presence of these diagnoses does not preclude the  
417 Contractor’s responsibility to provide appropriate mental health services and supports:

418

419	315	Specific delays in development
420	316	Psychic factors associated with diseases classified elsewhere
421	317	Mild mental retardation

422           318           Other specific mental retardation  
423           319           Unspecific mental retardation

424

425   **4A.6.1 ICD-10 Codes**

426

427   Upon their proposed adoption by CMS in October 2011, or upon whatever alternative date is  
428   ultimately selected by CMS, the Departments intend to adopt the ICD-10 coding system for  
429   mental health services. This will require the recoding of all covered diagnoses at that time.

430

431   **4A.7 EVIDENCE-BASED COVERAGE**

432

433   The Contractor shall develop, maintain and at least annually review and update a compendium of  
434   evidence-based mental health practices, and shall periodically advise the Departments regarding  
435   how to modify Covered, Required and Optional Services to be consistent with established  
436   evidence-based practices.

437

438   **4A.8 ACCESSIBILITY REQUIREMENTS IN THE PROVISION OF MENTAL**  
439   **HEALTH SERVICES**

440   4A.8.1 The Contractor must provide at least as much access to covered mental health services as  
441   exists within Medicaid's fee-for-service delivery system.

442   4A.8.2 The Contractor must require that providers meet access standards established in 441 IAC  
443   88.67(4) for timely access to care and services, taking into account the urgency of need  
444   for services.

445   4A.8.3 The Contractor must require that network providers offer hours of operation that are no  
446   less than the hours of operation offered to commercial Enrollees or comparable to  
447   Medicaid fee-for-service, if the provider serves only Enrollees.

448   4A.8.4 The Contractor must assure that services are available 24 hours a day, 7 days a week,  
449   when medically necessary.

450

451   4A.8.5 The Contractor must: a) establish mechanisms to ensure that network providers comply  
452   with the access requirements (below and pursuant to those established in 441 IAC  
453   88.67(4)), and b) monitor regularly to determine compliance, integrating monitoring  
454   activity into the network management function (see Section 5C.5), and taking corrective  
455   action if there is a failure to comply.

456

457

- Timeliness Standards:

458

- 100% of Enrollees with emergency needs are seen by an appropriate provider within 15 minutes of presentation at a service delivery site, whether a network provider or a non-network provider;

459

460

- As of July 1, 2010, 100% of Enrollees in need of mobile crisis services receive services within one hour of presentation or request;

461

462

- 100% of Enrollees with urgent non-emergency needs are seen by an appropriate provider within one hour of presentation at a service delivery site or within 24 hours of telephone contact with provider or Contractor;

463

464

465

- 100% of Enrollees with persistent symptoms are seen by an appropriate provider within 48 hours of reporting symptoms, and

466

467

- 468 • 100% of Enrollees with need for routine services are seen by an  
469 appropriate provider within four weeks of the request for an  
470 appointment.
- 471 • Geographic Standards:
- 472 • 100% of Enrollees residing within an urban (see Section 10 for definition  
473 of urban) setting have access to inpatient mental health within 30  
474 minutes from their primary residence using GeoAccess standards for  
475 urban travel time;
- 476 • 100% of Enrollees residing within an urban setting have access to  
477 outpatient mental health and substance abuse services, including  
478 community-based services, within 45 minutes from their primary  
479 residence using GeoAccess standards for urban travel time;
- 480 • 100% of Enrollees residing within a rural setting (see Section 10 for  
481 definition of rural) have access to inpatient mental health and to inpatient  
482 substance abuse services within 45 minutes from their primary residence,  
483 and
- 484 • 100% of Enrollees residing within a rural setting have access to  
485 outpatient mental health and to outpatient substance abuse services,  
486 including community-based services, within 45 minutes from their  
487 primary residence, unless the Contractor has been unable to develop  
488 additional capacity for the services despite documented best efforts  
489 accepted by the Departments.

490  
491 4A.8.6. The availability of professionals will vary from area to area, but access problems may be  
492 especially acute in rural areas. The Contractor must establish a program of assertive  
493 provider outreach to rural areas where mental health services may be less available than  
494 in more urban areas. The Contractor also must monitor utilization in regions across the  
495 state and in rural and urban areas to assure equality of service access and availability.  
496 Where the Contractor's monitoring shows the need for increased access to services, the  
497 Contractor shall submit an action plan to the Departments for their approval.

498 4A.8.7 The Contractor must permit Enrollees to self-refer to any network provider of their  
499 choice for medically necessary services.

500

500

1

2

3

4

5

6

7

8

**SECTION 4B**

**SERVICE REQUIREMENTS RELATED TO THE  
SUBSTANCE ABUSE TREATMENT  
NEEDS OF ELIGIBLE PERSONS**

9

**4B.1 PHILOSOPHY IN THE DESIGN AND DELIVERY OF SUBSTANCE ABUSE  
TREATMENT SERVICES AND SUPPORTS**

10

11

The Departments believe that the most effective and appropriate substance abuse services are best delivered as part of a recovery-oriented care system that welcomes and engages Eligible Persons at any point and at all points in their personal recovery efforts. A major benefit of the Iowa Plan is the ability to provide flexibility in the design and funding of substance abuse services to Eligible Persons. As the Iowa Plan evolves, the focus of substance abuse services delivery will continue to grow beyond expanding the array of services and supports and coordinating service and support delivery, including for Eligible Persons involved in other service delivery systems or with other funders. This means the Contractor will be expected to embrace and incorporate into its policies and practices the following values:

12

13

14

15

16

17

18

19

20

- hope based in the knowledge that personally-valued recovery is possible;

21

- self-determination;

22

- empowering relationships;

23

- meaningful roles in society, and

24

- eliminating stigma and discrimination.

25

26

The Iowa Plan philosophy contains the following principles related to the delivery of substance abuse services and supports, and to which the Contractor is expected to adhere:

27

28

- The Contractor must allow each Eligible Person to choose his or her provider to the extent possible and appropriate, within the context of Iowa Plan funding and provider networks.

29

30

31

- The Contractor will establish policies that support the involvement of those significant in the Eligible Person's life, as appropriate.

32

33

- The Contractor will establish policies that support the leadership of the Eligible Person in decisions about services and supports provided to meet the Eligible Person's substance abuse needs. Policies will relate to the Eligible Person's interaction with the

34

35

36 Contractor as well as the Eligible Person's interaction with providers of direct service  
37 and those such as DHS/JCS workers, the Department of Corrections, Drug Court and  
38 Family Drug Court and others participating in an Eligible Person's services and service  
39 planning.

- 40 • To the extent possible, the Contractor will work with all providers and other entities  
41 serving an Eligible Person to coordinate services for the purpose of eliminating both  
42 gaps in service and duplication of services.
- 43 • The Contractor will establish and promote strategies to engage Eligible Persons who  
44 may have histories of inconsistent involvement in treatment.
- 45 • In the delivery of all substance abuse services and supports offered under the Iowa Plan,  
46 the Contractor is encouraged to explore the use of emerging technology (e.g., telehealth)  
47 as a way to expand access to services and extend the reach of substance abuse  
48 professionals, particularly into rural areas of the state.
- 49 • Women with dependent children and pregnant women have recognized needs for services  
50 that expand beyond the typical substance abuse treatments. The Contractor must take  
51 into account other supportive assistance that serves both the primary recipient of services  
52 and her children to enhance recovery opportunities in accordance with substance abuse  
53 block grant requirements.

54 **4B.2 REHABILITATION, RECOVERY AND STRENGTH-BASED APPROACH TO**  
55 **SERVICES**

56 The Contractor must provide the following core activities as part of its effort to provide recovery-  
57 based services to Eligible Persons:

- 58 • identification and implementation of the preferences of Eligible Persons and families in  
59 the design of services and supports;
- 60 • facilitation of the development of recovery persons-operated programs and use of peer  
61 support, including recovering persons/family teams for Eligible Persons of all ages and  
62 behavioral health conditions;
- 63 • facilitation of the utilization of non-treatment services and supports, including  
64 coordination with IDPH's Access To Recovery program;
- 65 • facilitation of development of resources to support self-management and relapse  
66 prevention skills, and
- 67 • activities to support the development and maintenance of healthy social networks and  
68 skills, employment, school performance or retirement activities.

69 **4B.2.1 Peer Support/Peer Recovery Coaching**

70 The Contractor shall develop substance abuse peer support or peer recovery coaching services.  
71 Such services may give recovering persons, including Eligible Persons as appropriate, volunteer  
72 or employment opportunities through which they support their own recovery by supporting others  
73 in their recovery efforts. The Contractor will develop a service description for substance abuse  
74 peer support/recovery coaching that includes practitioner qualifications.

75 **4B.2.2 Individual Service Coordination and Treatment Planning Requirements**

76 The Contractor must work with providers to emphasize the importance of exploring Eligible  
77 Person strengths in the process of service planning and including the Eligible Person in the design

78 of a crisis plan or relapse management plan that addresses the Eligible Person’s self-identified  
79 triggers.

80 **4B.2.3 Study Use of Flexible Funds**

81  
82 The Contractor shall study the possibility of, and present to the Departments for approval a  
83 proposal for, funding required services through flexible funds. The flexible funds proposal  
84 should include the empowerment of Enrollees to direct their own care by allowing Enrollees and  
85 their families to design their own menu of appropriate services and supports. The Departments  
86 believe that flexible funds may be most advantageous in cases where children and families are  
87 engaged in multiple systems including child welfare, schools, and public housing.  
88

89 **4B. 3 COVERED SERVICES FOR SUBSTANCE ABUSE CONDITIONS**

90 This section lists those substance abuse services which are required by the Medicaid state plan,  
91 those which are required by IDPH, and those offered as required or optional services through the  
92 Iowa Plan. The Iowa Plan may link to but does not fund substance abuse prevention services.

93 **4B.3.1 Covered and Required Services**

94 The Contractor must provide and ensure access to a full range of substance abuse treatment and  
95 related services. This includes, at a minimum, necessary substance abuse care for the IPDH  
96 population, at least those services which are included in the Medicaid state plan and are provided  
97 in the Medicaid fee-for-service system; and, services and supports at least equal to that which has  
98 been available for the Eligible Persons under the Iowa Plan to date.

99 The Contractor shall use the criteria for service necessity for substance abuse services. The  
100 Contractor may not sets limits on the amount, scope or duration of these services for Enrollees  
101 which are not imposed in the fee-for-service program as reflected in the Iowa Administrative  
102 Code 441 Chapter 78 and the Iowa Medicaid State Plan.

103 The Contractor must develop two networks of providers, who have entered into written contracts  
104 with the Contractor, to ensure availability of the services listed below for both adults and  
105 children. A full continuum of substance abuse treatment services and supports must be available  
106 within each region (see **Attachments to Section 1** for a list and map of the IDPH regions and  
107 service areas) in accordance with the accessibility standards in Section 4B.6. The following are  
108 the covered and required Iowa Plan substance abuse services.

- 109 • Outpatient Treatment (ASAM PPC-2R Level I.);
- 110 • Ambulatory Detoxification (ASAM PPC-2R Level I.D.) (Enrollees only);
- 111 • Intensive Outpatient (ASAM PPC-2R Level II.1.);
- 112 • Partial Hospitalization (day treatment) (ASAM PPC-2R Level II.5.);
- 113 • Ambulatory Detoxification (ASAM PPC-2R Level II.D.) (Enrollees only);
- 114 • Clinically Managed Low Intensity Residential Treatment (ASAM PPC-2R Level III.1.);
- 115 • Clinically Managed Residential Detoxification (ASAM PPC-2R Level III.2-D.)  
116 (Enrollees only);
- 117 • Clinically Managed Medium Intensity Residential Treatment (ASAM PPC-2R Level  
118 III.3.);
- 119 • Clinically Managed High Intensity Residential Treatment (ASAM PPC-2R Level III.5.);

- 120 • Medically Monitored Intensive Inpatient Treatment (ASAM PPC-2R Level III.7.);
- 121 • Medically Monitored Inpatient Detoxification as per ASAM PPC-2R Level III.7-D.)
- 122 (Enrollees only);
- 123 • Medically Managed Intensive Inpatient Services (ASAM PPC-2R Level IV.)
- 124 (Enrollees only);
- 125 • Medically Managed Inpatient Detoxification (ASAM PPC-2R Level IV-D.)
- 126 (Enrollees only);
- 127 • detoxification services including such services by a provider licensed under chapter 135B
- 128 (Enrollees only);
- 129 • PMIC substance abuse services consisting of treatment provided by a substance abuse
- 130 licensed PMIC and consistent with the nature of care provided by a PMIC as described in
- 131 Iowa Code chapter 135H (Enrollees only);
- 132 • emergency services for substance abuse conditions available 24 hours a day, seven days a
- 133 week (Enrollees only);
- 134 • ambulance services for substance abuse conditions (Enrollees only);
- 135 • intake, assessment and diagnosis services, including appropriate physical examinations,
- 136 urine screening, and all necessary medical testing to determine a substance abuse
- 137 diagnosis, identification of medical or health problems, and screening for contagious
- 138 diseases;
- 139 • evaluation, treatment planning, and service coordination;
- 140 • all services appropriately provided as part of substance abuse treatment. Such services
- 141 would vary according to the level of service, and may include, but not necessarily be
- 142 limited to, the following:
- 143 • lodging and dietary services;
- 144 • physician, physician assistant, psychologist, nurse, certified addictions counselor,
- 145 social worker, and trained staff services;
- 146 • rehabilitation therapy and counseling;
- 147 • family counseling and intervention for the primary recipient of services, including
- 148 co-dependent/collateral counseling with primary recipient of services;
- 149 • diagnostic X-ray, specific to substance abuse treatment;
- 150 • diagnostic urine testing, specific to substance abuse treatment;
- 151 • psychiatric, psychological and medical laboratory testing, specific to substance abuse
- 152 treatment;
- 153 • equipment and supplies;
- 154 • cost of prescription drugs for Enrollees at Level IV-D and Level IV where
- 155 prescription drugs of any kind are included;
- 156 • substance abuse counseling services when provided by approved opioid treatment
- 157 programs that are licensed under Iowa Code Chapter 125 (The costs of Bupenorphine and
- 158 Methadone dispensing will not be covered under the contract.);

- 159 • substance abuse treatment services determined necessary subsequent to an EPSDT  
160 screening meeting OBRA 89 requirements (Enrollees only);
- 161 • substance abuse screening, evaluation and treatment for Enrollees convicted of Operating  
162 a Motor Vehicle While Intoxicated (OWI), Iowa Code Section 321J.2 and Enrollees  
163 whose driving licenses or non-resident operating privileges are revoked under Chapter  
164 321J, provided that such treatment service meets the criteria for service necessity;
- 165 • substance abuse treatment for IDPH Participants convicted of Operating a Motor Vehicle  
166 While Intoxicated (OWI), Iowa Code Section 321J.2 and IDPH Participants whose  
167 driving licenses or non-resident operating privileges are revoked under Chapter 321J,  
168 provided that such treatment service meets the criteria for service necessity and sliding  
169 fee scale;
- 170 • court-ordered evaluation for substance abuse;
- 171 • court-ordered testing for alcohol and drugs (Enrollees only);
- 172 • court-ordered treatment which meets criteria for treatment services (except for adult  
173 Enrollees at a state mental health institute) (Enrollees only);
- 174 • cost of prescription drugs is not the responsibility of the Contractor, except at Level IV-D  
175 and Level IV where prescription drugs of any kind are included (Enrollees only), and
- 176 • second opinion as medically necessary and appropriate for the Enrollee's condition and  
177 identified needs from a qualified health care professional within the network or arranged  
178 for outside the network at no cost to the Enrollee.

#### 179 **4B.3.2 Methamphetamine ("Meth") Funding**

180 IDPH will provide the Contractor with funding for specialized services for IDPH Participants  
181 who report use of methamphetamine. The Contractor shall be required to work with Iowa Plan  
182 providers holding IDPH-funded substance abuse services contracts to ensure that such providers  
183 use case management and other practices to extend the length of stay of IDPH Participants  
184 reporting methamphetamine use, consistent with best practices identified by SAMHSA and  
185 guidelines established by IDPH.

186 Section 9.1 (3) (e) of this RFP describes the provisions for Meth Funding payment to the  
187 Contractor.

#### 188 **4B.3.3 Optional Services and Supports**

189 The Contractor has the authority to develop alternative services and supports to meet the  
190 substance abuse treatment needs of Enrollees. Such optional services and supports should not  
191 duplicate services available through other delivery systems, and must be implemented only after  
192 approval by the Departments. Examples of optional services include, but are not limited to:

- 194 • 23-hour observation in a 24-hour treatment facility, and
- 195 • housing (room and board) services to facilitate appropriate utilization of outpatient levels  
196 of service.

#### 198 **4B.3.4 EVIDENCE-BASED COVERAGE**

199 The Contractor shall develop, maintain and at least annually review and update a compendium of  
200 evidence-based substance abuse treatment practices, and shall periodically advise the  
201 Departments regarding how to modify Covered, Required and Optional Services to be consistent  
202 with established evidence-based practices.

203

204 **4B.4 COVERED SUBSTANCE ABUSE DIAGNOSES**

205 **4B.4.1 Covered Substance Abuse Diagnoses for Iowa Plan Enrollees**

206 The Contractor will be responsible for furnishing service necessary covered and required services  
207 for the substance abuse needs of Iowa Plan Enrollees who have the following diagnoses as  
208 defined in the ICD-9-CM:

209           291     Alcoholic Psychoses

210           292     Drug Psychoses

211           303     Alcohol Dependence Syndrome

212           304     Drug Dependence

213           305     Non-Dependent Abuse of Drugs

214 The Contractor will be responsible for any diagnoses added to ICD-9-CM during the course of  
215 the contract. Services for a covered diagnosis cannot be denied solely on the basis of an  
216 individual also having a non-covered diagnosis.

217 **4B.4.2 ICD-10 Coverage Codes**

218 Upon their adoption in October 2011, the Departments intend to adopt the ICD-10 coding system.  
219 This will require the recoding of all covered diagnoses at that time.

220

221 **4B.4.3 Covered Substance Abuse Disorders for Iowa Plan IDPH Participants**

222 The Contractor will be responsible for furnishing necessary covered and required services for the  
223 substance abuse treatment need of IDPH Participants who have the following substance abuse  
224 disorders:

225           • Non-Dependent Abuse of Alcohol

226           • Alcohol Dependency

227           • Drug Dependency

228           • Non-Dependent Abuse of Drugs

229           • Intervention for Significant Others when the diagnosed substance abuse client is not  
230 admitted to treatment

231

232 **4B.5 SPECIAL CONSIDERATIONS PERTAINING TO SUBSTANCE ABUSE**  
233 **TREATMENT**

234 **4B.5.1 Compliance with Funding Requirements**

235 The Contractor will ensure compliance with federal and state requirements for the Medicaid and  
236 IDPH funding streams and will monitor and report compliance with requirements established by  
237 the Substance Abuse and Mental Health Services Administration (SAMHSA) for the SAPT block  
238 grant, by IDPH for state appropriations, and by the Centers for Medicare and Medicaid Services  
239 for Medicaid.

240 **4B.5.2 Contractor Staff Qualifications**

241 The Contractor will ensure that non-psychiatrist staff involved in the determination and  
242 monitoring of care shall be qualified as substance abuse professionals according to the Iowa  
243 Board of Certification.

244

245 **4B.5.3 Criteria of Service Necessity and Authorization for Services**

246 The Contractor must utilize the ASAM PPC-2R and the PMIC Admission and Continued Stay  
247 Criteria. The Contractor may develop guidelines to implement the criteria, including guidelines  
248 that take into account the special needs, history of services, and the need for longer episodes of  
249 treatment of Enrollees entering substance abuse PMICs and Eligible Persons entering the Women  
250 and Children’s Programs. All such guidelines developed by the Contractor must be approved by  
251 the Departments and shared with providers at least thirty days prior to implementation of the  
252 guidelines.

253 For Iowa Plan Enrollees, the Contractor may require authorization for substance abuse treatment  
254 services at the higher levels of service. The Contractor shall not require authorization for  
255 substance abuse treatment services for Enrollees at the ASAM PPC-2R Level I (Outpatient  
256 Services), Level II.1 (Intensive Outpatient), Level II.5 (Partial Hospitalization) and Level III.I  
257 (Clinically Managed Low Intensity Residential). For IDPH Participants, the Contractor may not  
258 require authorization for any level of service.

259 The Contractor will ensure that contracted providers use these required criteria for determination  
260 of level of service, including when authorization from the Contractor is not required.

261 **4B.5.4 Substance Abuse Program Licensure Required**

262 Programs providing treatment services through IDPH funds must be licensed by IDPH. Programs  
263 providing substance abuse treatment services through Medicaid funding must be licensed by  
264 IDPH or be exempt from licensure in accordance with Iowa Code Section 125.13 (2) “a”.

265 **4B.5.5 Court-Ordered Substance Abuse Services**

266 The Contractor is responsible for the provision of all substance abuse services ordered for  
267 Eligible Persons through a court action when:

- 268 • except for evaluations, the covered and required services ordered by the court  
269 meet the criteria of service necessity, and
- 270 • the court orders treatment with a substance abuse licensed provider, and,
- 271 • for IDPH Participants, the court orders treatment and it is provided by a network  
272 provider contracted to serve IDPH Participants.

273 The Contractor shall work with the courts to examine the appropriateness of court-ordered  
274 placements and identify specific appropriate alternatives for the courts to consider.

275 The Contractor has the right to establish policies that require providers of court-ordered substance  
276 abuse services to provide notification and documentation of court-ordered treatment.

277 **4B.5.6 Block Grant Requirements for IDPH Participants**

278 Treatment services provided with SAPT Block Grants must follow federally mandated  
279 requirements, and, in all cases, the block grant funds must be the payers of last resort. SAPT  
280 Block Grants; Interim Final Rule requirements (from Public Health Service Act section 1919 to  
281 1976 and 45 CFR Part 96, Substance Abuse Prevention and Treatment Block Grants, Interim  
282 Final Rule) are summarized below.

- 283 • Meeting required set asides - Federal law requires that states expend their block grant  
284 allocation such that 20% of their funds provide prevention.
- 285 • Services for women/pregnant women - Federal law requires all public substance abuse  
286 treatment programs to serve women and pregnant women. Additionally, states must expend

287 not less than the amount equal to the amount spent in fiscal year 1994 for treatment capacity  
288 for women and pregnant women (i.e., \$1,302,477. The actual amounts expended in each of  
289 fiscal years 2002 and 2003 was \$1,390,939). In the specialized Women and Children's  
290 Programs the following must be provided:

- 291       • primary medical care for women who are receiving substance abuse services  
292       including prenatal care and while women are receiving such treatment, child care;
- 293       • primary pediatric care for their children, including immunizations;
- 294       • gender specific substance abuse treatment and other therapeutic interventions for  
295       women that may address issues of relationships, sexual and physical abuse and  
296       parenting, and child care while the women are receiving these services;
- 297       • therapeutic interventions for children in custody of women in treatment which may,  
298       among other things, address their developmental needs, and their issues of sexual and  
299       physical abuse and neglect;
- 300       • sufficient case management and transportation services to ensure that women and  
301       their children have access to the services described above;
- 302       • comprehensive services including case management to assist in establishing  
303       eligibility for public assistance programs provided by federal, state or local  
304       governments; employment and training programs; education and special education  
305       programs; drug-free housing for women and their children; prenatal care and other  
306       health care services; therapeutic day care for children; Head Start; and other early  
307       childhood programs, and
- 308       • women who are attempting to regain custody of their children are included in this  
309       population.
- 310       • Services to intravenous substance abusers - Federal law requires specified services for  
311       individuals treated for intravenous substance abuse. These include:
  - 312           • each individual who requests and is in need of treatment for intravenous drug abuse  
313           shall be admitted to the program not later than 14 days after making the request for  
314           admission to such a program, or 120 days after the date of such request, if no  
315           program has the capacity to admit the individual on the date of such request and if  
316           interim services are made available to the individual not later than 48 hours after such  
317           request;
  - 318           • use of outreach services - providers are required to carry out activities to encourage  
319           individuals in need of treatment to undergo such treatment. Outreach services must  
320           also promote awareness among injecting drug abusers about the relationship between  
321           injecting drug abuse and communicable diseases and select, train and supervise  
322           outreach workers;
  - 323           • TB - providers are required to directly or through arrangements with other public or  
324           nonprofit private entities, routinely make available tuberculosis services to IDPH  
325           Participants in need of such services. In the case of an individual in need of such  
326           treatment who is denied admission to the program on the basis of lack of the capacity  
327           of the program to admit; they are further required to assure referral of an individual in  
328           need of such services to another provider of tuberculosis services if such services  
329           cannot be made available at the program, and

- 330                   • HIV - providers are required to directly or through arrangements with other public or  
331                   nonprofit private entities, routinely make available HIV services to IDPH Participants  
332                   in need of such services.

333                   **4B.5.7 Women and Children’s Programs**

334                   The nature of Women and Children’s Programs is such that the scope and duration of treatment  
335                   services differ from other substance abuse treatment services provided at the same levels of care.  
336                   The Contractor shall establish authorization policies and practices that take into consideration the  
337                   nature of these programs and ensure immediate access for Eligible Persons. The Contractor will  
338                   coordinate the use of both the Medicaid and the IDPH funding streams to ensure the maintenance  
339                   of the comprehensive array of treatment and supportive services that have historically been a  
340                   successful part of the Women and Children’s Programs and are required as a condition of the  
341                   substance abuse block grant funding:

- 342                   • Medicaid funding for covered substance abuse treatment services for Enrollees, and  
343                   • IDPH funding for other services and supports for Eligible Persons and for treatment  
344                   of IDPH Participants.

345                   **4B.5.8 Psychiatric Medical Institutions For Children (PMIC) (Enrollees Only)**

346                   Persons admitted to a substance abuse licensed PMIC with a primary diagnosis of substance  
347                   abuse typically present a need for concurrent substance abuse treatment and mental health care  
348                   which is part of the nature of the care provided by a substance abuse licensed PMIC. It is not  
349                   uncommon for an Enrollee’s primary diagnosis to change over the course of treatment while in  
350                   the PMIC. The need for substance abuse PMIC services is determined by the Enrollee’s  
351                   admitting diagnosis and, once determined, is not altered by a change in diagnosis as long as  
352                   treatment at a substance abuse licensed PMIC remains appropriate and meets the Enrollee’s  
353                   needs. Because many persons entering PMICs apply for and obtain Medicaid eligibility and  
354                   enrollment upon or after admission, the Contractor must manage all new admissions in the same  
355                   manner as if that person were an Iowa Plan Enrollee at the date of admission.

356                   If a person is admitted to a substance abuse licensed PMIC and is a Medicaid Member or later  
357                   becomes a Medicaid Member (including obtaining retroactive Medicaid eligibility which  
358                   typically includes up to three months of eligibility prior to application) for all or any of the  
359                   months that the person resides in the PMIC, and is not otherwise designated an Enrollee (by  
360                   inclusion on the Contractor’s enrollment tape or inclusion in the regular capitation payment),  
361                   that Member is considered an Enrollee.

362  
363                   If a person obtains Medicaid eligibility as a result of residing in a substance abuse licensed  
364                   PMIC and is considered enrolled as described in this section for one or more months and is  
365                   not included in the regular Capitation Payment for those months, DHS will make a manual  
366                   capitation payment quarterly for those Enrollees and months of enrollment not otherwise  
367                   paid. The Contractor shall provide a list, at least quarterly, of individuals receiving PMIC  
368                   services and months of service not included in the regular capitation payment.

369  
370                   **4B.5.9 Substance Abuse Treatment Services at the Mt. Pleasant State Mental Health**  
371                   **Institute (Enrollees only)**

372                   State mental health institutes shall be part of the Contractor’s provider network. The Contractor  
373                   must authorize inpatient care at the licensed substance abuse treatment program at the Mt.  
374                   Pleasant State Mental Health Hospital for persons who are admitted on a voluntary basis and  
375                   meet the criteria of service necessity. Iowa Plan Enrollees seeking voluntary admission to the

376 MHI who do not meet the criteria of service necessity shall not be admitted or allowed continued  
377 admission without approval of the appropriate county, community pre-screening agency, or  
378 Central Point of Coordination.

379 The Contractor's responsibility is limited to voluntary admissions. Services to Enrollees who are  
380 involuntarily admitted for substance abuse evaluation or treatment at the Mt. Pleasant State  
381 Mental Health Institute are not the Contractor's responsibility.

382  
383 **4B.5.10 Cost Sharing**

384 The Contractor shall not require Iowa Plan Enrollee co-payment or cost sharing for any of the  
385 services covered within the scope of the program. There shall be no charge for missed appoint-  
386 ments. Further, the Contractor will ensure that contracted providers do not charge Enrollees for  
387 covered and required services when payment is denied by the Contractor due to provider's failure  
388 to adhere to contractual requirements.

389 IDPH Participants at or below 200% of poverty level will cost share on the basis of a sliding fee  
390 scale based on income and family size and approved the IDPH. There shall be no charge for  
391 missed appointments, but a one-time no-show fee, not to exceed an amount established by IDPH,  
392 may be charged to IDPH Participants.

393  
394 **4B.5.11 IDPH Minimum Number and Participant Mix (IDPH Participants only)**

395 The Contractor, through its network providers, is required to provide services to a minimum  
396 number of IDPH Participants annually. Further, the Contractor is required to provide services to a  
397 minimum percent of Participants from certain categories: women, pregnant women, criminal  
398 justice referral source, unemployed, prior substance abuse treatment, race other than white, and  
399 monthly taxable income under \$1,000. Minimum number and percentage requirements are  
400 established by IDPH and may be updated annually by IDPH.

401 **4B.6 ACCESSIBILITY REQUIREMENTS IN THE PROVISION OF SUBSTANCE**  
402 **ABUSE SERVICES**

403 4B.6.1 The Contractor must provide at least as much access to covered substance abuse services  
404 as exists within Medicaid's fee-for-service delivery system for Enrollees.

405 4B.6.2 The Contractor must require that providers meet access standards established in 441 IAC  
406 88.67(4) for timely access to care and services for Enrollees, taking into account the  
407 urgency of need for services.

408 4B.6.3 The Contractor must require that network providers offer hours of operation that are no  
409 less than the hours of operation offered to commercial Enrollees or comparable to  
410 Medicaid fee-for-service, if the provider serves only Enrollees.

411  
412 4B.6.4 The Contractor must ensure that services are available to Enrollees 24 hours a day, 7 days  
413 a week, when medically necessary.

414  
415 4B.6.5 The Contractor must: a) establish mechanisms to ensure that network providers comply  
416 with the timely access requirements, and b) monitor regularly to determine compliance,  
417 integrating monitoring activity into the network management function (see Section 5C.5),  
418 and taking corrective action if there is a failure to comply.

419  
420 **4B.6.6 Accessibility Requirements for the Provider Network**

421 The Contractor will ensure access to covered and required substance abuse treatment services for  
422 Eligible Persons. The access shall be measured by:

423 • Timeliness Standards:

- 424 • Eligible Persons with emergency needs must be seen within 15 minutes of  
425 presentation with provider.
- 426 • Eligible Persons with urgent non-emergency needs must be seen within one hour of  
427 presentation at a service delivery site or within 24 hours of telephone contact with  
428 provider or Contractor.
- 429 • Eligible Persons with persistent symptoms must be seen within 48 hours of reporting  
430 symptoms; and those with need for routine services must be seen within four weeks  
431 of the request for appointment.
- 432 • Eligible Persons who are pregnant women in need of routine services must be  
433 admitted within 48 hours of seeking treatment.
- 434 • Eligible Persons who are intravenous (IV) drug users must be admitted not later than  
435 14 days after making the request for admission, or 120 days after the date of such  
436 request if no program has the capacity to admit the individual on the date of such  
437 request and if interim services are made available to the individual not later than 48  
438 hours after such request.

439 • Priority In Treatment:

- 440 • Priority must be given to those Eligible Persons with the greatest clinical need.
- 441 • In establishing clinical need, priority must be given to substance abuse that results in  
442 the highest personal and social cost as measured by severity of personal and social  
443 consequences, and the number of abusers.
- 444 • The ranked priority for admissions to treatment shall be as follows: (1) pregnant  
445 women injecting drug users, (2) pregnant substance abusers (3) injecting drug users,  
446 (4) all others.

447 • Geographic Standards:

- 448 • 100% of Enrollees residing within an urban (see Section 10 for definition of urban)  
449 setting have access to inpatient, residential, intensive outpatient, and partial  
450 hospitalization substance services within 60 minutes from their primary residence  
451 using GeoAccess standards for urban travel time;
- 452 • 100% of Enrollees residing within an urban setting have access to outpatient  
453 substance abuse services within 60 minutes from their primary residence using  
454 GeoAccess standards for urban travel time;
- 455 • 100% of Enrollees residing within a rural setting (see Section 10 for definition of  
456 rural) have access to inpatient, residential, intensive outpatient, and partial  
457 hospitalization substance services within 90 minutes from their primary residence  
458 using GeoAccess standards for urban travel time;
- 459 • 100% of Enrollees residing within a rural setting have access to outpatient substance  
460 abuse services within 90 minutes from their primary residence using GeoAccess  
461 standards for urban travel time;

- 462 • The Contractor must establish a program of assertive outreach to rural areas where  
463 substance abuse services may be less available than in more urban areas.
- 464 • The Contractor also must monitor utilization in regions across the state and in rural  
465 and urban areas to assure equality of service access and availability.
- 466 • The Contractor must provide at least as much access for Enrollees to covered and  
467 required services as exists within Medicaid's fee-for-service delivery system.
- 468

468

469

470

471

472

473

474

475

476

477

**SECTION 4C**

**SERVICE REQUIREMENTS RELATED TO**

**THE**

**MENTAL HEALTH**

**AND SUBSTANCE ABUSE NEEDS**

**OF IOWA PLAN ENROLLEES**

478

479 **4C.1 SERVICE REQUIREMENTS RELATED TO BOTH MENTAL HEALTH AND**  
480 **SUBSTANCE ABUSE NEEDS**

481 This section addresses mental health and substance abuse services for Iowa Plan Enrollees.

482

483 **4C.1.1 Coverage and Payment for Emergency Services**

484

485 The Contractor is responsible for coverage and payment of emergency services and post -  
486 stabilization services where required in 42 CFR 438.114.

487

488 1) An Enrollee who has an emergency medical condition may not be held liable for payment of  
489 subsequent screening and treatment needed to diagnose the specific condition or stabilize the  
490 Enrollee.

491 2) The attending emergency physician, or the provider actually treating the Enrollee, is  
492 responsible for determining when the Enrollee is sufficiently stabilized from an emergency  
493 medical condition for transfer or discharge from an emergency room, and that determination  
494 is binding on the Contractor.

495 3) The Contractor may not deny payment for treatment obtained when an Enrollee had an  
496 emergency medical condition, including cases in which the absence of immediate medical  
497 attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition  
498 of emergency medical condition.

499 4) The Contractor may not deny payment for treatment obtained when a Contractor  
500 representative instructs the Enrollee to seek emergency services.

501 5) The Contractor may not limit what constitutes an emergency medical condition on the basis  
502 of lists of diagnoses or symptoms. However, the diagnoses and/or the symptoms relating to  
503 the reason the individual seeks emergency services must be related to a mental health or  
504 substance abuse condition.

- 505 6) The Contractor will cover emergency services when the provider notifies the Contractor  
506 within 10 calendar days of presentation for emergency services.
- 507 7) Emergency services for covered conditions must be reimbursed for Enrollees regardless of  
508 whether authorized in advance or whether the provider of the service is a part of the service  
509 network.
- 510 8) For emergency services provided to an Iowa Plan Enrollee by a network or non-network  
511 provider when psychiatric or substance abuse diagnoses are the primary condition, the  
512 Contractor may:
- 513 • provide a minimum triage fee to the hospital regardless of whether the facility  
514 notifies the Contractor; the triage fee shall be no less than is paid through the FFS  
515 Medicaid program;
  - 516 • reimburse the facility for emergency services provided, contingent upon the facility's  
517 compliance with notification policies;
  - 518 • reimburse non-network providers an emergency room fee which is no less than the  
519 minimum payment which would be made to a network provider, and
  - 520 • ensure follow-up contact within 72 hours of the provider's notification with at least  
521 85% of Enrollees served in an emergency room for whom inpatient treatment was  
522 requested, and no 24-hour level of care was authorized.
- 523 9) Any provider of emergency services that does not have in effect a contract with a Medicaid  
524 managed care entity that establishes payment amounts for services furnished to a member  
525 enrolled in the entity's Medicaid managed care plan, must accept as payment in full no more  
526 than the amounts (less any payments for indirect costs of medical education and direct costs  
527 of graduate medical education) that it could collect if the member received medical assistance  
528 under Title XIX other than through enrollment in such an entity.

529 **4C.1.2 Coverage and Payment for Post-Stabilization Services**

530 Post-stabilization services are covered and paid for in accordance with provisions set forth at 42  
531 CFR 438.114 and which are listed below:

- 532
- 533 1) The Contractor is financially responsible for medically necessary post-stabilization covered  
534 services that are pre-approved by an Iowa Plan provider or other Iowa Plan representative  
535 that the Contractor has authorized to make pre-approval decisions.
- 536 2) The Contractor is financially responsible for medically necessary post-stabilization covered  
537 services obtained within or outside the network that are not pre-approved, but administered to  
538 maintain the Enrollee's stabilized condition within 1 hour of a request to the Contractor for  
539 pre-approval of further post-stabilization covered services.
- 540 3) The Contractor is financially responsible for medically necessary post-stabilization covered  
541 services obtained within or outside the network that are not pre-approved, but administered to  
542 maintain, improve or resolve the Enrollee's stabilized condition if:
- 543 • the Contractor does not respond to a request for pre-approval within 1 hour;
  - 544 • the Contractor cannot be contacted, or
  - 545 • the Contractor and the treating physician cannot reach an agreement concerning the  
546 Enrollee's care and the Contractor's physician is not available for consultation. In this  
547 situation, the Contractor must give the treating physician the opportunity to consult

548 with the Contractor's physician and the treating physician may continue with care of  
549 the Enrollee until the Contractor's physician is reached or one of the criteria of  
550 422.133(c)(3) is met.

551 4) The Contractor's financial responsibility for medically necessary post-stabilization covered  
552 services it has not pre-approved ends when:

- 553 • a network physician with privileges at the treating hospital assumes responsibility for  
554 the Enrollee's care;
- 555 • a network physician assumes responsibility for the Enrollee's care through transfer;
- 556 • the Contractor's representative and the treating physician reach an agreement  
557 concerning the Enrollee's care, or
- 558 • the Enrollee is discharged.

#### 559 **4C.1.3 Transportation**

561 The Contractor is responsible for providing ambulance services for both mental health and  
562 substance abuse treatment services. Transportation for the Enrollee also is the responsibility of  
563 the Contractor when necessary to transport an Enrollee who is receiving emergency covered  
564 services from a non-participating provider to a participating provider and when necessary to  
565 transport an Enrollee between two 24-hour treatment settings funded through the Contractor. The  
566 Contractor's responsibility to provide for transportation in this instance is not impacted by the  
567 inclusion or non-inclusion of transportation services in a county's management plan.

#### 568 **4C.2 SERVICES FOR CHILDREN WITH SERIOUS BEHAVIORAL HEALTH** 569 **CONDITIONS**

571  
572 4C.2.1 In keeping with the priorities of the Departments and the MHDS' focus on development  
573 of a system of care for children's behavioral health services, provision of quality care to  
574 children under the Iowa Plan will be a key responsibility of the Contractor.

575 The Contractor will be required to implement a screening protocol and comprehensive  
576 treatment approach for serious, behavioral health conditions for children. These protocols  
577 require the Departments' approval and must be developed using industry standards for  
578 the detection of behavioral health conditions, which, if untreated, may cause serious  
579 disruption in a child's development and success in the community.

580 4C.2.2 The Contractor shall work with providers to help the family to identify informal and  
581 natural community supports that can help stabilize a child's behavioral health symptoms  
582 as an integral component of discharge planning.

583 4C.2.3 The Contractor shall work with providers to develop a crisis plan that helps the family to  
584 identify triggers and timely interventions to reduce the risk to the child and family and  
585 offer family-identified supports and interventions.

586 4C.2.4 The Contractor will work collaboratively with local school systems to develop effective  
587 trainings, interventions and supports for school systems to respond effectively to needs of  
588 children with behavioral health issues. Services may include telephonic consultations  
589 provided by a child psychiatry team or with the Contractor, emergency stabilization  
590 response to crisis situations, on-site mental health counseling, follow-up with a child's  
591 family, identification and mobilization of community resources, and referral to  
592 community mental health agencies.

593 **4C.3 DISTINGUISHING MEDICAL SERVICES FROM MENTAL HEALTH AND**  
594 **SUBSTANCE ABUSE SERVICES**

595 In case of a dispute regarding whether a service is medical, mental health or substance abuse,  
596 DHS will serve as the final arbiter, first using the list of covered and required services from this  
597 RFP and then considering the service codes which were used as the basis for the development of  
598 the original Iowa Plan capitation payment, or other means as determined by DHS.

599

600

600

601

602

603

604

## **SECTION 5**

### **MANAGING SERVICE PROVISION**

605

#### **5.1 SUPPORTING THE PHILOSOPHY OF THE IOWA PLAN**

607 The Contractor, while precluded from directly providing covered, required or optional  
608 services, is responsible for managing the provision of services to assure that Eligible  
609 Persons receive appropriate and effective care. The way in which the Contractor  
610 organizes and implements its management functions must be consistent with the  
611 philosophy of the Iowa Plan. Through this procurement the Departments have updated  
612 that philosophy to emphasize the following:

613

##### **5.1.1 Recovery-Oriented Care System**

614 The Iowa Plan will emphasize a recovery-oriented care system. “Recovery” is a  
615 process of restoring or developing a positive and meaningful sense of identity apart  
616 from one’s condition and then rebuilding one’s life despite, or within, the limitations  
617 imposed by that condition. A recovery-oriented care system shall:

618

619

620

621

622

623

624

625

626

627

628

629

630

- identify and build upon each recovering individual’s strengths and areas of health in addressing his or her needs;
- encourage hope and emphasize individual dignity and respect;
- maintain a high degree of accessibility, including age and gender appropriate and culturally competent care;
- demonstrate effectiveness in engaging and retaining Eligible Persons in care such that they can achieve the highest degree of stability and recovery with sustained effects, and
- ensure Eligible Person and family involvement in system design and management.

631

632

633

634

635

636

This orientation will require the Contractor to continually ask whether existing services are effectively engaging Iowa Plan Eligible Persons, and if they are not, determine with Eligible Person and family input how they should be modified to do so.

##### **5.1.2 Integrated and Coordinated Service Delivery**

While the Departments and its current Contractor have worked to address this issue in the past, the Departments believe there is opportunity to further improve service system integration. To that end, the Contractor shall convene a work group to develop a detailed set of recommendations regarding steps to improve integration and coordination at multiple levels, including at a minimum across the continuum of mental health and substance abuse services, across mental

637 health and mental retardation/developmental disability services, physical and mental health, and  
638 coordination of Contractor and county operations. The work group shall include provider, county,  
639 consumer advocate and state staff and shall coordinate its work with the DHS/IDPH Co-  
640 Occurring Policy Academy. The Contractor must submit recommendations by April 30, 2010.  
641 The recommendations must be provided in the context of existing financial constraints that may  
642 limit the actions the state may be able to take to address identified improvements.

643  
644 Throughout the contract period, the Contractor will be expected to work with the Departments,  
645 statewide advisory and work groups, local planning groups, consumer and family advocacy  
646 groups and others involved in planning and evaluating Iowa's service delivery system to identify  
647 opportunities to improve service integration and coordination, implement new strategies, and  
648 evaluate their impact. The Contractor also will be expected to participate in state and  
649 community-based efforts to improve local service capacity for targeted community-based  
650 services.

651

## 652 **5.2 PARTICIPATING IN SERVICE SYSTEM DEVELOPMENT EFFORTS**

653 Medicaid funds provide a substantial proportion of the dollars available to pay for mental health  
654 services across the state. IDPH and DHS each fund a significant proportion of substance abuse  
655 treatment. As the Departments' agent, the Contractor must participate in local, regional and  
656 statewide planning efforts to help ensure the fullest integration of Iowa Plan resources into the  
657 service delivery system. This will include, but not be limited to:

- 658 • participation in planning efforts initiated by the DHS and IDPH;
- 659 • participation with county or multi-county planning efforts to implement requirements for  
660 county management plans;
- 661 • participation with Decategorization Boards, including outreach to the education system  
662 both in arranging services for individual children and to explore jointly funded programs,  
663 and participation with DHS/JCS in the development of services for children, and  
664 participation with adult correctional personnel.

665

665  
666  
667  
668  
669  
670  
671  
672  
673  
674  
675  
676  
677  
678  
679  
680  
681  
682  
683  
684  
685  
686  
687  
688  
689  
690  
691  
692  
693  
694  
695  
696  
697  
698  
699  
700  
701  
702  
703

**SECTION 5A**  
**UTILIZATION MANAGEMENT**

**5A.1 ORGANIZATION OF UTILIZATION MANAGEMENT STAFF (Enrollees only)**

Managed behavioral healthcare organizations (MBHOs) use appropriately credentialed clinicians to review the presenting conditions of an Enrollee, to apply the MBHO’s Utilization Management Guidelines, to authorize the appropriate level of care, and to monitor and coordinate services for Enrollees. These clinicians are known by a variety of titles. In this RFP, staff who perform these functions will be referred to as “Utilization Management staff.”

5A.1.1 Utilization Management staffing shall minimally include the following, directly accountable to the Contractor Executive Director:

- a. an ASAM-certified psychiatrist, who shall be the Clinical Director, with substantial involvement in the Utilization Management function, and
- b. a dually credentialed mental health and substance abuse professional, meaning a mental health professional credentialed at the independent level and holding certification as a Certified Alcohol and Drug Counselor (CADC) or Advanced Certified Alcohol and Drug Counselor (ACADC) with at least three years of managerial experience performing managed behavioral health utilization management to serve as the Utilization Management Director.

5A.1.2 Utilization Management services shall be available 24 hours a day seven days a week from an office(s) located in the State of Iowa.

5A.1.3 The Contractor will assign its Utilization Management staff in a way that ensures maximum coordination with local service delivery systems. The Contractor further will ensure:

- 5A.1.3.1 availability of Utilization Management reviewer staff with knowledge of services available in the geographical area to which they are assigned;
- 5A.1.3.2 availability of Utilization Management reviewer staff who shall be licensed or certified practitioners holding current Iowa licenses or certifications appropriate to the service(s) they review and authorize (with CADC or ACADC required for Utilization Management reviewer staff who review and/or authorize substance abuse services); expertise in assessing/authorizing mental health and substance abuse services for adults including those with multiple, serious or chronic needs; expertise in assessing/authorizing mental health and substance abuse services to address the special needs of children and their families;

- 704 5A.1.3.3 availability of Utilization Management reviewer staff with knowledge of the  
705 CW/JJ service system and ways in which Iowa Plan services should interface  
706 with that system;
- 707 5A.1.3.4 availability of Utilization Management reviewer staff with competencies in  
708 cultures represented by the ethnic backgrounds of Iowa Plan Enrollees;
- 709 5A.1.3.5 availability of Utilization Management staff to work on-site in joint treatment  
710 planning conferences for individual Enrollees and in community service  
711 planning. The number of Utilization Management staff available for on-site  
712 planning shall be no less than one clinician for every IDPH region (see  
713 **Attachments to Section 1** for list and map of regions);
- 714 5A.1.3.6 continuity of Utilization Management for Enrollees accessing services,  
715 especially those who use multiple services or use services for an extended  
716 period of time;
- 717 5A.1.3.7 continuity of Utilization Management for Enrollees as they move from one  
718 level of care to another or from one provider to another;
- 719 5A.1.3.8 assignment of Utilization Management staff in a way which ensures continuity  
720 of communication and maximum coordination with local service delivery  
721 systems, and
- 722 5A.1.3.9 compensation of individuals or entities that conduct utilization management  
723 activities will not be structured so as to provide incentives for the individual or  
724 entity to deny, limit, or discontinue medically necessary services to any  
725 Enrollee.
- 726 **5A.2 SERVICE AUTHORIZATION REVIEW and NOTIFICATION OF ADVERSE**  
727 **ACTION (Enrollees only)**
- 728 **5A.2.1 General Requirements**  
729
- 730 5A.2.1.1 The Contractor must have in place, and follow, written policies and procedures  
731 for processing requests for initial and continuing authorizations of services.  
732
- 733 5A.2.1.2 The Contractor shall authorize reimbursement for mental health services for Iowa  
734 Plan Enrollees when it is determined by the Contractor that there is a  
735 psychosocial necessity for services, applying the Utilization Management  
736 Guidelines described in Section 5A.3.
- 737 5A.2.1.3 The Contractor shall authorize reimbursement for substance abuse treatment  
738 services for Iowa Plan Enrollees when it is determined by the Contractor that  
739 there is a service necessity for services, applying the Utilization Management  
740 Guidelines described in Section 5A.3.
- 741 5A.2.1.5 The Contractor must have in effect mechanisms to ensure consistent application  
742 of review criteria for authorization decisions by physician and non-physician  
743 reviewers; and consult with the requesting provider when appropriate.

- 744 5A.2.1.6 The Contractor may limit payment to only those services that the Contractor has  
745 authorized or exempted from authorization under guidelines which the  
746 Contractor has developed or adopted and the Departments have approved.  
747
- 748 5A.2.1.7 Only a psychiatrist shall make a decision not to authorize any initial or  
749 concurrent request, or to authorize a service in the amount, duration, or scope that  
750 is less than the request, for 24-hour adult mental health services, with the  
751 exception of the following services, unless the Departments approve an  
752 alternative policy:
- 753 • Intensive Psychiatric Rehabilitation
- 754 5A.2.1.8 Only a child psychiatrist shall make a decision not to authorize any initial or  
755 concurrent request, or to authorize a service in the amount, duration, or scope that  
756 is less than the request, for 24-hour child mental health services, unless the  
757 Departments approve an alternative policy.
- 758 5A.2.1.9 Only a psychiatrist who is certified by the American Society in Addiction  
759 Medicine (ASAM), or who has extensive demonstrated substance abuse  
760 experience that meets the Departments' approval, shall make a decision not to  
761 authorize any initial or concurrent request, or to authorize a service in the  
762 amount, duration, or scope that is less than the request for substance abuse  
763 services, as determined by the Contractor and approved by the Departments.
- 764 5A.2.1.10 All authorizations or non-authorizations by the Contractor shall be documented  
765 in the Contractor's records and non-authorizations shall refer to both the  
766 Contractor's Utilization Management Guidelines, and the relevant citations from  
767 the Iowa Administrative Code which support the decision.
- 768 5A.2.1.11 The Contractor shall evaluate options for waiving service authorization  
769 requirements for high-performing providers, and present its findings and  
770 proposed actions, if any, to the Departments no later than 12 months after the  
771 contract implementation date.

772 **5A.2.2 Notification of Adverse Action for Service Authorization Requests**

- 773 5A.2.2.1 The Contractor will provide appropriate and timely written notice to an Enrollee of any  
774 decision to deny a service authorization request, or to authorize a service in an amount,  
775 duration, or scope that is less than requested or agreed upon, or any action, as "action"  
776 is defined in this section, except for denial of payment. Notice is not required to the  
777 Enrollee when an action is due to the provider's failure to adhere to contractual  
778 requirements and there is no adverse action against the Enrollee.  
779
- 780 5A.2.2.2 The notice must explain:
- 781 a. the action the Contractor has taken or intends to take;
  - 782 b. the reasons for the action;
  - 783 c. the Enrollee's or the provider's right to file an appeal;
  - 784 d. procedures for exercising Enrollee's rights to appeal or grieve;
  - 785 e. the Enrollee's right to request a state fair hearing after he or she has exhausted  
786 the Contractor's appeal process;

- 787 f. circumstances under which expedited resolution is available and how to request  
788 it;
- 789 g. the Enrollee's rights to have benefits continue pending the resolution of the  
790 appeal as defined in Section 5B, how to request that benefits be continued, and  
791 the circumstances under which the Enrollee may be required to pay the costs of  
792 these services;
- 793 h. that during the state fair hearing: the Enrollee may represent him(her)self or use  
794 legal counsel, a relative, a friend, or a spokesperson;
- 795 i. the specific regulations that support, or the change in federal or state law that  
796 requires, the action, and
- 797 j. the individual's right to request an evidentiary hearing if one is available or a  
798 state agency hearing, or in cases of an action based on change in law, the  
799 circumstances under which a hearing will be granted.  
800

801 5A.2.2.3 The notice must be in writing and must meet the language requirements:

- 802 a. DHS shall identify the non-English languages prevalent (i.e., spoken by a  
803 significant number or percentage of the Enrollee and potential population);
- 804 b. the Contractor must make available written information in each prevalent non-  
805 English language;
- 806 c. the Contractor must make oral interpretation services available for all languages  
807 free of charge, and
- 808 d. the Contractor must notify Enrollees that oral interpretation is available for any  
809 language and written information is available in prevalent languages, and how to  
810 access those services.  
811

812 5A.2.2.4 The notice must meet format requirements.

- 813 a. Written material must use an easily understood format, and be available in  
814 alternative formats that take into consideration those with special needs.
- 815 b. Enrollees must be informed of the availability of alternative formats and how to  
816 access those formats.

817

818 5A.2.2.5 The Contractor shall give notice at least 10 days before the date of action when the  
819 action is a termination, suspension, or reduction of previously authorized Medicaid-  
820 covered services (except the period of advanced notice is shortened to 5 days if  
821 probable recipient fraud has been verified) by the date of the action for the following:

- 822 a. in the death of a recipient;
- 823 b. a signed written Enrollee statement requesting service termination or giving  
824 information requiring termination or reduction of services (where the Enrollee  
825 understands that this must be the result of supplying that information);
- 826 c. the recipient's admission to an institution where he or she is ineligible for  
827 further services;
- 828 d. the recipient's address is unknown and mail directed to him or her has no  
829 forwarding address;

- 830 e. the recipient has been accepted for Medicaid services by another local  
831 jurisdiction;
- 832 f. the recipient's physician prescribes the change in the level of medical care, or
- 833 g. the previously authorized service is substituted with a higher level of service.  
834

835 5A.2.2.6 The Contractor shall give notice to the provider on the date of action when the action is  
836 a denial of payment. Notice is not required to the Enrollee when the action is due to  
837 the provider's failure to adhere to contractual requirements and there is no adverse  
838 action against the Enrollee.  
839

840 5A.2.2.7 Standard Review: The Contractor shall give notice as expeditiously as the Enrollee's  
841 health condition requires which may not exceed 14 calendar days following receipt of  
842 the request for service, with a possible extension of up to 14 additional calendar days, if  
843 the Enrollee, or the provider, requests extension; or the Contractor justifies a need for  
844 additional information and can demonstrate (if DHS requests) how the extension is in  
845 the Enrollee's interest.  
846

847 If the Contractor extends the timeframe, the Contractor must give the Enrollee written  
848 notice of the reason for the decision to extend the timeframe and inform the Enrollee of  
849 the right to file a grievance if he or she disagrees with that decision; and issue and carry  
850 out its determination as expeditiously as the Enrollee's health condition requires and  
851 not later than the date the extension expires.  
852

853 5A.2.2.8 Expedited Review: For cases in which a provider indicates, or the Contractor  
854 determines, that following the standard timeframe could seriously jeopardize the  
855 Enrollee's life or health or ability to attain, maintain, or regain maximum function, the  
856 Contractor shall make an expedited authorization decision and provide notice as  
857 expeditiously as the Enrollee's health condition requires and no later than 3 working  
858 days after receipt of the request for service. Contractor may extend the 3 working days  
859 time period by up to 14 calendar days if the Enrollee requests an extension, or if  
860 Contractor justifies a need for additional information and can demonstrate (in response  
861 to DHS' request) how the extension is in the Enrollee's interest.  
862

863 5A.2.2.9 The Contractor shall give notice on the date that the timeframes expire when service  
864 authorization decisions are not reached within the timeframes for either standard or  
865 expedited service authorizations. Untimely service authorizations are adverse actions.  
866

867 5A.2.2.10 Notices of decision that inform Enrollees and providers of adverse action will cite the  
868 Iowa Administrative Code chapter and subheading supporting the action in non-  
869 authorization and care review letters that advise Enrollees of the right to appeal.  
870

### 871 **5A.2.3 Review of Contractor's Utilization Management Process** 872

873 DHS or its agent will review on a monthly basis a sample of appeals, prior authorization  
874 approvals and denials, and other components of the Contractor's Utilization Management  
875 processes to ensure that the Contractor is appropriately applying its Utilization Management  
876 criteria. The Contractor shall facilitate DHS or its agent procuring documents and data necessary  
877 to perform such reviews. The Contractor will reimburse DHS or its agent for costs incurred  
878 during the review process up to a maximum of \$50,000 annually.

879  
880  
881  
882  
883  
884  
885  
886  
887  
888  
889  
890

**5A.3 DEVELOPING, ADOPTING, IMPLEMENTING AND UPDATING  
UTILIZATION MANAGEMENT GUIDELINES**

The Contractor shall develop or adopt Utilization Management Guidelines to interpret the psychosocial necessity of any or all mental health services and supports, and the service necessity of any or all substance abuse services, provided to Iowa Plan Eligible Persons. For mental health services, the Contractor may design and implement Utilization Management Guidelines which are consistent with those standards as set forth in the 441 Iowa Administrative Code, Chapter 88, Division IV. For substance abuse treatment services, the Contractor must utilize the ASAM PPC-2R and the PMIC Admission and Continued Stay Criteria.

**5A.3.1 Psychosocial Necessity for Mental Health Treatment (Enrollees only)**

891  
892 In the context of the Iowa Plan, psychosocial necessity is an expansion of the concept of medical  
893 necessity and shall mean clinical, rehabilitative or supportive mental health services which meet  
894 all of the following conditions:

- 895 • appropriate and necessary to the symptoms, diagnoses or treatment of a covered mental health  
896 diagnosis;
- 897 • provided for the diagnosis or direct care and treatment of a mental disorder;
- 898 • within standards of good practice for mental health treatment;
- 899 • required to meet the mental health need of the Enrollee and not primarily for the convenience  
900 of the Enrollee, the provider, or the Contractor, and
- 901 • the most appropriate type of service which would reasonably meet the need of the Enrollee in  
902 the least costly manner;

903  
904

after consideration of:

- 905
- 906 • the Enrollee’s clinical history including the impact of previous treatment and service  
907 interventions;
- 908 • services being provided concurrently by other delivery systems;
- 909 • the potential for services/supports to avert the need for more intensive treatment;
- 910 • the potential for services/supports to allow the Enrollee to maintain functioning improvement  
911 attained through previous treatment;
- 912 • unique circumstances which may impact the accessibility or appropriateness of particular  
913 services for an individual Enrollee (e.g., availability of transportation, lack of natural supports  
914 including a place to live), and
- 915 • the Enrollee’s choice of provider or treatment location.

916  
917  
918

5A.3.1.1 The guidelines for interpreting psychosocial necessity must:

- 919 a. be based on valid and reliable clinical evidence or a consensus of health care  
920 professionals in the particular field;
- 921 b. consider the needs of the Enrollees;

- 922 c. be adopted in consultation with contracting health care professionals, and
- 923 d. be reviewed and updated periodically as appropriate.

924

925 **5A.3.2 Service Necessity for Substance Abuse Treatment**

926

927 The Contractor shall adopt guidelines to implement the criteria of service necessity for substance  
928 abuse treatment. For substance abuse treatment services, the Contractor must utilize the ASAM  
929 PPC-2R and the PMIC Admission and Continued Stay Criteria.

930

931 **5.A.3.3 Utilization Management Guidelines Development, Utilization and Modification**

932

933 5.A.3.3.1 The Contractor must disseminate Utilization Management Guidelines to all  
934 affected providers and, upon request, to Eligible Persons and potential Eligible  
935 Persons. The Contractor also must include the Utilization Management  
936 Guidelines on the provider website.

937

938 5.A.3.3.2 In the development and implementation of Utilization Management (UM)  
939 Guidelines, the Contractor shall include policies and procedures which recognize  
940 the need for long-term services for some Iowa Plan Eligible Persons and the need  
941 for some Eligible Persons to access several services concurrently. These needs  
942 shall be recognized for both children and adults.

943 5.A.3.3.3 All Utilization Management Guidelines developed or adopted by the Contractor  
944 and any modifications made to the guidelines must be approved by the  
945 Departments and shared with providers at least thirty (30) days prior to  
946 implementation of the guidelines.

947

948 5.A.3.3.4 The Contractor will ensure that contracted providers use the required Utilization  
949 Management Guidelines for determination of level of service, even when  
950 authorization from Contractor is not required.

951

952 5.A.3.3.5 The Contractor must ensure that decisions for utilization management, Eligible  
953 Persons education, coverage of services, and other areas to which the guidelines  
954 apply shall be consistent with the guidelines.

955

956 5.A.3.3.6 The Contractor may limit payment to only those services to Enrollees that the  
957 Contractor has authorized under the guidelines which the Contractor has  
958 developed and the Departments have approved. Any denial of payment for  
959 services to Enrollees is subject to appeal to DHS pursuant to standards in both  
960 state administrative rules and the state plan or waiver.

961 5A.3.3.7 The Contractor shall develop, maintain and at least annually review and update a  
962 compendium of evidence-based mental health and substance abuse practices (see  
963 Section 4A.7) and shall utilize that compendium to advise the Departments and  
964 recommend, as appropriate, revisions to its Utilization Management Guidelines.

965 5A.3.3.8 The Contractor shall provide a forum to receive practitioner suggestions for UM  
966 Guideline revisions at least annually, and shall document all changes made  
967 subsequent to practitioner input.

968 **5A.4 ADMINISTRATIVE AUTHORIZATION OF SERVICES (Enrollees only)**

969 In addition to the use of Utilization Management Guidelines for authorizing services, the  
970 Contractor shall also maintain a process for the administrative authorization of services. This  
971 administrative authorization will be used when contractual requirements mandate the  
972 authorization and reimbursement for services that do not fall within the Contractor's Utilization  
973 Management Guidelines.

974 Instances in which administrative authorization must be performed include, but are not limited to,  
975 those set forth in Section 5A.6 regarding Special Service Considerations. Other instances in  
976 which administrative authorization of services may be required are described in requirements  
977 outlined in Sections 4A, 4B and 4C.

978  
979 **5A.5 ADMINISTRATIVE CRISIS SERVICES, CASE MANAGEMENT, SERVICE**  
980 **COORDINATION and INTENSIVE CLINICAL MANAGEMENT**

981 Certain administrative services are necessary to provide Iowa Plan Eligible Persons with  
982 immediate access to appropriate treatment and to assure integration in the planning and delivery  
983 of all services they need. The Contractor must ensure continuation of the project where the  
984 Iowa Plan Contractor collaborates with the IME on a care management program for Members  
985 identified by IME that need referral to the Iowa Plan for mental health services. Conversely,  
986 Enrollees in the Iowa Plan are identified for IME for medical needs that are affecting behavioral  
987 health services.

988 **5A.5.1 Administrative Crisis Services**

989 The Contractor shall provide:

- 990 • 24-hours-a-day, seven-days-a-week, administrative crisis services including a toll-free  
991 telephone number hot line which offers crisis counseling and referral services;
- 992 • the staff providing this service must be practitioners licensed in the State of Iowa with special  
993 training in crisis management and triage for all services covered by the Plan, and
- 994 • translator services and a TTY number must be available at all times.

995 **5A.5.2 Case Management**

996 The Contractor shall provide:

- 997 • coordination and collaboration with IME where IME identifies Enrollees in need of mental  
998 health and substance abuse services and refers them to the Contractor, and the Contractor  
999 refers Enrollees with medical needs to IME for care;
- 1000 • treatment planning conducted jointly with Eligible Persons, providers, caseworkers (TCMs,  
1001 DHS or JCO workers, Corrections), and others important to those Eligible Persons who are  
1002 accessing multiple services concurrently or consecutively; joint treatment planning may result  
1003 in an integrated plan for funding and delivering services when representatives of other  
1004 delivery systems, in addition to the Contractor, commit financial resources to fund a plan  
1005 which includes highly individualized services;
- 1006 • discharge planning with Iowa Plan Enrollees and their service providers even if the  
1007 Enrollee's care is not being reimbursed by the Contractor (for example, an inpatient stay has  
1008 been non-authorized, but discharge planning and coordination is required to assure  
1009 appropriate outpatient follow-up for the Iowa Plan Enrollee), and

- 1010 • a requirement that all network providers participate in family team meetings and other team  
1011 meetings in cases involving children in the CW/JJ system.

1012 **5A.5.3 Service Coordination**

1013 The Contractor shall provide:

- 1014 • focused coordination for the treatment programs of those who are considered high risk or  
1015 high utilizers; this requirement mandates the Contractor to identify people with high needs  
1016 and to initiate ongoing treatment planning and service coordination with the Eligible Person  
1017 and others working with the Eligible Person;
- 1018 • for Enrollees determined to need a course of treatment or regular care monitoring, a  
1019 mechanism to allow Enrollees to directly access a network specialist for covered services as  
1020 appropriate for the Enrollee's condition and identified needs;
- 1021 • information required by courts in coordination with officers and staff of the criminal/judicial  
1022 system and/or DHS/JCS workers;
- 1023 • within applicable laws of confidentiality, notification of the authorization or non-  
1024 authorization of services to the DHS/JCS worker if one is working with the Enrollee;
- 1025 • a requirement that all network providers request a release of information or authorization to  
1026 disclose from each Iowa Plan Enrollee to allow the network provider to coordinate treatment  
1027 with the Enrollee's primary care physician; and that network providers, having received such  
1028 a release or authorization, provide timely notification to primary care physicians of the  
1029 Enrollee's treatment throughout the time the Enrollee receives mental health or substance  
1030 abuse treatment from the network provider; special emphasis shall be placed on notifying the  
1031 Enrollee's primary care physician of the initiation of, or change in, psychotropic medication;
- 1032 • Medicaid primary care case manager physician notification of an Enrollee's admission for  
1033 inpatient services;
- 1034 • identification of Enrollee special health care needs to appropriate providers, and
- 1035 • assurance that in the process of care coordination each Eligible Person's privacy is protected  
1036 consistent with the confidentiality requirements in 45 CFR parts 160 and 164.

1037 **5A.5.4 Intensive Clinical Management (Enrollees only)**

1038 The Contractor shall implement an Intensive Clinical Management (ICM) program to provide  
1039 support to Enrollees who are identified by the Contractor as being of the highest risk. Through  
1040 the ICM program, the Contractor shall be responsible, in addition to the case management and  
1041 service coordination services described in Section 5A.5.2 and 5A.5.3, for the following:

- 1042 • all case management functions, including but not limited to, coordinating and authorizing  
1043 behavioral health services, establishing a home visit schedule, and providing face-to-face  
1044 contacts with community-based providers;
- 1045 • promoting treatment modalities and other support services that maintain the Enrollee's  
1046 optimal level of functioning and that promote the Enrollee's recovery, rehabilitation and  
1047 resiliency;
- 1048 • behavioral health services concurrent review and service coordination across co-occurring  
1049 diagnoses and other state agencies and entities, and arranging behavioral health consultations  
1050 when indicated;

- 1051 • coordinating with DHS medical case management staff for MediPass members who are also  
1052 receiving medical case management services, and
- 1053 • monitoring the Enrollee's clinical condition, and making timely treatment plan modifications  
1054 and other strategic interventions to avoid clinical regression and to minimize the effects of  
1055 social circumstances at home, school or work that might otherwise have an adverse effect on  
1056 an Enrollee's clinical condition.

1057

1058 **5A.6 SPECIAL SERVICE CONSIDERATIONS (Enrollees Only)**

1059

1060 **5A.6.1 Ensuring Safety through Adequate Discharge Planning for Youth**

1061 The Contractor shall implement policies to ensure that no Iowa Plan Enrollee under age 18 who  
1062 has been receiving Iowa Plan-funded services in a 24-hour treatment setting is discharged from  
1063 that setting until a discharge plan has been developed which provides appropriate follow-up care  
1064 and treatment which is available and accessible to that eligible. A safe and appropriate living  
1065 arrangement must be an integral part of that discharge plan. The discharge plan must be  
1066 implemented at the point of discharge from the 24-hour treatment setting.

1067 The Contractor shall initiate and enforce policies which require providers to initiate discharge  
1068 planning at the point of admission to a 24-hour treatment setting and to identify as early as  
1069 possible the need for involvement of the courts, DHS or other agencies, in addition to the child's  
1070 family where appropriate. The Contractor and all appropriate agencies are mandated to work  
1071 together to facilitate all arrangements necessary to allow for the Enrollee's discharge or transfer  
1072 to the least restrictive appropriate setting when indicated by his or her clinical condition.

1073 When 24-hour services provided through the Iowa Plan are being non-authorized and the  
1074 Contractor is not required to pay for services at the 24-hour level of care because the services do  
1075 not meet the criteria of psychosocial necessity or service necessity, the Contractor is required  
1076 (pursuant to DHS' Keep Kids Safe policy, and consistent with 441 IAC Ch 88.67 (8)) to  
1077 authorize up to 14 calendar days of additional funding on an administrative basis for eligibles  
1078 under the age of 18 if a safe and appropriate living arrangement is not available because:

1079

- 1080 1) a court order is in effect that must be modified to allow the placement of the child into  
1081 that living arrangement;
- 1082 2) a court order is required to allow placement of the child into the appropriate living  
1083 arrangement;
- 1084 3) a bed is not available in the level of care which has been determined as clinically  
1085 appropriate for the child, or
- 1086 4) services and supports must be arranged to assist the natural family, foster family, or other  
1087 living arrangement to become ready to assist the Enrollee after the Enrollee's return to  
1088 that environment.

1089

1090 It is the strong desire of the Departments to avert discharges from 24-hour settings to shelters and  
1091 to ensure the inclusion of an appropriate living situation as an integral part of all discharge  
1092 planning from 24-hour treatment settings. Therefore, the Departments will monitor all discharges  
1093 of Iowa Plan Enrollees age 17 or younger who are discharged to a shelter or those with no  
1094 discharge destination indicated in a discharge plan from a 24-hour setting funded by the  
1095 Contractor.

1096 The Contractor will submit monthly a listing of those children for whom shelter was the  
1097 discharge destination and those for whom there was no indicated discharge destination, a  
1098 summary of the reasons shelter was selected as the discharge destination or for the lack of  
1099 discharge destination, and the names of those who agreed on behalf of the child to the shelter  
1100 placement or discharge without designated destination.

1101 The Contractor shall be involved in and support the discharge planning of any Iowa Plan Enrollee  
1102 who is receiving 24-hour care, whether or not that care is being funded in whole, or in part, by the  
1103 Iowa Plan. The Contractor shall work with the Enrollee, the Enrollee's family as appropriate, and  
1104 others who are working with the Enrollee, in authorizing mental health and/or substance abuse  
1105 services that will continue the recovery process begun in the 24-hour treatment setting.

1106 The Contractor shall maintain records to allow verification of compliance with these  
1107 requirements.

1108 **5A.6.2 Ensuring Safety through Adequate Discharge Planning for Adults**

1109 The Contractor shall implement policies to ensure that no Iowa Plan Enrollee age 18 or older who  
1110 has been receiving Iowa Plan-funded services in a 24-hour treatment setting is discharged from  
1111 that setting until a discharge plan has been developed which provides appropriate mental health  
1112 and/or substance abuse follow-up care and treatment which is available and accessible to that  
1113 Enrollee. If an Enrollee leaves against medical advice, the Contractor and provider will not be  
1114 held responsible for this requirement. The Contractor shall work with the Enrollee, the Enrollee's  
1115 family as appropriate, and others who are working with the Enrollee, in authorizing mental health  
1116 and/or substance abuse services that will continue the recovery process begun in the 24-hour  
1117 treatment setting.

1118 The Contractor shall be involved in and support the discharge planning of any Iowa Plan Enrollee  
1119 who is receiving 24-hour care, whether or not that care is being funded in whole, or in part, by the  
1120 Iowa Plan.

1121 It is the desire of the Departments to avert discharges from 24-hour settings to shelters and to  
1122 ensure the inclusion of an appropriate living situation as an integral part of all discharge planning  
1123 from 24-hour treatment settings. Therefore the Departments will monitor all discharges of Iowa  
1124 Plan Enrollee age 18 or older who are discharged to a shelter or with no designated discharge  
1125 destination. The Contractor will submit monthly a listing of those Enrollees for whom a shelter  
1126 was the discharge destination and a summary of the reasons shelter was selected as the discharge  
1127 destination and a list of those for whom there was no designated discharge designation.

1128 The Contractor shall maintain records to allow verification of compliance with this requirement.

1129 **5A.6.3 Always Offer an Alternative**

1130 The Contractor shall always offer services appropriate to the presenting mental health and/or  
1131 substance abuse needs of an Iowa Plan Enrollee. If services requested by or on behalf of an  
1132 Enrollee do not meet the Contractor's Utilization Management Guidelines, the Contractor shall  
1133 offer an alternative that is appropriate based on those Guidelines. Alternatives offered shall be  
1134 available to the Enrollee within the accessibility guidelines set forth in this RFP (Sections 4A and  
1135 4B).

1136 If a provider chooses to provide services to an Iowa Plan Enrollee at a higher level than offered  
1137 by the Contractor, the provider shall have the right to be reimbursed at the level of care which  
1138 was offered by the Contractor if that provider is appropriately licensed and has a contract with the  
1139 Contractor for the alternative which was offered.

1140 **5A.6.4 Avoidance of Cost Shifting and Duplicate Billings, and Separation of Fee-For-**  
1141 **Service Benefits**

1142  
1143 To avoid cost shifting, duplicate billings between Medicaid programs, and to ensure separation of  
1144 certain fee-for-service benefits from Iowa Plan covered services, the Contractor may require prior  
1145 authorization for all or any levels of substance abuse or mental health services that are provided  
1146 by providers who also provide remedial and habilitation services. The decision to prior authorize  
1147 services will be based on changes in past utilization patterns, quality improvement clinical  
1148 reviews where duplicate services are uncovered, or as part of a provider corrective action plan.

1149  
1150 DHS will serve as an arbiter when service responsibility is questioned by a Managed Care  
1151 Organization under IME and/or the Iowa Plan.  
1152

1152

1153

1154

1155

1156

1157

1158

**SECTION 5B**  
**GRIEVANCE SYSTEM AND**  
**COMPLAINT PROCESS**

1159

**5B.1 GRIEVANCE SYSTEM (Enrollees only)**

1160

The grievance system is defined to include a grievance process, an appeal process, and access to the State's fair hearing system for Iowa Plan Enrollees. See Section 10 for definitions of a grievance and of an appeal.

1161

1162

1163

The Contractor shall establish a grievance system that meets the following requirements:

1164

1165

5B.1.1 provides Enrollees reasonable assistance in completing forms and other procedural steps not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability;

1166

1167

1168

1169

5B.1.2 acknowledges receipt of each grievance and appeal;

1170

1171

5B.1.3 ensures that decision makers on grievances and appeals were not involved in previous levels of review or decision-making and who are health care professionals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply:

1172

1173

1174

1175

- a denial appeal based on lack of medical necessity;
- a grievance regarding denial of expedited resolutions of an appeal, or
- any grievance or appeal involving clinical issues;

1176

1177

1178

1179

5B.1.4 provides the following grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time they enter into a contract:

1180

1181

- the Enrollee's right to a state fair hearing after one level of appeal, how to obtain a hearing, and right to representation at a hearing;
- the Enrollee's right to file grievances and appeals and their requirements and timeframes for filing;
- the availability of assistance in filing;
- the toll-free numbers to file oral grievances and appeals;
- the Enrollee's right to request continuation of benefits (as defined in 42 C.F.R. § 438.420(b)(1)) during an appeal or state fair hearing; if DHS's action in a state fair hearing is upheld, the Enrollee may be liable for the cost of any continued benefits;

1182

1183

1184

1185

1186

1187

1188

1189

1190

- 1191 • any state-determined provider appeal rights to challenge the failure of the  
1192 organization to cover a service, and  
1193

1194 5B.1.5 maintains records of grievances and appeals, including tracking grievances and appeals  
1195 from receipt to resolution.  
1196

1197 **5B.2 APPEALS PROCESS (Enrollees only)**  
1198

1199 The appeal process will incorporate the following provisions:  
1200

1201 5B.2.1 an Enrollee may file an appeal with the Contractor. A provider, acting on behalf of the  
1202 Enrollee, may file the appeal;  
1203

1204 5B.2.2 the Enrollee or provider may file an appeal within a reasonable timeframe not to exceed  
1205 30 days from the date on the notice of action;  
1206

1207 5B.2.3 the Enrollee or provider may file an appeal either orally or in writing; however, an oral  
1208 request to appeal must be followed by a written, signed, appeal;  
1209

1210 5B.2.4 the Contractor shall ensure that oral inquiries seeking to appeal an action are treated as  
1211 appeals and confirm those inquiries in writing upon receipt of the written, signed appeal,  
1212 unless the Enrollee or the provider requests expedited resolution;  
1213

1214 5B.2.5 the Contractor shall provide a reasonable opportunity to present evidence, and allegations  
1215 of fact or law, in person as well as in writing;  
1216

1217 5B.2.6 the Contractor shall allow the Enrollee and the Enrollee's representative the opportunity,  
1218 before and during the appeal process, to examine the Enrollee's case file, including  
1219 medical records, and any other documents and records;  
1220

1221 5B.2.7 the Contractor shall consider the Enrollee's representative, or an estate representative of a  
1222 deceased Enrollee as parties to the appeal;  
1223

1224 5B.2.8 the Contractor shall resolve 95% of appeals and provide notice, as expeditiously as the  
1225 Enrollee's health condition requires within 14 calendar days from the date the Contractor  
1226 receives the written appeal, and 100% must be resolved within 45 calendar days;  
1227

1228 5B.2.9 the Contractor may extend the initial timeframe by up to 14 calendar days:  
1229

1230 5B.2.9.1 if the Enrollee requests the extension;

1231 5B.2.9.2 with approval by DHS, when the Contractor shows that there is need for  
1232 additional information and how the delay is in the Enrollee's interest. The  
1233 Contractor must notify the Enrollee of the reason for the extension, and  
1234

1235 5B.2.10 an Enrollee may seek a state fair hearing if the Enrollee is not satisfied with the  
1236 Contractor's decision in response to a first appeal.  
1237

1238 Notification of Disposition  
1239

- 1240 5B.2.11 The Contractor must provide written notice of disposition. The written resolution notice  
1241 must include:  
1242  
1243 a) the results and date of the appeal resolution;  
1244 b) for decisions not wholly in the Enrollee's favor:  
1245 i) the right to request a state fair hearing;  
1246 ii) how to request a state fair hearing;  
1247 iii) the right to continue to receive benefits (pursuant to 42 CFR 438.420)  
1248 pending a hearing;  
1249 iv) how to request the continuation of benefits;  
1250 v) notice that if the Department's action is upheld in a hearing, the Enrollee  
1251 may be liable for the cost of any continued benefits;  
1252 vi) the relevant citation from the Iowa Administrative code, which supports the  
1253 decision;  
1254 vii) that in the state fair hearing:  
1255 o the Enrollee may represent him(her)self or use legal counsel, a  
1256 relative, a friend, or a spokesperson;  
1257 o the specific regulations that support, or the change in federal or state  
1258 law that requires, the action, and  
1259 o an explanation of the individual's right to request an evidentiary  
1260 hearing if one is available or a state agency hearing, or in cases of an  
1261 action based on change in law, the circumstances under which a  
1262 hearing will be granted.

1263  
1264 Benefits During An Appeal and State Fair Hearing

- 1265 5B.2.12 The Contractor must continue the Enrollee's benefits if all of the following criteria  
1266 are met:  
1267  
1268 a) the appeal is filed timely, meaning on or before the later of the following:  
1269  
1270 i) within 10 days of the Contractor mailing the notice of action;  
1271 ii) the intended effective date of the Contractor's proposed action;  
1272  
1273 b) the appeal involves the termination, suspension, or reduction of a previously  
1274 authorized course of treatment;  
1275  
1276 c) the services were ordered by an authorized provider;  
1277  
1278 d) the authorization period has not expired, and  
1279 e) the Enrollee requests extension of benefits.  
1280 5B.2.13 If the authorization period has expired or the authorized units of service are  
exhausted Enrollees or their designee may request an extension of services.

- 1281                    However, such extensions are considered a new request for services and the  
1282                    Contractor is not obligated to continue services if such new request is denied.  
1283
- 1284    5B.2.14        If the Contractor continues or reinstates the Enrollee’s benefits while the appeal is  
1285                    pending, the benefits must be continued until one of following occurs:  
1286  
1287                    i) the Enrollee withdraws the appeal;  
1288                    ii) the Enrollee does not request a fair hearing within 10 days from when the  
1289                    Contractor mails an adverse decision;  
1290                    iii) a state fair hearing decision adverse to the Enrollee is made, or  
1291                    iv) the authorization expires or authorization service limits are met.  
1292
- 1293    5B.2.15        The Contractor may recover the cost of the continuation of services furnished to the  
1294                    Enrollee while the appeal was pending if the final resolution of the appeal upholds  
1295                    the Contractor’s action.  
1296
- 1297    5B.2.16        The Contractor must authorize or facilitate the provision of the disputed services  
1298                    promptly, and as expeditiously as the Enrollee’s health condition requires if the  
1299                    services were not furnished while the appeal was pending and the Contractor or the  
1300                    state fair hearing officer reverses a decision to deny, limit, or delay services.  
1301
- 1302    5B.2.17        The Contractor must pay for disputed services, in accordance with state policy and  
1303                    regulations, if the Contractor or the state fair hearing officer reverses a decision to  
1304                    deny authorization of services, and the Enrollee received the disputed services while  
1305                    the appeal was pending.  
1306
- 1307    Expedited Appeals  
1308
- 1309    5B.2.18        The Contractor is required to follow all standard appeal requirements for expedited  
1310                    requests except where differences are specifically noted in the requirements for  
1311                    expedited resolution.  
1312
- 1313    5B.2.19        The Contractor must establish and maintain an expedited review process for appeals,  
1314                    when the Contractor determines (for a request from the Enrollee) or the provider  
1315                    indicates (in making the request on the Enrollee’s behalf or supporting the Enrollee’s  
1316                    request) that taking the time for a standard resolution could seriously jeopardize the  
1317                    Enrollee’s life or health or ability to attain, maintain, or regain maximum function.  
1318
- 1319    5B.2.20        The Enrollee or provider may file an expedited appeal either orally or writing. No  
1320                    additional Enrollee follow-up is required.  
1321
- 1322    5B.2.21        The Contractor must inform the Enrollee of the limited time available for the  
1323                    Enrollee to present evidence and allegations of fact or law, in person and in writing,  
1324                    in the case of expedited resolution.  
1325
- 1326    5B.2.22        The Contractor must resolve each expedited appeal and provide notice, as  
1327                    expeditiously as the Enrollee’s health condition requires, within 3 working days after  
1328                    the Contractor receives the appeal.  
1329

- 1330 5B.2.23 The Contractor may extend the timeframes by up to 14 calendar days if the Enrollee  
1331 requests the extension.  
1332
- 1333 5B.2.24 The Contractor may extend the timeframes by up to 14 calendar days, with approval  
1334 by DHS, when the Contractor shows that there is need for additional information and  
1335 how the delay is in the Enrollee’s interest. The Contractor will notify the Enrollee of  
1336 the reason for the extension.  
1337
- 1338 5B.2.25 In addition to written notice, the Contractor must also make reasonable efforts to  
1339 provide oral notice.  
1340
- 1341 5B.2.26 The Contractor must ensure that punitive action is not taken against a provider who  
1342 either requests an expedited resolution or supports an Enrollee’s appeal.  
1343
- 1344 5B.2.27 If the Contractor denies a request for expedited resolution of an appeal, it must—  
1345  
1346 i) transfer the appeal to the standard timeframe for an appeal, and  
1347 ii) make reasonable efforts to give the Enrollee prompt oral notice of the denial and  
1348 give a written notice within 2 calendar days.  
1349

1350 Note: This decision (i.e., the denial of a request for expedited resolution of an appeal) does not  
1351 constitute an action or require a notice of adverse action. The Enrollee may file a grievance in  
1352 response to this decision.  
1353

1354 Access to State Fair Hearing  
1355

- 1356 5B.2.28 Enrollees or their designee will have the right to appeal any action as defined above  
1357 to DHS under the provisions of the 441 Iowa Administrative Code Chapter 7. The  
1358 Enrollee or provider should exhaust the first level of the Contractor’s internal appeals  
1359 process prior to appealing to DHS. The appeal rights under 441 IAC Chapter 7 apply  
1360 to decisions not to grant prior authorization as well as decisions to discontinue  
1361 services that have received prior authorization.  
1362
- 1363 5B.2.29 The determination of whether to seek review of a proposed decision by an  
1364 Administrative Law Judge shall be made at the discretion of DHS and any final  
1365 decision is binding upon the Contractor.  
1366
- 1367 5B.2.30 DHS is a party to the state fair hearing and shall be represented by the Contractor.  
1368 The Enrollee or the Enrollee’s estate is also a party and may be represented.  
1369

1370 **5B.3 GRIEVANCE PROCESS (Enrollees only)**  
1371

1372 The grievance process shall ensure the following:  
1373

- 1374 5B.3.1 Enrollees or their designee may file a grievance either orally or in writing;  
1375
- 1376 5B.3.2 the Contractor may require others who are not Enrollees or their designees to initiate  
1377 the process with a written request;  
1378

1379 5B.3.3 the Contractor must dispose of each grievance and provide notice, as expeditiously as  
1380 the Enrollee's health condition requires and within the state timeframes which are:  
1381 95% of all grievances shall be resolved within 14 days of receipt of all required  
1382 documentation and 100% shall be resolved within 90 days of the receipt of all  
1383 required documentation, and  
1384

1385 5B.3.4 that the grievance decision is the final step in the Grievance Process and all grievance  
1386 decisions are in writing.  
1387

1388 **5B.4 COMPLAINT PROCESS (IDPH Participants)**

1389 The Contractor shall work with IDPH to develop a system to provide IDPH Participants with a  
1390 mechanism to file a formal complaint with the Contractor. Such complaint system must be  
1391 operational by the contract implementation date.

1392

1393

1394

1395

1396

1397

**SECTION 5C**  
**PROVIDER NETWORK**

1398

**5C.1 PROVIDER NETWORK DEVELOPMENT AND COMPOSITION**

1399

The Contractor shall establish two provider networks, one for Iowa Plan Enrollees and one for IDPH Participants. In establishing the provider networks, the Contractor must meet the following requirements.

1400

1401

1402

1403

5C.1.1 The Contractor must maintain a network of appropriate providers that is sufficient to provide adequate access (pursuant to access requirements established in 441 IAC 88.67(4)), for Enrollees and IDPH Participants to Iowa Plan services including specialty services covered under the contract.

1404

1405

1406

1407

1408

5C.1.2 Maintain or, as appropriate, renew prior to the contract implementation date, provider contracts with all providers in the previous Iowa Plan contract's network. (Note: Bidders are not required to have a fully contracted panel at the time of proposal submission; however, the Bidder's response shall detail how it will ensure a fully contracted panel by the contract implementation date.)

1409

1410

1411

1412

1413

1414

5C.1.3 The Departments must approve all standard contract provisions required of network providers prior to offering contract terms to the provider network.

1415

1416

1417

5C.1.4 The Contractor shall follow an open panel approach to provider recruitment for services to Enrollees; that is, the Contractor will contract with all providers of mental health and substance abuse services who are appropriately licensed, certified or accredited, who meet the credentialing criteria, who agree to the standard contract provisions and who wish to participate.

1418

1419

1420

1421

1422

For services to IDPH Participants, the Contractor shall competitively procure a network in accordance with 401 IAC, chapter 12.

1423

1424

1425

1426

5C.1.5 The Contractor may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

1427

1428

1429

1430

5C.1.6 If the Contractor declines written requests of providers to be included in its services to Enrollees network, the Contractor must give the affected providers written notice of the reason for its decision.

1431

1432

1433 5C.1.7 The Contractor must establish and implement written policies for the selection and  
1434 retention of providers of Enrollee services that include the following, as specified in 42  
1435 CFR 438.214:

- 1436 • a documented process for credentialing and recredentialing of provider;
- 1437 • selection policies and procedures that may not discriminate against particular
- 1438 providers that serve high-risk populations or specialize in conditions that
- 1439 require costly treatment, and
- 1440 • a policy stating that the Contractor may not employ or contract with
- 1441 providers excluded from participation in federal health care programs under
- 1442 section 1128 or 1128A of the Social Security Act, based on notification by
- 1443 DHS.
- 1444

1445 5C.1.8 The Contractor shall utilize credentialing criteria approved by the Departments and  
1446 ensure that all providers of Enrollee services meet the criteria, the basic components of  
1447 which shall include the following:

- 1448 • licensing, accreditation, certification, training, specialty board eligibility or
- 1449 certification;
- 1450 • current status of professional license, restrictions, and history of any loss of
- 1451 licensure in any state;
- 1452 • DEA number and copy of certification, where applicable;
- 1453 • hospital privileges, name of hospitals, and scope of privileges, where
- 1454 applicable;
- 1455 • malpractice insurance, carrier name, amount of coverage, copy of the face
- 1456 sheet, and scope of coverage;
- 1457 • malpractice history, pending claims, and successful claims against the
- 1458 provider;
- 1459 • record of continuing professional education;
- 1460 • Medicare, Medicaid, and federal tax identification numbers;
- 1461 • location, service area and telephone numbers of all offices, hours of
- 1462 operation, and provisions for emergency care and back-up;
- 1463 • areas of special experience, skills and training;
- 1464 • physical accessibility for persons with disabilities, and
- 1465 • review of satisfaction survey data, quality assessment data, provider profile
- 1466 data, and of any complaints made or grievances filed against the provider
- 1467 within at least the past two years (re-credentialing only).
- 1468

1469 The IDPH Participant network shall utilize licensing under Code of Iowa Chapter 125  
1470 as the sole credentialing criteria.

1471 5C.1.9 The Contractor shall ensure that providers are recredentialed at least every three years.  
1472  
1473

- 1474 5C.1.10 In the case where the Contractor's corporate rules would require more strict  
1475 credentialing than the Iowa Code, the Contractor must allow professionals to provide  
1476 services consistent with what may provided under the Iowa Code.  
1477
- 1478 5C.1.11 The Contractor has the option to propose to DHS for approval, other provider  
1479 categories for network membership, which are not licensed, certified or accredited  
1480 providers of mental health treatment. In proposing such alternative or step-down  
1481 services, the Contractor must clearly demonstrate the provision of a level of mental  
1482 health treatment appropriate to the needs of Enrollees who the Contractor proposes to  
1483 serve with such services.  
1484
- 1485 5C.1.12 The Contractor shall provide assurance that any health care facilities utilized are  
1486 licensed by the appropriate state agency where the facilities are located. These  
1487 facilities shall be accredited by the Joint Commission on Accreditation of Hospitals or  
1488 the American Osteopathic Association; or they shall be certified as a provider for  
1489 Medicare or Medicaid; or as otherwise accredited or licensed in accordance with state  
1490 or federal law.
- 1491 5C.1.13 The Contractor shall only contract, either directly or through sub-contracts, for the  
1492 provision of Targeted Case Management with the provider designated by the county  
1493 board of supervisors.
- 1494 5C.1.14 The Contractor will ensure access to treatment services for all cultural, ethnic, and  
1495 gender groups.
- 1496 5C.1.15 The Contractor will ensure access to and coordination of mental health and substance  
1497 abuse treatment services that accommodate Eligible Persons with special needs and  
1498 complex issues.
- 1499 The Contractor shall provide the services of interpreters or others with special training  
1500 as necessary to comply with this requirement.
- 1501 5C.1.16 If Contractor's provider network is unable to provide medically necessary services  
1502 covered under the contract to a particular Enrollee, the Contractor must adequately and  
1503 timely cover these services out of network for the Enrollee, for as long as the  
1504 Contractor is unable to provide them within its network. The Contractor must negotiate  
1505 and execute written arrangements with non-network providers, when necessary, to  
1506 ensure access to covered services. Out-of-network providers must coordinate with the  
1507 Contractor with respect to payment. The Contractor will ensure that no provider bills  
1508 an Enrollee for all or any part of the cost of an Iowa Plan service.  
1509
- 1510 The Contractor must cover out of network services for a transition period of up to 30-  
1511 days for new Enrollees to transition to network providers, provided the out of network  
1512 provider agrees to payment at network rates. The Contractor will assist in the transition  
1513 to a network provider.  
1514
- 1515 5C.1.17 During the term of the contract the Contractor shall propose for the Departments'  
1516 review and approval special new Iowa Plan covered services and programs for Eligible  
1517 Persons for which the Contractor may need to adapt its provider network.  
1518
- 1519 5C.1.18 The Contractor shall perform a cost-benefit analysis for any new service it proposes to  
1520 develop, as directed by the Departments, including whether the proposed service would  
1521 have an impact on the Medicaid capitation rates or on the IDPH payments.

- 1522 5C.1.19 The Contractor shall implement those new special services and programs approved by  
1523 the Departments.
- 1524 5C.1.20 **Self-Help and Community Service Initiatives**
- 1525 The Contractor shall work in collaboration with recognized self-help and peer support  
1526 leaders to:
- 1527 a) create and support programs that assist Eligible Persons in accessing non-  
1528 Medicaid community services and supports including, for example, appropriate  
1529 self-help and consumer-run services in their area;
- 1530 b) facilitate and maintain self-help and peer support groups and related activities,  
1531 and
- 1532 c) provide peer-education and peer-support services for Eligible Persons through  
1533 recognized self-help and peer-support leaders.
- 1534 5C.1.21 **Special Provisions for Individuals with Multiple Issues and Complex Needs**  
1535
- 1536 The Contractor shall:
- 1537
- 1538 a) provide a continuum of Iowa Plan covered services that meet the needs of  
1539 Eligible Persons with multiple issues and complex needs;
- 1540 b) ensure that providers who deliver Iowa Plan covered services to Eligible  
1541 Persons with multiple issues and complex needs have training, experience and  
1542 education in treating individuals with such clinical presentation;
- 1543 c) require providers to ensure that Eligible Persons with multiple issues and  
1544 complex needs have treatment plans through which they receive simultaneous  
1545 and coordinated care for all issues and needs, and
- 1546 d) require providers to coordinate with other providers outside of the behavioral  
1547 health domain where an Eligible Person's multiple issues and complex needs  
1548 are outside the behavioral health domain.
- 1549 5C.1.22 The Contractor must document to the Departments how the networks meet the  
1550 requirements (as defined in Section 4A and 4B) for:
- 1551 a) appropriate range of services for the population served;
- 1552 b) adequate capacity, and
- 1553 c) adequate geographic distribution.  
1554
- 1555 5C.1.23 The Contractor must document adequate capacity when:
- 1556 a) at any time there is a significant change (as defined by the State) in the  
1557 Contractor's operation that would affect adequate capacity and services;
- 1558 b) if there are changes in services, benefits, geographic service areas, or
- 1559 c) if a new population is enrolled in the Iowa Plan.

1560

1561 5C.1.24 In accordance with 42 CFR 438.12 (a), this section may not be construed to:

- 1562 a) require the Contractor to contract with providers beyond the number necessary  
1563 to meet the needs of Eligible Persons;
- 1564 b) preclude the Contractor from using different reimbursement amounts for  
1565 different specialties or for different practitioners in the same specialty, or
- 1566 c) preclude the Contractor from establishing measures that are designed to  
1567 maintain quality of services and control costs and are consistent with its  
1568 responsibilities to Eligible Persons.

1569

1570 **5C.2 PROVIDER REIMBURSEMENT**

1571

1572 5C.2.1 The Contractor shall ensure that all provider contracts include provisions:

1573

- 1574 • requiring providers to accept as payment in full the Contractor's payment for  
1575 covered, required and optional services provided to Enrollees, and
- 1576 • prohibiting providers from charging Enrollees in full or in part for any service  
1577 provided under the contract or imposing any financial penalties on them, including  
1578 charges for canceling or missing appointments, unless otherwise explicitly approved  
1579 by the Departments.

1580

1581 5C.2.2 The Contractor shall enter into no arrangements which include sub-capitation, case rate,  
1582 or other risk-sharing financial arrangements unless the Contractor:

- 1583 • submits the proposed payment methodology to the Departments for review and  
1584 obtains approval. Any provider payment methodology proposal that the Contractor  
1585 presents to the Departments must satisfy the following minimum requirements. It  
1586 must:
- 1587 • balance cost incentives with access and quality incentives;
- 1588 • ensure that those providers for whom the Contractor proposes to use such  
1589 payment methodologies are able to demonstrate the managerial, operational  
1590 and financial capability to manage the proposed risk arrangement, and
- 1591 • demonstrate through provider profiling that the provider(s) with whom those  
1592 arrangements are being considered have met the Contractor's standards for  
1593 the delivery of quality mental health and substance abuse services. In  
1594 determining the quality of services, the Contractor may consider services  
1595 delivered and quality assessment reviews of the previous contract period.
- 1596
- 1597 • obtains approval from the Departments prior to finalization. Regardless of any sub-  
1598 contractual arrangements, the Contractor shall remain solely responsible for  
1599 compliance with the terms of the contract.

1600

1601 5C.2.3 The Departments reserve the right to set payment methodologies or minimum  
1602 reimbursement rates for certain provider categories. For the purposes of this RFP, the  
1603 Departments establish the following requirements:

- 1604 • psychiatrists shall be reimbursed for services to Iowa Plan Enrollees at the Medicaid  
1605 fee schedule;

- 1606 • Community Mental Health Center services shall be reimbursed for services to Iowa  
1607 Plan Enrollees at cost, as defined by DHS, and
- 1608 • inpatient hospital services to Enrollees shall be reimbursed at cost, as defined by  
1609 DHS.
- 1610 • in conformity with the Deficit Reduction Act of 2005, Pub. L. No. 109-171 S. 6085,  
1611 120 Stat.121 (2006), any provider of emergency services that does not have in effect  
1612 a contract with a Medicaid managed care entity that establishes payment amounts for  
1613 services furnished to a beneficiary enrolled in the entity's Medicaid managed care  
1614 plan, must accept as payment in full no more than the amounts (less any payments for  
1615 indirect costs of medical education and direct costs of graduate medical education)  
1616 that it could collect if the beneficiary received medical assistance under Title XIX  
1617 other than through enrollment in such an entity.

1618 5C.2.4 The Departments encourage the Contractor to develop a pay-for-performance incentive  
1619 program for certain providers within the Contractor's networks. All pay-for-performance  
1620 programs must receive the approval of the Departments prior to implementation.  
1621

### 1622 **5C.3 RELATIONSHIP BETWEEN CONTRACTOR AND NETWORK PROVIDERS**

1623 Any Contractor that engages or proposes to engage in a relationship(s) with any other parties that  
1624 have any legal, financial, contractual or related party interests with a provider or group of  
1625 providers to be reimbursed through the Iowa Plan must demonstrate both (1) an organizational  
1626 structure and (2) policies and procedures which would prevent the opportunity for, or an actual  
1627 practice which allows, a situation in which the Contractor gains any financial benefit from any  
1628 policy or practice related to network recruitment, referral, reimbursement, service authorization,  
1629 monitoring and oversight, or any other practice which might bring financial gain.  
1630

1631 Situations which might indicate an attempt to assure financial gain include, but are not limited to:  
1632

- 1633 a) a change of the distribution of referrals or reimbursement among providers within a  
1634 level of care;
- 1635 b) referral by the Contractor to only those providers with whom the Contractor shares  
1636 an organizational relationship;
- 1637 c) preferential financial arrangements by the Contractor with those providers with  
1638 whom the Contractor shares an organizational relationship;
- 1639 d) different requirements for credentialing, privileging, profiling or other network  
1640 management strategies for those providers with whom the Contractor shares an  
1641 organizational relationship;
- 1642 e) distribution of community reinvestment moneys in a way which gives preference to  
1643 providers with whom the Contractor shares an organizational relationship, and
- 1644 f) substantiated complaints by Eligible Persons of limitations on their access to  
1645 participating providers of their choice within an approved level of care.  
1646

1647 Should the Contractor have an organizational relationship with a direct service provider(s), and  
1648 should preferential treatment be determined by the Departments at any time during the contract  
1649 period, the Departments reserve the right to sanction the Contractor including, but not limited to:  
1650

- 1651 a) requiring an independent audit to be done at the expense of the Contractor;

- 1652           b) paying any costs incurred by the Departments to eliminate the preferential treatment,  
1653           including costs associated with any legal or equitable remedy;
- 1654           c) imposing limits on the amount of reimbursement allowable to the direct service  
1655           providers represented by the organizational relationship, and
- 1656           d) removing the direct service provider(s) from the network by terminating the contract.  
1657

1658       **5C.4 PROHIBITION ON RESTRICTIONS ON PROVIDER-ELIGIBLE PERSON**  
1659       **COMMUNICATION**

1660       The Contractor may not prohibit, or otherwise restrict, a health care professional acting within the  
1661       lawful scope of practice, from advising or advocating on behalf of an Eligible Person who is his  
1662       or her patient:

- 1663           a) for the Eligible Person’s health status, medical care, or treatment options, including  
1664           any alternative treatment that may be self-administered;
- 1665           b) for any information the Eligible Person needs in order to decide among all relevant  
1666           treatment options;
- 1667           c) for the Eligible Person’s risks, benefits, and consequences of treatment or non-  
1668           treatment, and
- 1669           d) for the Eligible Person’s right to participate in decisions regarding his or her health  
1670           care, including the right to refuse treatment, and to express preferences about future  
1671           treatment decisions.  
1672  
1673  
1674  
1675

1676       **5C.5 NETWORK MANAGEMENT**

1677       The Contractor shall conduct ongoing network management activities, with the greatest attention  
1678       paid to providers who serve comparatively large numbers of Iowa Plan Eligible Persons. The  
1679       activities shall include, but not be limited to:

- 1680       5C.5.1 developing, and submitting to the Departments for approval, an Iowa Plan provider  
1681       manual that:
- 1682           a. contains dated Contractor policy and procedure information, including, in part,  
1683           credentialing criteria, Utilization Management Guidelines and procedures, billing and  
1684           payment procedures, provider and Eligible Person grievance and complaint  
1685           processes, and network management requirements;
- 1686           b. is distributed to all network providers following approval of the Departments at least  
1687           30 days prior to the contract implementation date, and then to network and non-  
1688           network providers upon request thereafter;
- 1689           c. is updated regularly, and distributed in whole or in part to network providers at least  
1690           30 days in advance of any policy or procedure change;

- 1691       5C.5.2 developing a website for use by network providers to make available the provider  
1692       manual, for both network and out-of-network providers with information on Iowa Plan  
1693       rules, including Utilization Guidelines, best practices, and the ability to assist providers  
1694       with determining whether an individual is an Enrollee.

- 1695 5C.5.3 developing quarterly, provider-specific profile reports minimally for those high volume  
1696 mental health inpatient providers and outpatient providers who collectively represent  
1697 50% of the aggregate annual mental health inpatient admissions and outpatient visits,  
1698 respectively and for those substance abuse inpatient providers and outpatient providers  
1699 who collectively represent 50% of the aggregate annual substance abuse inpatient  
1700 admissions and outpatient visits, all Community Mental Health Centers, and all IDPH-  
1701 funded substance abuse providers;
- 1702 a. the reports shall include a multi-dimensional assessment of each provider's  
1703 performance using indicators for performance which address, at a minimum, clinical  
1704 quality, access, utilization management, application of the principles of rehabilitation  
1705 and recovery, pharmaceutical management, linkage with primary care physicians, and  
1706 clinical record keeping. The indicators selected must be clinically relevant,  
1707 quantitatively measurable, and appropriate to the Iowa Plan population;
- 1708 b. substance abuse provider profile reports shall draw upon the information generated  
1709 by retrospective monitoring performed in conformance with Section 5.D.1.2.o;
- 1710 c. the reports shall compare providers to benchmarks for each performance indicator,  
1711 such as Iowa Plan provider network averages, national standards such as NOMS, or  
1712 Contractor benchmarks from other states, as available;
- 1713 d. the Contractor shall submit the proposed profile report contents and formats to the  
1714 Departments for review and approval prior to implementing them;
- 1715 e. the Contractor shall transmit the profile reports to the measured providers quarterly,  
1716 and shall identify each provider's opportunities for improvement, physically meeting  
1717 with the highest volume providers ("highest volume" to be defined by the  
1718 Departments) at least twice a year to establish quantitative performance improvement  
1719 goals and track provider attainment of the goals. The goals shall be informed by the  
1720 practice profiles, as well as any other pertinent information in the possession of the  
1721 Contractor;
- 1722 f. the Contractor shall provide technical assistance to providers, as needed based on the  
1723 Contractor's assessment of a provider's performance or upon request of a provider.  
1724 Technical assistance will vary based on provider need, but will range from billing  
1725 issues to assistance with office procedures and service delivery to training sessions  
1726 for multiple providers with common opportunities for performance improvement;
- 1727 g. the Contractor shall take appropriate action with those providers whose performance  
1728 has failed to improve pursuant to the terms of the provider's improvement goals;
- 1729 h. the Contractor shall implement the profile reporting program within the first 12  
1730 months of the contract.
- 1731 5C.5.4 taking appropriate action with those providers whose performance has been determined  
1732 by the Contractor to be out of contractual compliance. Such action may include  
1733 suspending the provider's ability to expand services, suspending the provider's ability to  
1734 see new Iowa Plan patients, and contract termination;

- 1735 5C.5.5 instituting programs to recognize providers whose performance exceeds expectations;  
1736 determining the reasons for the successful performance of those providers and sharing  
1737 “best practice” methods or programs with other providers of similar programs;
- 1738 5C.5.6 offering orientation and ongoing training to network providers at least quarterly. The  
1739 curriculum will include application of the principles of rehabilitation and recovery,  
1740 quality management, services for Eligible Persons with multiple issues and complex  
1741 needs, orientation to Contractor policies and procedures, and other appropriate topics  
1742 identified by the Contractor. The agenda for each training shall be submitted for review  
1743 and approval to the Departments prior to being finalized, and
- 1744 5C.5.7 unless the Contractor has instituted a pay-for-performance program as defined in 5C.2.4  
1745 that utilizes incentives for quality improvement, piloting a two-year provider  
1746 performance incentive program beginning in the second year of the contract, integrating  
1747 the pilot into the Contractor’s network management responsibilities;
- 1748 a. the pilot shall be designed with network provider involvement and focus on service  
1749 process and/or outcome improvement;
- 1750 b. the Contractor shall establish an evaluation methodology to assess the impact of the  
1751 pilot, and
- 1752 c. shall obtain approval from the Departments of the pilot and the planned evaluation  
1753 methodology prior to the pilot’s commencement.
- 1754

1754

1755

1756

1757

1758

1759

1760

**SECTION 5D**

**QUALITY ASSESSMENT AND  
PERFORMANCE IMPROVEMENT**

1761

**5D.1 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM**

1762

The Contractor shall implement a comprehensive ongoing quality assessment and performance improvement (QA) program that incorporates ongoing review of all major areas of the Contractor's responsibility in operating the Iowa Plan. The program shall incorporate the principles of continuous quality improvement.

1763

1764

1765

1766

1767

1768

1769

1770

1771

The Departments shall require the Contractor to take action to correct all changes indicated by the findings of the QA process or by other monitoring processes implemented by the Contractor, the Departments or entities performing monitoring and evaluation on behalf of the Departments. The Contractor must cooperate with the state's External Quality Review of its operations and comply with its findings and requirements. In addition, the QA program shall incorporate the following requirements:

1772

QA Program Organization

1773

1774

1775

1776

5D1.1 A quality assessment and performance improvement program shall be staffed by persons dedicated only to the monitoring and evaluation of services provided; staff with QA responsibilities shall also have responsibility and authority to address any deficiencies found. Staffing shall minimally include the following:

1777

1778

1779

1780

1781

1782

1783

1784

- a.) a designated psychiatrist, who shall be a Clinical Director, Medical Director or Associate Medical Director, with substantial involvement in the QA program;
- b.) a qualified individual with at least three years of managerial experience performing managed behavioral health QA to serve as Director of Quality Assurance and Performance Improvement and be directly accountable to the Contractor's Executive Director, and
- c.) QA program staff with experience in public behavioral health QA, data analysis, and quality improvement project management.

1785

QA Plan

1786

1787

1788

1789

1790

5D.1.2 The Contractor shall develop a QA plan that is updated annually, no later than 60 days after the last day of each contract year, presented to the Departments for review and approval, and then implemented. The QA plan shall describe planned improvement activities, informed by the assessment of prior year efforts, and including but not limited to:

- 1791 a. timelines, objectives and goals for planned improvement projects and activities,  
1792 including clinical and non-clinical initiatives and those improvement projects  
1793 generated by the Quality Improvement Goals described below in Section 5D.2. The  
1794 projects shall be designed to achieve, through ongoing measurements and  
1795 intervention, significant improvement, sustained over time, in clinical care and non-  
1796 clinical care areas that are expected to have a favorable effect on health outcomes and  
1797 Eligible Person satisfaction. The performance improvement projects must involve the  
1798 following:  
1799
- 1800 1. measurement of performance using objective quality indicators;
  - 1801 2. implementation of system interventions to achieve improvement in quality;
  - 1802 3. evaluation of the effectiveness of the interventions, and
  - 1803 4. planning and initiation of activities for increasing or sustaining improvement.
- 1804
- 1805 The Contractor must complete each project in a reasonable time period so as to  
1806 generally allow information on the success of performance improvement projects in  
1807 the aggregate to produce new information on quality of care every year. The  
1808 Contractor must report and present the status and results of each project to the  
1809 Departments at least twice a year, and as requested.
- 1810 b. dissemination of evidence-based clinical practice guidelines and process  
1811 improvement methodologies to network providers;
- 1812 c. a process to monitor variation in practice patterns, and the identification of outliers;
- 1813 d. strategies designed to promote practice patterns that are consistent with evidence-  
1814 based clinical practice guidelines through the use of education, technical support and  
1815 provider incentives;
- 1816 e. analysis of clinical record reviews conducted at provider sites, including retrospective  
1817 treatment reviews required on substance abuse services;
- 1818 f. analysis of the effectiveness of treatment services<sup>3</sup>, employing both standard  
1819 measures of symptom reduction/management, as well as measures of functional  
1820 status and recovery (e.g., development of relationships, employment, and  
1821 participation in community). Such analysis shall include, but not be limited to:  
1822
- 1823 • review of assessment scores resulting from the administration of scales  
1824 administered by network providers and the Contractor to assess the changes in  
1825 functioning of selected Eligible Persons. Longitudinal assessment using the  
1826 clinical scales shall be done at intervals recommended by the scales selected.  
1827 The Contractor shall recommend to the Departments an approach to meet this  
1828 requirement, including the assessment instrument (or “scale”) to be used, and the  
1829 methodology for its application. The Departments reserve the right to approve or  
1830 specify the instrument(s) and analysis methodology to be used;

---

<sup>3</sup> Potential assessment instruments for Contractor consideration include the Treatment Outcome Package (TOP) for adults; Global Appraisal of Individual Needs (GAIN) for adults and adolescents with substance use disorders; and Children and Adolescent Needs and Strengths (CANS) for children and youth under age 21.

- 1831 • administration no less than semi-annually of an Eligible Person experience of  
1832 care survey(s) with results provided for separately for mental health and  
1833 substance abuse services, with substance abuse services information further  
1834 sorted for Enrollees and IDPH Participants. If the Contractor conducts surveys  
1835 using its own staff, the Contractor must demonstrate the validity of the study and  
1836 conclusions to the Departments. The survey shall assess both child and adult  
1837 services and mental health and substance abuse services. The Contractor shall  
1838 recommend to the Departments an approach to meet this requirement, including  
1839 the experience of care survey to be used, and the methodology for its application.  
1840 The Departments reserve the right to approve or specify the instrument(s) and  
1841 analysis methodology to be used;
- 1842 • administration of an Iowa Plan Eligible Person peer-to-peer assessment using  
1843 recovering persons who have been trained to do system evaluation; the  
1844 Contractor shall recommend to the Departments an approach to meet this  
1845 requirement, including the experience of care survey to be used, and the  
1846 methodology for its application. The Departments reserve the right to approve or  
1847 specify the instrument(s) and analysis methodology to be used;
- 1848 • review of statistical indicators of effectiveness using Contractor administrative  
1849 data;
- 1850 g. assessment of whether qualified and clinically appropriate network providers are  
1851 available to provide each Iowa Plan covered and required service, and the degree to  
1852 which they are:
- 1853 • accessible within the access standards required by the contract;
- 1854 • accessible to individuals with physical disabilities;
- 1855 • able, either directly or through a skilled interpreter, to communicate with the  
1856 Eligible Person in his/her primary language;
- 1857 • communicate with primary care providers, when appropriate;
- 1858
- 1859 h. provision for monitoring of the prescribing patterns of network prescribers and  
1860 overall utilization changes of behavioral health medication by Iowa Plan enrollees  
1861 using DHS pharmacy data made available to the Contractor to improve the quality of  
1862 care and case management (including UM and Intensive Clinical Management).  
1863 Such as:
- 1864 • identify medication utilization that deviates from current clinical practice  
1865 guidelines for Behavioral Health conditions. The Contractor will utilize a  
1866 pharmacist who is knowledgeable in behavioral health for this purpose;
- 1867 • identify those members whose utilization of controlled substances warrants  
1868 intervention either due to multiple prescribers, excessive quantities and/or  
1869 prescribing that is inconsistent with the member's clinical profile, e.g., a member  
1870 on opioid replacement therapy for substance abuse treatment receiving controlled  
1871 substances prescriptions;
- 1872 • coordinate monitoring efforts with the Iowa Medicaid Drug Utilization Review  
1873 Commission;

- 1874 • provide education, support and technical assistance to general practitioners and  
1875 primary care clinicians to assist them in appropriately prescribing medications for  
1876 behavioral health conditions without a full review by a psychiatrist;
- 1877 i. assessment of the provision of services to Eligible Persons with special health care  
1878 and other needs, as described in 5C.1.14;  
1879
- 1880 j. assessment of the impact of programs funded through the Contractor for mental  
1881 health and substance abuse programs of prevention, early intervention and outreach  
1882 to Enrollees;
- 1883 k. assessment of the access to, and evolution of, the service delivery system including  
1884 overuse, underuse and misuse; special measures shall be developed and implemented  
1885 to highlight any problems of access being experienced by Iowa Plan Eligible Persons  
1886 living in rural areas of the state;
- 1887 l. assessment of the degree to which the provider network met the needs of the Eligible  
1888 Persons for linguistic and cultural competence;
- 1889 m. assessment and summary of critical incidents reported by network and non-network  
1890 providers, including actions taken in response;
- 1891 n. assessment of the subjects and outcomes of appeals, grievances and complaints,  
1892 including timeframes required to reach resolution, and opportunities for  
1893 improvement;
- 1894 o. at least annually, conduct retrospective reviews of substance abuse treatment  
1895 providers' clinical records of substance abuse treatment with CADC or ACADC  
1896 reviewers to monitor:
- 1897 a. that the criteria of service necessity are met;
- 1898 b. that services provided are consistent with the level of care authorized;
- 1899 c. that clinical services at all levels of care are appropriate and consistent  
1900 with best practices disseminated by the Contractor;
- 1901 d. that I-SMART data are accurately reported;
- 1902 e. that IDPH funds are used as payment of last resort for IDPH Participants;
- 1903 f. that providers maintain structured record keeping systems including  
1904 documentation of delivery of all appropriate components of treatment  
1905 services;
- 1906 g. compliance with other contractual requirements;
- 1907 p. provision for the solicitation of recommendations from Eligible Persons at quarterly  
1908 forums and subsequently assessing whether any changes in policies or procedures  
1909 should be made based on the recommendations. The process shall also track the  
1910 recommendations made and whether and how they ultimately affect Iowa Plan  
1911 policies and procedures;
- 1912 q. assessment of provider satisfaction through a not-less-than annual administration of  
1913 the following provider surveys:
- 1914 • a survey of referral agencies to both assess satisfaction and to identify needed  
1915 services;

- 1916                     • a provider satisfaction survey with results stratified by provider type and  
1917                     specialty and provided for separate program components as well as in  
1918                     aggregate;
- 1919                     r. activities promoting coordination of medical and behavioral health care services  
1920                     through initiatives that assist primary care providers in identifying and treating  
1921                     depression in the primary care setting; and promoting collaboration between physical  
1922                     health and behavioral health providers, and
- 1923                     s. adhering to all requirements contained in the DHS CMS-approved Iowa Medicaid  
1924                     Managed Care Quality Assurance System. This document can be found in the on-line  
1925                     resource room.

1926     5D.1.3 The Contractor shall provide QA reports to the Departments quarterly; following a  
1927             format(s) developed jointly by the Departments and the Contractor; reports shall reflect  
1928             activity for each component of the Iowa Plan, including Quality Improvement Goals, as  
1929             well as for the overall Iowa Plan. The reports shall highlight in an executive summary a)  
1930             performance toward Quality Improvement Goals, b) non-Quality Improvement Goal  
1931             accomplishments; and c) areas warranting priority attention for improvement.

1932     5D.1.4 The Contractor shall achieve at least One-Year Accreditation as a Managed Behavioral  
1933             Health Organization from the National Committee on Quality Assurance within 24  
1934             months of the contract implementation date and shall maintain accreditation pursuant to  
1935             the requirements of NCQA.

1936     5D.1.5 The Contractor shall participate in annual, external quality reviews required by the  
1937             Centers for Medicare and Medicaid Services as requested by DHS, and shall participate  
1938             in SAPT Block Grant applications and Technical Reviews required by SAMSHA, as  
1939             requested by IDPH.

1941     5D.1.6 The Contractor shall serve as a resource to DHS' Mental Health/Development Disability  
1942             Redesign Project when so requested by DHS or IDPH. This project may result in  
1943             changes that will impact provider responsibilities as defined within this RFP.

1945     5D.1.7 The Contractor shall work with IDPH to comply with federal performance partnership  
1946             grant requirements and prepare reports and presentations to the State Board of Health, as  
1947             requested by IDPH.

1948  
1949     **5D.2    QUALITY IMPROVEMENT GOALS**

1950  
1951     The Contractor's Quality Improvement Goals shall be developed annually and informed by the  
1952     findings of the quality assessment and performance improvement program required in Section  
1953     5D.1 and the Performance Indicators required in Section 5D.3. The Contractor also may identify  
1954     other areas, such as those internal to the Contractor's operation, for inclusion in Quality  
1955     Improvement Goals.

1956     The Contractor shall:

1957     5D.2.1 identify and propose five annual contractual Quality Improvement Goals for the  
1958             Departments' review and approval no later than four months prior to the end of each  
1959             contract year. The goals shall be highly specified and measurable. They may be  
1960             comprised of administrative service, quality, and service and program development goals,  
1961             although no more than two goals may address administrative service. The goals shall

- 1962 reflect areas that present significant opportunities for performance improvement. The  
1963 proposed Goals shall be accompanied by measures and time frames for demonstrating  
1964 that such Quality Improvement Goals are achieved. Should the Departments and  
1965 Contractor be unable to reach agreement on the improvement goals and/or the measures,  
1966 the Departments shall establish the improvement goals and/or measures. It is expected  
1967 that the agreed-upon Improvement Goals will be incorporated into the Contract as an  
1968 amendment as they are modified and/or replaced from year to year.  
1969
- 1970 5D.2.2 present the Quality Improvement Goals, as negotiated by the Departments and the  
1971 Contractor, to the Iowa Plan Advisory Committee at their last meeting prior to the start of  
1972 each new contract year;
- 1973 5D.2.3 incorporate the annual Quality Improvement Goals and measures into the Contract  
1974 effective as of the start of each new contract year;
- 1975 5D.2.4 meet with the Departments twice a year to review progress towards the performance  
1976 Improvement Goals in contract status meetings and with the Iowa Plan Advisory  
1977 Committee and the Iowa Plan Clinical Advisory Committee as requested by the  
1978 Departments and/or the Committees. The Contractor shall provide the Departments with  
1979 a written update detailing progress toward meeting the annual Quality Improvement  
1980 Goals no later than two weeks prior to each contract status meeting, and
- 1981 5D.2.5 if the Departments determine that the Contractor is not in compliance with the  
1982 requirements of the annual Quality Improvement Goals, the Contractor shall prepare and  
1983 submit a corrective action plan to the Departments for approval. The plan and its  
1984 implementation shall be reviewed by the Departments.
- 1985 The Centers for Medicare and Medicaid Services, in consultation with DHS, may specify topics  
1986 for Quality Improvement Goals.  
1987
- 1988 **5D.3 PERFORMANCE INDICATORS AND THE IOWA PLAN CONTRACTOR**
- 1989 It has been the Departments' practice to use a set of Performance Indicators to track Contractor  
1990 performance. Iowa Plan performance indicators and performance targets were initially developed  
1991 following an extensive process of stakeholder input and serve to focus Contractor attention on  
1992 performance in areas defined as important to Iowa Plan Eligible Persons, the Departments and  
1993 others interested in Iowa's behavioral health care delivery system.
- 1994 Certain performance indicators, considered by the Departments to be especially significant to  
1995 either the quality of treatment or efficiency of administration of the Iowa Plan, will be selected  
1996 annually as indicators to which either incentives or disincentives are attached. See Section 9.3.3,  
1997 9.4.2 and **Attachments to Section 9** for additional information.
- 1998 The Departments will continue developing and refining performance indicators by which to  
1999 measure the performance of the Iowa Plan Contractor. The Departments will reassess the  
2000 performance indicators annually and reserve the right to add to, modify, substitute and delete  
2001 performance indicators throughout the contract term.
- 2002 **5D.4 ADVISORY COMMITTEES**
- 2003 **5D.4.1 The Iowa Plan Advisory Committee**

2004 The Departments shall appoint an Advisory Committee for the Iowa Plan to advise the  
2005 Departments on strategic and operational issues regarding the Iowa Plan and to provide for  
2006 ongoing public input in its evolution. Membership on the Advisory Committee will be offered to  
2007 representatives of stakeholder groups, including Eligible Persons. The Contractor will work with  
2008 the Departments to staff and support the efforts of the Advisory Committee.

2009 The Advisory Committee's responsibilities will include the following:

- 2010 • review of the Contractor's annual Quality Assessment and Performance Improvement Plan  
2011 (QA Plan) (see Section 5D.1.2);
- 2012 • input to the Departments on annual Quality Improvement Goals (see Section 5D.2) for the  
2013 Contractor, and periodic review of performance relative to those goals;
- 2014 • review of year-end performance relative to the QA Plan, including review of the Performance  
2015 Indicators;
- 2016 • feedback on operational issues being experienced by Eligible Persons, family members,  
2017 and/or providers, and
- 2018 • input on potential areas for service development or service improvement.

#### 2019 **5D.4.2 The Iowa Plan Clinical Advisory Committee**

2020 The Contractor shall appoint a Clinical Advisory Committee for the Iowa Plan to advise the  
2021 Contractor on clinical issues regarding the Iowa Plan. Membership on the Clinical Advisory  
2022 Committee will be offered to representatives of network providers of varied clinical specialties  
2023 and training. The Contractor shall obtain the Departments' approval prior to making Clinical  
2024 Advisory Committee appointments.

2025 The Clinical Advisory Committee's responsibilities will include the following:

- 2026 • review of Utilization Management Guidelines and of potential changes to such Guidelines;
- 2027 • review of utilization management programs and protocols;
- 2028 • review of practice across the Contractor's provider network;
- 2029 • identification of service gaps and recommendation of strategies to improve access;
- 2030 • review of level of functioning scales and development of recommendations on scales to be  
2031 used to assess change in the functioning of selected Iowa Plan Eligible Persons, and
- 2032 • input on Quality Assessment and Performance Improvement opportunities and project design.  
2033

#### 2034 **5D.4.3 The Iowa Plan Recovery Advisory Committee for Consumers and Families**

2035

2036 The Contractor shall appoint a Recovery Advisory Committee for Consumers and Families  
2037 (Recovery Advisory Committee) for the Iowa Plan to advise the Contractor on issues regarding  
2038 the Iowa Plan. Membership on the Recovery Advisory Committee will be offered to Eligible  
2039 Persons and to family members of Eligible Persons, with provision made to schedule meetings at  
2040 times and locations that accommodate Eligible Persons and families, provide conference call  
2041 capability, and assist Eligible Persons and family members with transportation. The Contractor

2042 shall obtain the Departments' approval prior to making Recovery Advisory Committee  
2043 appointments.

2044 The Recovery Advisory Committee's responsibilities will include the following:

- 2045 • review of the Contractor's annual Quality Assessment and Performance Improvement Plan  
2046 (QA Plan) (see Section 5D.1.2);
- 2047 • input to the Departments on annual Quality Improvement Goals (see Section 5D.2) for the  
2048 Contractor, and periodic review of performance relative to those goals;
- 2049 • review of year-end performance relative to the QA Plan, including review of the Performance  
2050 Indicators;
- 2051 • advising the Contractor and Departments on the application of the principles of rehabilitation  
2052 and recovery to the Iowa Plan;
- 2053 • feedback on operational issues being experienced by Eligible Persons and family members,  
2054 and
- 2055 • input on potential areas for service development or service improvement.

2056 **5D.5 OTHER MECHANISMS TO OBTAIN AND UTILIZE PUBLIC INPUT**

2057 The Contractor shall provide opportunities for persons interested in, or impacted by, the operation  
2058 of the Iowa Plan, to offer input and feedback regarding the Contractor's implementation and  
2059 ongoing management of the Iowa Plan. At a minimum the Contractor shall make available:

2060 5D.5.1 provider roundtables, no less than quarterly, to review policies and procedures, and to  
2061 seek suggestions and best practices among network providers and representatives of  
2062 provider organizations;

2063 5D.5.2 a forum no less than semi-annually to seek input from Eligible Persons, family members,  
2064 advocates, and representatives of organizations which advocate for Eligible Persons, and

2065 5D.5.3 a formal linkage between Iowa Plan advisory groups and other state initiatives that are  
2066 developing initiatives that relate to behavioral health issues or otherwise impact the Iowa  
2067 Plan.

2068 5D.5.4 processes for the routine solicitation of input from Eligible Persons, family members,  
2069 providers, public agency staff and other community representatives regarding the service  
2070 delivery system and issues that may be locally-specific. The Contractor must ensure that  
2071 consumers have input into the development of the local service network.

2072 Issues raised by stakeholders through the required public input processes shall be incorporated  
2073 into the Contractor's quality assessment and performance improvement program, and into other  
2074 Contractor operational planning and management activities as indicated by the nature of the  
2075 input.

2076

2077

2078

2079

2080

2081

2082

**SECTION 5E**  
**OUTREACH TO IOWA PLAN ELIGIBLE PERSONS**

**5E.1 OUTREACH TO IOWA PLAN ENROLLEES**

2083 The Contractor shall develop a comprehensive program to provide all Iowa Plan Enrollees with  
2084 appropriate information about the Iowa Plan, about services and providers available, and  
2085 education related to maintaining good mental health and avoiding substance abuse. Enrollee  
2086 outreach shall include at a minimum:

2087 5E.1.1 provision of information about the Iowa Plan described in 5E.1.2 and 5E.1.3 provided to  
2088 Enrollees within 10 working days of the date their names are first provided by DHS to  
2089 the Contractor, and thereafter, no less than annually;

2090 5E.1.2 provision of information about the Iowa Plan to Enrollees upon enrollment pertaining to  
2091 the following:

- 2092 • services covered;
- 2093 • an explanation regarding how decisions about the amount, duration, and scope of  
2094 service that will be provided are based on a determination of psychosocial  
2095 necessity and/ or service necessity; the explanation will also address how  
2096 together, these are known as the determination of what constitutes Medically  
2097 Necessary Services;
- 2098 • how to access services, including authorization requirements;
- 2099 • identity, location, qualifications, and availability of providers included in  
2100 network;
- 2101 • non-English language capacity of network providers;
- 2102 • any restrictions on the Enrollee's freedom of choice among network providers;
- 2103 • how to request a change in providers;
- 2104 • when referrals are needed and how to request referrals;
- 2105 • policy on the use of providers out-of-network;
- 2106 • provision of after-hours and emergency care, including the fact that prior  
2107 authorization is not required for emergency services, the Enrollee may use any  
2108 hospital, and what constitutes emergency and post-stabilization services as  
2109 defined in 42 CFR 438.114(a) and in Section 10 of this RFP;

- 2110 • availability of toll-free telephone information and crisis assistance;
- 2111 • how to access Medicaid-funded services not covered by the Iowa Plan, including
- 2112 pharmacy services, transportation services and any services not covered by a
- 2113 provider because of moral or religious grounds;
- 2114 • policies on Advance Directives, as set forth in 42 CFR 438.6(i)(1);
- 2115 • statement of Enrollee rights and responsibilities in accordance with 42 CFR
- 2116 438.100 including the right to:
  - 2117 • receive information;
  - 2118 • be treated with respect and due consideration for dignity and privacy;
  - 2119 • receive information on available treatment options and alternatives;
  - 2120 • participate in health care decisions;
  - 2121 • refuse treatment;
  - 2122 • be free from restraint or seclusion used as a means of coercion, discipline,
  - 2123 convenience or retaliation as specified in other federal regulations on the use
  - 2124 of restraints and seclusion, and
  - 2125 • in cases in which the privacy rule set forth in 45 CFR parts 160 and 164
  - 2126 subparts A and E applies, the right to request and receive a copy of medical
  - 2127 records, and request that they be amended or corrected as specified in 45
  - 2128 CFR 164.524 and 164.526;
  - 2129
- 2130 5E.1.3 the following information on grievance, appeal and fair hearing procedures in a
- 2131 description approved by DHS:
  - 2132 • the right to file grievances and appeals;
  - 2133 • the requirements and timeframes for filing a grievance or appeal;
  - 2134 • the availability of assistance in the filing process;
  - 2135 • the toll-free telephone numbers that the Enrollee can use to file a grievance or an
  - 2136 appeal by telephone;
  - 2137 • for state fair hearings: the right to hearing under 441 Iowa Administrative Code,
  - 2138 Chapter 7; the method for obtaining a hearing; and the rules that govern
  - 2139 representation at the hearing;
  - 2140 • the right, when requested by the Enrollee, for benefits to continue (as defined in
  - 2141 Section 5.B.2.12 of this RFP) if the Enrollee files an appeal or a request for state
  - 2142 fair hearing within the timeframes specified for filing; and notice that the
  - 2143 Enrollee may be required to pay the cost of services furnished while the appeal is
  - 2144 pending, if the final decision is adverse to the Enrollee;
  - 2145 • any appeal rights that the State chooses to make available to providers to
  - 2146 challenge the failure of the organization to cover a service;
  - 2147
- 2148 5E.1.4 written procedures for notifying Enrollees of a change in benefits or office sites;

2149 5E.1.5 written notice of any change in the information specified in 5E.1.2 and 5E.1.4 at least 30  
2150 days before the intended effective date of the change, when the State notifies the  
2151 Contractor that the change is significant;

2152 5E.1.6 provision of written information in Spanish. The Contractor must notify Enrollees that  
2153 written information is available in Spanish and other languages, as determined by DHS;

2154 5E.1.7 availability and provision of oral interpretation services for all non-English languages,  
2155 available free of charge to each Enrollee receiving covered services. The Contractor  
2156 must notify Enrollees that oral interpretation is available and how to access those  
2157 services;

2158 5E.1.8 provision of information in a manner and form that may be easily understood by each  
2159 Enrollee and potential Enrollee;

2160 • written material must use easily understood language at a 5<sup>th</sup> grade reading level  
2161 and in a simple format;

2162 • written material must also be available in large print or Braille and in an  
2163 appropriate manner that takes into consideration the special needs of those who,  
2164 for example, are visually limited or have limited reading proficiency;

2165 • interpreter services must be made available, and

2166 • the Contractor must provide access for Enrollees using TDD/TDY.

2167

2168 5E.1.9 provision of information to all Enrollees and potential Enrollees explaining that  
2169 information is available in alternative formats and how to access those formats;

2170

2171 5E.1.10 written notice of termination of a contracted provider, within 15 days after receipt or  
2172 issuance of the termination notice, to each Enrollee who was seen on a regular basis (i.e.,  
2173 the Enrollee has made one or more visits to the practitioner within the last 180 days) by  
2174 the terminated provider, and

2175 5E.1.11 provision of the following information about the Iowa Plan upon request:

2176 • information on the structure and operation of the Iowa Plan, and

2177 • any physician incentive plans implemented by the Contractor.

2178

## 2179 **5E.2 OUTREACH TO IDPH PARTICIPANTS**

2180

2181 The Contractor must provide educational materials and forums to IDPH Participants that provide  
2182 at a minimum the following information:

2183 • services covered;

2184 • how to access services;

2185 • identity, location qualifications and availability of providers included in the network;

2186 • non-English language capacity of network providers;

2187 • any restrictions on the IDPH Participants freedom of choice among network providers;

2188 • provision of after-hours and emergency care;

- 2189           • availability of toll-free telephone information and crisis assistance, and  
2190           • the right to file a complaint.

2191

2192   **5E.3   ADVANCE DIRECTIVES (Enrollees Only)**

2193

2194   5E.3.1   The Contractor must maintain written policy and procedures meeting 42 CFR 489  
2195           Subpart I concerning advance directives, as defined in 42 CFR 489.100, with respect to  
2196           all adult Enrollees receiving medical care by or through the Iowa Plan.

2197

2198   5E.3.2   The Contractor must inform Enrollees that grievances concerning noncompliance with  
2199           the advance directive requirements may be filed with the state survey and certification  
2200           entity.

2201

2202   5E.3.3   The Contractor must provide written information on advance directives policies to adult  
2203           Enrollees, including:

2204

- their rights under the law of the State;

2205

- the Contractor's policies on implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience, and

2206

2207

2208

- a description of applicable state law, which must reflect any changes in state law within 90 days of the effective date of the change.

2209

2210

2211

2211

2212

2213

2214

2215

2216

**SECTION 6**

**REQUIRED ADMINISTRATIVE CAPABILITIES**

2217

**2218 6.1 SUPPORTING THE OPERATION OF THE IOWA PLAN**

2219

2220 To effectively and efficiently manage the delivery of services, the Contractor must establish a  
2221 variety of administrative systems. To the maximum extent possible, the Contractor shall integrate  
2222 administrative systems and streamline administrative operations between services funded by DHS  
2223 and those funded through IDPH. Notwithstanding the integration of the administrative operations,  
2224 the Contractor shall account separately for services and administrative costs paid through funds  
2225 provided by DHS and IDPH.

2226 The Contractor shall work cooperatively with the Departments in delivering the services to the  
2227 Iowa Plan Enrollees and IDPH Participants and participate in planning delivery of care.

2228 The Contractor must have offices in the Des Moines metropolitan area. At the request of  
2229 Departments' staff, the Contractor will be required to attend meetings at the Departments' offices  
2230 in Des Moines related to the implementation and ongoing operation of the Iowa Plan.

**2231 6.1.2. Contractor Staffing Requirements**

2232 The Contractor must have staff in sufficient numbers and sufficient expertise to administer the  
2233 Iowa Plan on behalf of the Departments. At a minimum, the Contractor staff must include, as  
2234 separate positions, the following key personnel located in the Des Moines area office:

- 2235 • an Executive Director, responsible for overall administration of the Iowa Plan;
- 2236 • a Clinical Director, responsible for providing clinical leadership; an Iowa-licensed  
2237 ASAM-certified psychiatrist;
- 2238 • a Chief Operating Officer, responsible for day-to-day operations of the Iowa Plan;
- 2239 • a Chief Financial Officer, responsible for oversight of the financial activities and  
2240 soundness of the Iowa Plan
- 2241 • a Director of Network Management, responsible for overseeing the management of  
2242 the provider network, including assuring access and appropriate credentialing of  
2243 providers among other functions,

- 2244 • a Director of Member Services, responsible for overseeing Eligible Persons  
2245 interactions with the Iowa Plan and education and outreach to Eligible Persons and  
2246 family members;
- 2247 • a Director of Quality Assurance and Performance Improvement (QA), as described  
2248 in Section 5D;
- 2249 • a Director of Utilization Management, as described in Section 5A, and
- 2250 • a Manager of Appeals, Grievances and Complaints, responsible for overseeing and  
2251 monitoring the appeals, grievances and complaints, and ensuring that recurring  
2252 issues are addressed through the QA Plan.

2253 **6.1.3 Qualifications of Staff**

2254 The Contractor shall be responsible for assuring that all persons working on the Iowa Plan on the  
2255 Contractor's behalf are properly licensed, certified or accredited as required under applicable  
2256 federal and state law. The Contractor shall maintain the current licenses of staff in a central file.  
2257 The Contractor shall provide service standards for service providers who are not otherwise  
2258 licensed, certified or accredited.

2259 **6.1.4 Changes to Key Personnel**

2260 The Departments must approve hiring of all staff serving as key personnel, as defined in Section  
2261 6.1.2. The Contractor must provide notice to the Departments of change to key personnel within  
2262 five working days of any change. Such written notice shall include proposed successor's name  
2263 and CV. Should the Departments not be satisfied with the performance of any key personnel, the  
2264 Departments may request their replacement and the Contractor shall make responding changes in  
2265 personnel.

2266 **6.2 TRANSITION PLANNING**

2267  
2268 The Contractor will be involved in a series of transitions throughout the duration of the contract.  
2269 Some may be negotiated with the Contractor when the Departments make policy changes.  
2270 However two transitions are inevitable: the one between the time when the winning Bidder is  
2271 announced for the contract period and the implementation of the contract (April 2009 through  
2272 December 2009); and the time between the selection of the winning Bidder of the next Iowa Plan  
2273 contract period and the implementation of that contract.  
2274

2275 6.2.1 The transition planning from the pre-implementation period until the contract operational  
2276 start date must include:

- 2277 • submission of a detailed work plan, for the Departments review and approval, that  
2278 includes all transition tasks, persons responsible, due dates and deliverables;
- 2279 • provision of weekly reports updating the status of pre-implementation activities  
2280 including but not limited to the hiring of staff, implementation of management  
2281 information system capability, and steps to provide adequate claims payment  
2282 capacity;
- 2283 • identification of the steps to assume responsibility for the range of services set forth  
2284 in this RFP, including, if determined necessary by the Departments, developing

- 2285 jointly with the current Contractor a plan for the transfer of responsibilities; such plan  
2286 must be finalized within one month of contract award;
- 2287 • willingness to accept the active service authorizations with network and non-network  
2288 providers approved by the current Contractor until new authorizations are completed;
- 2289 • willingness to accept the provider credentialing of the current Contractor until  
2290 independent credentialing can be completed if required, and
- 2291 • participation in other transition team meetings as directed by the Departments.
- 2292 6.2.2 The selected Contractor shall start pre-implementation work as soon as the award  
2293 selection is announced. Prior to the operational start date of the contract, the Contractor  
2294 must have:
- 2295 • hired and trained all staff necessary to perform the responsibilities set forth in the  
2296 contract;
- 2297 • no later than 75 days prior to the operational start date, hired staff with the expertise  
2298 necessary to work with other state agencies and funding streams to develop protocols  
2299 for the referrals and delivery of services concurrently and consecutively to persons  
2300 being served in multiple funding streams (e.g., policies guiding staff of all entities in  
2301 the appropriate way to initiate joint treatment planning and referral of Enrollees  
2302 between funders/providers);
- 2303 • no later than 75 days prior to the operational start date have hired and trained staff  
2304 necessary to plan and execute the transition of any management information system  
2305 requirements necessary for a smooth transition of Enrollee records and provider  
2306 reimbursement;
- 2307 • no later than 60 days prior to the operational start date, provide DHS with utilization  
2308 management guidelines for review and approval;
- 2309 • no later than 45 days prior to the operational start date, recruited and trained a mental  
2310 health and substance abuse services provider network which provides Enrollee access  
2311 to covered, required and optional services at least equal to that available during the  
2312 previous contract period;
- 2313 • no later than 45 days prior to the operational start date, have submitted to the  
2314 Departments for review and approval a comprehensive organizational QA plan that  
2315 reflects the Contractor's organizational quality management philosophy and  
2316 structure, consistent with the required content for a QA plan described within Section  
2317 5D;
- 2318 • no later than 30 days prior to the operational start date, have provided Department-  
2319 approved handbooks and other relevant information including, but not limited to the  
2320 transition process and benefits to all Iowa Plan Enrollees;
- 2321 • no later than 30 days prior to the operational start date, solicited bids from, selected  
2322 and trained a substance abuse services provider network which provides IDPH  
2323 Participant access to covered and required services at least equal to that available  
2324 under the previous contract period;
- 2325 • no later than 30 days prior to the operational start date, have mailed a Provider  
2326 Manual which has been approved by the Departments to all network providers;

- 2327 • no later than 30 days prior to the operational start date, have a management  
2328 information system established and functioning to allow testing of data transfers;
- 2329 • no later than 20 days prior to the operational start date, have hired and trained  
2330 Utilization Management staff to allow the new staff to work with the staff of the  
2331 current Contractor until the current contract period expires.  
2332
- 2333 6.2.3 The transition planning for the end of the contract period must include:
- 2334 • willingness to extend the contract, if necessary, at the request of the Departments;
- 2335 • creating or modifying contractual performance standards to ensure appropriate  
2336 staffing levels are maintained to manage daily responsibilities including cooperation  
2337 with transition activities;
- 2338 • creating a transition plan between the outgoing and incoming Contractor;
- 2339 • transfer of clinical and financial records as required by contract, including sharing  
2340 active authorizations, clinical data, lists of members who receive case management,  
2341 provider critical incident logs and other data that helps to ensure continuity of care;
- 2342 • providing training and orientation to the incoming Contractor for next contract  
2343 period, and
- 2344 • closing out financial responsibilities with providers and others with whom the  
2345 Contractor has been doing business, including clarifying financial responsibility, if  
2346 necessary, for claims which are incurred but not reimbursed during the transition  
2347 period and resolution of care reviews/appeals pending completion.

2348 **6.2.4 Readiness Assessment**

2349 If the successful Bidder is not the current Contractor, prior to implementation of the contract, the  
2350 Departments, in cooperation with the regional office of the Centers for Medicare and Medicaid  
2351 Services (CMS), will conduct a formal review of the Contractor's readiness to implement the  
2352 Iowa Plan. To ensure readiness to implement the Iowa Plan, the Contractor shall meet the pre-  
2353 implementation deadlines discussed in Section 6.2.2.

2354 Should the Contractor fail to meet the pre-implementation deadlines and the Departments  
2355 determine that the Contractor is responsible for its failure to meet the deadlines, the Departments  
2356 may assess liquidated damages of \$5000 per day.

2357 Upon successful completion of the readiness review and with the concurrence of the regional  
2358 office of the CMS, the Departments will issue the Contractor an approval letter which authorizes  
2359 the Contractor to begin operations and authorizes funds for the Medicaid capitation payments and  
2360 IDPH payments for the first month of the contract period.

2361 **6.2.5 Date of Implementation**

2362 Should the Contractor fail to begin full operation of the Iowa Plan on January 1, 2010, and should  
2363 the Departments determine that the Contractor is responsible for the delay, the Departments may  
2364 assess liquidated damages of \$150,000 for each month implementation is delayed. The amount of  
2365 the damages may be prorated if necessary.  
2366

2367 **6.3 CLINICAL RECORD KEEPING (Enrollees only)**

2368 The Contractor must maintain records of each Enrollee who requests services (or those for whom  
2369 services are requested), whether or not services are authorized subsequent to the request. Clinical

2370 records also must be kept for each Enrollee who utilizes services, even if no authorization process  
2371 was required for the service utilized. While most of this information also may be present in the  
2372 records of providers serving Enrollees, the Contractor must maintain within its management  
2373 information system the information necessary to assist in authorizing and monitoring services as  
2374 well as providing data necessary for quality assessment and other evaluative activities. The  
2375 Contractor's clinical record must include, but is not limited to:

- 2376 • documentation of the diagnosis and functional assessment score;
- 2377 • determination of and documentation of the levels of functioning, as determined by a  
2378 clinical scale, for each Enrollee who meets the definition of a person with a serious  
2379 mental illness or a child with a serious emotional disability; functioning shall be re-  
2380 determined no less than every six months;
- 2381 • documentation of clinical services requested, services authorized, services substituted,  
2382 services provided; for mental health services, such documentation shall reflect the  
2383 application of psychosocial necessity criteria; for substance abuse services, such  
2384 documentation shall reflect the application of service necessity criteria;
- 2385 • documentation of services not authorized, reasons for the non-authorization based on IAC  
2386 citations, and substitutions offered;
- 2387 • documentation of missed appointments, and subsequent attempts to follow up with the  
2388 Enrollee; follow-up on Enrollees discharged from the emergency room without an  
2389 admission for inpatient treatment or observation;
- 2390 • documentation of joint treatment planning, clinical consultation, or other interaction with  
2391 the Enrollees or providers and/or funders providing or seeking to provide services to the  
2392 Enrollee;
- 2393 • documentation of the Enrollees' medication management done by the Contractor's  
2394 clinical staff;
- 2395 • documentation of assessment and determination of level at admission, continued service  
2396 and discharge criteria for substance abuse services;
- 2397 • name(s) of persons key to the treatment planning of Enrollees who access multiple  
2398 services; such persons may include a DHS or JCO worker, the targeted case manager, or  
2399 a family member, and
- 2400 • documentation of the discharge plan for each Enrollee discharged from 24-hour services  
2401 reimbursed through the Contractor; this shall include the destination of the Enrollee upon  
2402 discharge.

2403 At the conclusion of the contract between the Departments and the Contractor, all clinical records  
2404 generated by the Contractor shall become the property of the Departments. Upon request, the  
2405 Contractor shall transfer the records to the Departments at no additional cost. The Contractor will  
2406 be allowed to keep copies of clinical records to the extent necessary to verify the accuracy of  
2407 claims submitted.  
2408

#### 2409 **6.4 MANAGEMENT INFORMATION SYSTEM**

2410  
2411 The Contractor must maintain a fully integrated information system(s) that supports all care  
2412 management functions, including utilization management, care management, claims payments,  
2413 service authorization, provider network management, provider profiling, incident reporting,  
2414 credentialing, member services, appeals, grievances and complaints, and quality management.

2415  
2416 At a minimum, receives, processes and reports data to and from the following management  
2417 information systems: the IDPH Iowa Service Management and Report Tool (I-SMART); the DHS  
2418 Medicaid Management Information System (MMIS); the DHS Title XIX eligibility system; and  
2419 the MHI (mental health institute) information system. MMIS and the Title XIX eligibility system  
2420 will be used for all Medicaid members. I-SMART will be used for all Eligible Persons who  
2421 receive Iowa Plan substance abuse treatment services. The Contractor must be capable of  
2422 receiving data from network providers on all clients receiving substance abuse services. Iowa  
2423 Plan substance abuse services network providers shall be required to report I-SMART data on all  
2424 clients receiving substance abuse services regardless of source of payment. Certain substance  
2425 abuse network providers submit I-SMART data using the historical SARS format. The MHI  
2426 information system is used by the state's four state mental health institutes except for those  
2427 served in the substance abuse treatment program at Mt. Pleasant, which uses I-SMART.  
2428  
2429 The Contractor's management information system must have the capacity to electronically  
2430 receive enrollment information from the DHS Title XIX eligibility system through a file transfer  
2431 process. It is not the intention of DHS to send daily information through magnetic media.  
2432  
2433 The Contractor's management information system also shall be capable of generating whatever  
2434 uniform reporting requirements are established by the Centers for Medicare and Medicaid  
2435 Services or other federal/state regulations.  
2436  
2437 To receive I-SMART data, the Contractor must use Microsoft Internet Explorer, have internet  
2438 access and gain security clearance from IDPH in order to access the ftp site. The Contractor also  
2439 must have SQL and Access applications as well as sufficient memory to open, store and process  
2440 the ftp transmission.  
2441  
2442 The Contractor may use a common identifier, including Enrollees' Social Security numbers, to  
2443 link databases and computer systems as required in the contract. However the Contractor is  
2444 prohibited from publishing, distributing or otherwise making available the Social Security  
2445 numbers of Iowa Plan Eligible Persons.  
2446  
2447 The Contractor shall perform the following Management Information System functions through a  
2448 system that integrates the Contractor's clinical record information, authorization and claims  
2449 payment data:

- 2450 • maintain an Enrollee database, using Medicaid state ID numbers, on a county-by-county  
2451 basis which contains eligibility begin and end dates; enrollment history; utilization and  
2452 expenditure information (Enrollees only);
- 2453 • county of legal settlement for Enrollees shall be included in the Contractor's management  
2454 information system subsequent to a written agreement with a county or a county's  
2455 representative to provide and update such information as well as to provide required  
2456 consumer releases (Enrollees only)<sup>4</sup>;

---

<sup>4</sup> The determination of an Iowa's county of legal settlement carries with it an obligation that the designated county accept financial responsibility for certain services set forth in the Iowa Code and in that county's management plan. Therefore only officials of a county can make a determination of legal settlement. If the Contractor is to utilize information about an Enrollee's county of legal settlement, that information must be provided and updated as necessary by the county. With appropriate releases of information and with the approval of the Departments, the Contractor may contract with a county(ies) to provide

- 2457 • maintain a database which will incorporate required clinical information (from Section  
2458 6.3) on those Enrollees who access mental health and substance abuse treatment;
- 2459 • maintain information and generate reports required by the performance indicators  
2460 established to assess the Contractor's performance;
- 2461 • conduct claims processing and payment (Enrollees only);
- 2462 • maintain data to support medication management activities (Enrollees only);
- 2463 • maintain data documenting distribution of the capitation payment according to the  
2464 proposal submitted by the Contractor (Enrollees);
- 2465 • maintain data on incurred but not yet reimbursed claims (Enrollees only);
- 2466 • maintain data on third party liability payments and receipts (Enrollees only);
- 2467 • maintain data on the time required to process and mail claims payment (Enrollees only);
- 2468 • maintain critical incident data;
- 2469 • maintain clinical and functional outcomes data and data to support other QA activities  
2470 such as provider profiling and Iowa Plan Eligible Persons and provider satisfaction  
2471 surveys;
- 2472 • maintain data on clinical reviews, appeals, grievances and complaints and their outcomes;
- 2473 • maintain data on services requested, authorized, provided and denied (Enrollees only);
- 2474 • maintain the capacity to perform ad hoc reporting on an "as needed" basis, with a  
2475 turnaround time to average no more than five working days;
- 2476 • maintain data on all service referrals for mental health and substance abuse treatment  
2477 outside the Iowa Plan;
- 2478 • maintain a data base, using I-SMART, state ID number, on a county-by-county basis  
2479 which contains information;
- 2480 • maintain all data in such a manner as to be able to generate information specific to mental  
2481 health and substance abuse services; and for substance abuse services, between services  
2482 to Enrollees and IDPH Participants;
- 2483 • maintain all data in such a manner as to be able to generate information on Enrollees by  
2484 age of Enrollees and to identify Enrollees who are referred to CW/JJ services;
- 2485 • provide encounter data to DHS in a format specified by DHS;
- 2486 • ensure that data received from providers is accurate and complete by
  - 2487 • verifying the accuracy and timeliness of reported data;
  - 2488 • screening the data for completeness, logic, and consistency, and
  - 2489 • collecting service information in standardized formats to the extent feasible and  
2490 appropriate.
- 2491
- 2492 • make all collected data available to the Departments and to the CMS, upon request.

---

management reports which present information on services provided to Iowa Plan Enrollees who also receive county-funded services. The Contractor shall be reimbursed by each contracting county for the cost of preparing such reports.

2493

2494 **6.4.1 General Systems Requirements**

2495 The management information system implemented by the Contractor shall conform to the  
2496 following general system requirements:

- 2497 • On-Line Access
- 2498 • On-line access to all major files and data elements within the MIS.
- 2499 • Timely Processing
- 2500 • Daily file updates: member, provider, prior authorization, and claims to be processed.
- 2501 • Weekly file updates: reference files, claim payments.

2502

2503 6.4.1.1 Edits, Audits, and Error Tracking

- 2504 1. Comprehensive automated edits and audits to ensure that data are valid and that contract  
2505 requirements are met.
- 2506 2. System should track errors by type and frequency. It should also be able to maintain  
2507 adequate audit trails to allow for the reconstruction of processing events.

2508

2509 6.4.1.2 System Controls and Balancing

2510 Adequate system of controls and balancing to ensure that all data input can be accounted for  
2511 and that all outputs can be validated.

2512

2513 6.4.1.3 Back-up of Processing and Transaction Files

- 2514 1. 24-hour back-up: eligibility verification, enrollment/eligibility update process, prior  
2515 authorization processing;
- 2516 2. 72-hour back-up: claims processing, and
- 2517 3. 2-week back-up: all other processes

2518

2519 **6.4.2 Data Management**

2520

2521 The Contractor must utilize the clinical data it receives to appropriately manage the care being  
2522 provided to Eligible Persons. As described in Section 6.5, the Contractor is required to submit a  
2523 number of reports to the Departments that require the use of data. In addition, the Departments  
2524 expect that the Contractor will utilize the data in its management of providers, assessment of care  
2525 being provided to Eligible Persons, to develop new services that will increase access and improve  
2526 the cost-effectiveness of the Iowa Plan, and to implement evidence-based practices across the  
2527 provider network.

2528

2529 **6.4.3 Pharmacy Information Transmission**

2530

2531 Each month IME will provide to the Contractor or the Contractor's designee a data tape reflecting  
2532 all pharmacy claims paid on behalf of Iowa Plan Enrollees. The Contractor is required to utilize  
2533 the data consistent with the requirements set forth in Section 5D, as well as to cooperate with the  
2534 Iowa Drug Utilization Review Commission in studies on the utilization of psychotropic  
2535 medication.

2536

2537 **6.5 CONTRACT MONITORING AND GENERAL REPORTING REQUIREMENTS**

2538

2539 The Departments will monitor the Contractor's performance pursuant to the terms of the Contract  
2540 and RFP by confirming timely receipt of deliverables referenced within and by monitoring

2541 appeals, fair hearings, and grievances, critical incidents, progress on projects established in the  
2542 Contract, required financial accounts, and review of the Contractor's QA plan and goals.

2543 The Contractor shall meet on a regular basis with the Contract Manager during the term of this  
2544 Contract to continually confirm that the Iowa Plan is being appropriately administered. At least  
2545 every six months, the parties will meet to review the Contractor's performance and compliance  
2546 with Contract terms. Topics of discussion will include timeliness, review of reports described  
2547 below, and evaluation of contract performance targets and results. To the extent that any  
2548 deficiencies are identified in the Contractor's performance, the Contractor shall submit and  
2549 comply with a corrective action plan acceptable to the Departments.

2550 Formats for reports and due dates, if not identified below, shall be negotiated by the Departments  
2551 and the Contractor. Failure of the Contractor to submit the required reports within the allotted  
2552 time frame may result in the imposition of disincentives as specified in Section 9. All reports  
2553 shall be provided in both hard copy and electronic format.

2554 The Departments reserve the right to request any report more frequently than indicated in the  
2555 Section below, based on performance concerns or for other reasons determined by the  
2556 Departments. The Departments also reserve the right to require additional reports beyond those  
2557 listed below.

2558  
2559 For at least the first six months of the contract period, the Departments will specify weekly  
2560 reports required of the Contractor to ensure contract implementation in compliance with the terms  
2561 of this RFP and the contract. Such reports will include, but are not limited to, reports of service  
2562 authorizations and non-authorizations, denials of payment, claims payment, and numbers of  
2563 providers with network status.

2564

#### 2565 **6.5.1 Reports Required Monthly**

2566

2567 The following reports shall be submitted each month; monthly reports are due no later than the  
2568 20<sup>th</sup> of the subsequent month:

2569 • General statistical reports in hard copy and in an electronic format compatible with  
2570 systems used by the Departments; information to be included, and format required will be  
2571 negotiated by the Departments and the Contractor. Included in monthly statistical reports  
2572 shall be a breakdown of expenditures from the Claims Fund reported by level of service  
2573 both by month of service and by month of payment and further categorized by age, sex  
2574 and capitation payment cell. (See the on-line resource room for a list of reports currently  
2575 received by the Departments. These reports shall serve as the minimum set of reports  
2576 required from the Contractor.)

2577 • Encounter data must be submitted electronically in a format that complies with  
2578 requirements of the Centers for Medicare and Medicaid Services. Encounter data must be  
2579 submitted by the 20<sup>th</sup> of the month subsequent to the month for which data are reflected.  
2580 All corrections to the monthly encounter data submission shall be finalized within 45  
2581 days from the date the initial error report for the month was sent to the Contractor or 59  
2582 days from the date the initial encounter data were due. Disincentive payments, specified  
2583 in Section 9, related to late reporting may be imposed if the Contractor exceeds the  
2584 timeline for more than two months of any contract year. See the on-line resource room  
2585 for the current requirements for encounter data. The error rate for encounter data cannot  
2586 exceed 1 percent.

- 2587 • Monthly I-SMART reports shall be provided to all network providers who provide  
2588 substance abuse treatment services and to IDPH, electronically. These reports shall  
2589 contain at a minimum a list of eligibles admitted with no services received during the last  
2590 two reporting months, services provided that were provided to eligibles (covers 12  
2591 months by treatment setting showing days, hours or units and eligibles who received  
2592 services), minimum IDPH Participant counts, discharges from Iowa Plan substance abuse  
2593 services, eligibles due for follow-up, and monthly services detail. (I-SMART reports,  
2594 forms, and manual will be available in the on-line Resource Room).
- 2595 • Monthly report to IDPH for the first six months, quarterly thereafter, on contract  
2596 conditions monitored by I-SMART, to include but not limited to: services provided to  
2597 persons from out-of-state, to Iowa Plan Enrollees, OWI evaluations and detox services  
2598 not billed to IDPH.
- 2599 • To enable the state's adherence to the requirements of federal financial participation, the  
2600 Contractor must report a description of certain transactions with parties of interest as per  
2601 the definitions of "transactions" and "parties of interest" found in the State Medicaid  
2602 Manual (SMM 2087.6(A-B)).  
2603

### 2604 **6.5.2 Reports Required Quarterly**

2605  
2606 The following reports shall be submitted within 30 days of the close of each calendar quarter:

- 2607 • financial statistical report covering the total number of Enrollees served in the Iowa Plan  
2608 on a monthly basis, revenues – including capitation payment and investment income,  
2609 medical expenses, administrative expenses, and net income to the Contractor. Expense  
2610 data shall be reported in the format of the Budget Worksheet, unless otherwise approved  
2611 in writing by DHS.
- 2612 • quality assessment and performance improvement report covering all areas established in  
2613 Section 5D in format to be negotiated between the Departments and the Contractor; the  
2614 first QA report shall be due 30 days after the close of the first quarter.
- 2615 • Staff and Provider Network Reports: showing changes in all key staff positions and  
2616 changes in the provider network, including GeoAccess reports on the provider network  
2617 for access and availability.
- 2618 • report on the number and percent of contracted providers who are credentialed by the  
2619 Contractor.
- 2620 • summary of findings of provider profiling by provider category (first report due in the  
2621 third quarter quality assessment and performance improvement report).
- 2622 • quarterly summary report on performance indicators.
- 2623 • a financial statement verifying the Contractor's continuous compliance with the  
2624 requirements to maintain a restricted insolvency protection account, a surplus fund,  
2625 working capital and any other applicable requirements related to the Contractor's  
2626 compliance with requirements for a Limited Service Organization.
- 2627 • a summary of the distribution of service expenditures for Enrollees for mental health and  
2628 substance abuse services; the summary information shall be provided separately for each  
2629 of the populations corresponding to the four Medicaid rate cells.

### 2630 **6.5.3 Reports Required Annually**

2631

2632 At a minimum, the following reports shall be submitted for each contract year:

2633

2634 **6.5.3.1 Annual Independent Audit**

2635

2636 An annual audited financial report that specifies the Contractor's financial activities under the  
2637 contract must be submitted within 6 months following the end of each calendar year. The report,  
2638 prepared using Statutory Accounting Principles as designated by the National Association of  
2639 Insurance Commissioners, must be prepared by an independent Certified Public Accountant on a  
2640 calendar year basis. One copy of the report must be sent directly to the state Medicaid director  
2641 and a second copy sent directly to the Director of the IDPH Division of Behavioral Health. The  
2642 Contractor shall provide a list of no less than three Certified Public Accounting firms and the  
2643 Departments will select the auditing firm from the list provided by the Contractor. The Contractor  
2644 is responsible for the cost of the audit. The format and contents shall be negotiated by the  
2645 Departments and the Contractor, but must include at a minimum:

- 2646 • a separate accounting for all revenues received from each of the reimbursement sources  
2647 in the contract: Medicaid capitation payments, and IDPH payments;
- 2648 • third party liability payments made by other third-party payers;
- 2649 • receipts received from other insurers;
- 2650 • a breakdown of the costs of service provision, administrative support functions, plan  
2651 management and profit including documentation of the Contractor's compliance with the  
2652 Budget Worksheet and narrative submitted by the Contractor in the Contractor's  
2653 proposal;
- 2654 • assessment of the Contractor's compliance with financial requirements of the contract  
2655 including compliance with requirements for insolvency protection, surplus funds,  
2656 working capital, and any additional requirements established in Administrative Rules for  
2657 organizations licensed as Limited Service Organizations, and
- 2658 • a separate letter from the independent Certified Public Accountant addressing non-  
2659 material findings, if any.

2660 The Contractor may be required to comply with other prescribed compliance and review  
2661 procedures.

2662 Upon completion of the audit, a press release shall be published to announce the availability of  
2663 the audit report for review by the public at the Contractor's office. The press release shall be  
2664 provided to the Departments for approval and release to appropriate newspapers. A copy of the  
2665 press release shall be maintained in the Contractor's office.

2666 In addition to the annual audit, the Contractor shall be required to submit to the Departments  
2667 copies of the quarterly National Association of Insurance Commissioners (NAIC) financial  
2668 reports.

2669 A final reconciliation shall be completed by the independent auditing firm that conducted the  
2670 annual audit. The final reconciliation will make any required adjustments to estimates included in  
2671 the audit completed within 6 months of the end of the contract year. The final reconciliation shall  
2672 be completed no sooner than 12 months following the end of the contract year. The final  
2673 reconciliation shall verify the amount due by the Contractor to the Community Reinvestment  
2674 Account for the contract year as well as the amount left in the Claims Fund at the end of the  
2675 contract year and thus, under the terms of the contract, due to be moved to the Community  
2676 Reinvestment Account.

2677  
2678  
2679  
2680  
2681  
2682  
2683  
2684  
2685  
2686  
2687  
2688  
2689  
2690  
2691  
2692  
2693  
2694  
2695  
2696  
2697  
2698  
2699  
2700  
2701  
2702  
2703  
2704  
2705  
2706  
2707  
2708  
2709  
2710  
2711  
2712  
2713  
2714  
2715  
2716  
2717  
2718  
2719  
2720  
2721  
2722  
2723  
2724  
2725  
2726

**6.5.3.2 Annual Quality Assessment and Performance Improvement Report**

An annual Quality Assessment and Performance Improvement Report shall be submitted within 60 days following the close of each contract year. The Report shall include, but not be limited to an assessment of the impact of the quality assessment and performance improvement program and plans for continuing improvement in the program. The annual Quality Assessment and Performance Improvement Report shall address at a minimum every requirement for the Contractor’s quality assurance program set forth in Section 5D. The annual Quality Assessment and Performance Improvement report shall include a summary of the substance abuse retrospective review activities, findings, follow-up actions, recommendations, timeframes and plans for continuing improvement.

**6.6 FINANCIAL REQUIREMENTS**

House File 557 amended Chapter 514B of the Code of Iowa and established Limited Service Organizations which are defined as organizations providing dental care services, vision care services, mental health services, substance abuse services, pharmaceutical services, podiatric care services, or such other services as may be determined by the Insurance Commissioner. The bill further requires that a person “shall not operate a limited service organization...without obtaining a certificate of authority under this Chapter.” Therefore the Contractor selected to implement the Iowa Plan shall be subject to the certification process developed by the Insurance Commissioner pursuant to this amendment of Chapter 514B. The Departments retain the right to require additional assurances if the Departments deem it in their best interest to do so.

To assure the financial solvency of the Contractor, the Contractor must establish and maintain three accounts. The accounts must be established prior to the payment of the first capitation payment. Reports verifying the accounts must be submitted within 30 days following the end of each calendar quarter.

**6.6.1 Insolvency Protection Account**

The Contractor shall maintain at all times an amount equal to two months of the total anticipated annual Medicaid capitation amount. The insolvency protection account must be a restricted account that may be drawn upon only with the authorized signatures of two persons designated by the Contractor and two persons designated by DHS. Should a determination of insolvency be made, DHS shall have the authority to draw on the account to pay incurred claims. Upon completion of the contract and/or settlement of all claims, the remaining balance in the account will be released to the Contractor.

**6.6.2 Surplus Fund**

The Contractor must maintain in surplus at all times, in the form of cash, short-term investments allowable as admitted assets, or restricted funds or deposits controlled by the Department of Human Services, an amount equal to 150% of the Contractor’s average monthly Medicaid claims fund (83.5% of the capitation payment) for the most recent quarter. Funds in the Insolvency Protection Account may be included in the surplus amount.

**6.6.3 Working Capital**

2727 The Contractor must maintain working capital in the form of cash or equivalent liquid assets  
2728 controlled by the Department of Human Services at least equal to the total amount of the  
2729 designated Medicaid administrative fund from the most recent three-month period of the  
2730 capitation payments.

2731

#### 2732 **6.6.4 Community Reinvestment Account**

2733

2734 The Contractor shall place 2.5% of its monthly capitation payments into the Community  
2735 Reinvestment Account for education and services that will be directed to Iowa Plan Enrollees.  
2736 Any interest earned on the Community Reinvestment Account must be returned to the state. The  
2737 Contractor shall use the funds, upon the approval of the Departments, to further access to care,  
2738 best practices and goals of recovery and coordination. The Contractor shall be required to  
2739 conduct a structured evaluation of all Community Reinvestment Account initiatives using a  
2740 rigorous evaluative mechanism subject to state approval.

2741

2742 DHS may change the percentage of its monthly capitation payments to be paid into the  
2743 Community Reinvestment Account at any point at during the contract period, with federal  
2744 approval. For additional requirements pertaining to the Community Reinvestment Account, see  
2745 Section 9.

2746

#### 2747 **6.6.5 Interest Earned**

2748

2749 All funds held in the Community Reinvestment Account must be placed in a separate interest-  
2750 bearing account. Likewise, all funds held in the Claims Fund must be placed in a separate  
2751 interest-bearing account. Pursuant to Iowa state law, all interest earned on funds held in the  
2752 Community Reinvestment Account and the Claims Fund shall be paid to DHS at the end of each  
2753 quarter.

2754

### 2755 **6.7 CLAIMS PAYMENT BY THE CONTRACTOR**

2756

#### 2757 **6.7.1 Medicaid Claims Payment**

2758

2759 The Contractor is responsible for paying all claims for mental health and substance abuse services  
2760 provided to Enrollees unless the services are excluded or unauthorized. The Contractor shall  
2761 allow providers at least twelve months following the provision of a service that is appropriate for  
2762 reimbursement under the terms of the contract to submit a claim for that service. In addition,  
2763

2764

- 2765 • the Contractor must provide a claims payment system which includes the capability to
- 2766 • the Contractor must provide a claims payment system which accurately supports payment
- 2767 of claims submitted for Enrollees' periods of eligibility, including retroactive eligibility.

2768

2769 The Contractor also shall have the capability to provide electronic remittance advice and to  
2770 transfer claims payment electronically. The Departments encourage the Contractor to process as  
2771 many claims as possible electronically. The Contractor shall track electronic vs. paper claim  
2772 submissions over time to measure success in increasing electronic submissions.

2773

2774 The Contractor shall comply with the following timeframes for the payment of claims.

2775 Timeframes are calculated from the day the claim is received by the Contractor until the date of

2776 the postmark (or electronic record for electronic remittance) which returns either the payment or  
2777 denial to the provider:

- 2778 • for at least 85% of claims submitted, payment shall be mailed or claims shall be denied  
2779 within 14 days of the date the claim is received by the Contractor;
- 2780 • for at least 90% of claims submitted, payment shall be mailed or claims shall be denied  
2781 within 30 days of the date the claim is received by the Contractor, and
- 2782 • for 100% of claims submitted, payment shall be mailed or claims shall be denied within  
2783 90 days of the date the claim is received by the Contractor.

2784 DHS may require repayment of up to 5% of each month's capitation payment for each month the  
2785 Contractor fails to meet any of these requirements until the Contractor can document compliance  
2786 for at least two consecutive months.

2787

#### 2788 **6.7.1.1 Requirements Related to Claims Submission**

2789

2790 The Contractor's claims payment system shall utilize the CMS Healthcare Common Procedural  
2791 Codes System (HCPC) for adjudication of provider claims. Level I and Level II codes shall be  
2792 recognized where they exist. If Level III codes do not exist for traditional Medicaid services the  
2793 Contractor shall jointly with the Department request standard codes of the national committees.

2794

2795 The Contractor shall comply with the requirements related to claims forms as set forth in the Iowa  
2796 Administrative Code Chapter 441-80.2. This will include the use of CMS-1500, Health  
2797 Insurance Claim Form for providers of outpatient services, and Form UB-04 for hospitals  
2798 providing inpatient or outpatient services. For providers filing electronic claims HIPAA formats  
2799 set forth in Iowa Administrative Code Chapter 441-80.2 shall be required. When an identified  
2800 problem exists with filing or accepting the HIPAA formats the Contractor shall follow the CMS  
2801 instructions.

2802

2803 Any claims forms or payment methodology developed by the Contractor for use by providers  
2804 must be approved by the Departments and must be in such a format as to assure the submission of  
2805 encounter data as required in this RFP.

2806

#### 2807 **6.7.1.2 Contractor Responsibility for Co-payments and Crossover Claims**

2808

2809 The Contractor shall not be responsible for co-payments and crossover claims for mental health  
2810 and substance abuse services provided to those Enrollees who are eligible for both Medicare and  
2811 Medicaid.

2812

#### 2813 **6.7.2 Payment by the Contractor of IDPH Funds**

2814

2815 The Contractor will provide prospective reimbursement each month to contracted IDPH-funded  
2816 substance abuse network providers for defined services for defined populations. (Section 9.3.4  
2817 provides details regarding the IDPH payment to the Contractor).

2818

#### 2819 **6.7.3 Coordination of Benefits**

2820

2821 The Contractor shall report any findings of third party liability for an Enrollee or IDPH  
2822 Participant to the Departments.

2823

2824 **6.8 FRAUD AND ABUSE**

2825

2826 The Contractor shall implement internal controls, policies, and procedures designed to prevent,  
2827 detect, review, report to the Departments, and assist in the prosecution of fraud and abuse  
2828 activities by providers, subcontractors, and Eligible Persons. The policies and procedures shall  
2829 articulate the Contractor's commitment to comply with all applicable Federal and State standards.  
2830 In order to implement the above, the Contractor must submit a written fraud and abuse plan to the  
2831 Departments for approval prior to the contract implementation date.

2832

2833 6.8.1 The Contractor's fraud and abuse plan must include, but is not limited to the  
2834 following components:

- 2835 • The designation of an Iowa compliance officer and a compliance committee  
2836 that are responsible for the Contractor's fraud and abuse program and  
2837 activities. The compliance officer is supervised by and reports to the  
2838 Executive Director;
- 2839 • Provision for a data system, resources and staff to perform the fraud, abuse,  
2840 and other compliance responsibilities;
- 2841 • Procedures for internal prevention, detection, reporting, review, and  
2842 corrective action;
- 2843 • Procedures for prompt response to detected offenses;
- 2844 • Procedures for reporting to the Departments, including timelines and use of  
2845 state approved forms;
- 2846 • Written standards for organizational conduct;
- 2847 • A compliance committee that periodically meets and documents review of  
2848 compliance issues. These issues include fraud, abuse, and regulatory and  
2849 contractual compliance.
- 2850 • Effective training and education for the compliance officer and the  
2851 organization's employees, management, board members, and subcontractors;
- 2852 • Inclusion of information about fraud and abuse identification and reporting in  
2853 Provider and Eligible Person materials; and
- 2854 • Enforcement of standards through well-publicized disciplinary guidelines.

2855

2856 6.8.2 The Contractor's fraud and abuse activities should include, but not be limited to the  
2857 following:

- 2858 • conducting regular reviews and audits of operations to guard against fraud  
2859 and abuse;
- 2860 • assessing and strengthening internal controls to ensure claims are submitted  
2861 and payments are made properly;
- 2862 • educating employees, network providers, and members about fraud and  
2863 abuse and how to report it;
- 2864 • effective organizational resources to respond to complaints of fraud and  
2865 abuse;

- 2866 • establishing procedures to process fraud and abuse complaints;
- 2867 • establishing procedures for reporting information to the Departments;
- 2868 • developing procedures to monitor utilization/service patterns of Providers,
- 2869 subcontractors, and Eligible Persons;
- 2870 • promulgating written policies for all employees, including management, and
- 2871 for all employees of any Contractor or agent, that provide detailed
- 2872 information about the following:
  - 2873 • the Federal False Claims Act under title 31 of the United States Code,
  - 2874 sections 3729 through 3733;
  - 2875 • administrative remedies for false claims and statements under title 31 of
  - 2876 the United States Code, chapter 38; any State laws pertaining to civil or
  - 2877 criminal penalties for false claims and statements;
  - 2878 • Whistleblower protections under such laws, with respect to the role of
  - 2879 such laws in preventing and detecting fraud, waste, and abuse in Federal
  - 2880 health care programs (as defined in title 42 of the United States Code,
  - 2881 section 1320a-7b(f)), and
  - 2882 • the Contractor's policies and procedures for detecting and preventing
  - 2883 fraud, waste, and abuse.
  - 2884

2885 6.8.3 The Contractor must report possible fraud or abuse activity to the Departments. The  
2886 Contractor must initiate an immediate investigation to gather facts regarding the possible  
2887 fraud or abuse. Documentation of the findings of the investigation must be delivered to  
2888 the Departments within ten (10) days of the identification of suspected fraud or abuse  
2889 activity. In addition, the Contractor shall provide reports of its investigative, corrective,  
2890 and legal activities with respect to fraud and abuse to the Departments in accordance with  
2891 contractual and regulatory requirements. The Contractor and its subcontractors shall  
2892 cooperate fully in any state reviews or investigations and in any subsequent legal action.  
2893 The Contractor must implement corrective actions in instances of fraud and abuse  
2894 detected by the State agency, or other authorized agencies or entities.  
2895  
2896

2896

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

**SECTION 7**

**FORMAT AND GENERAL REQUIREMENTS  
OF PROPOSALS**

To be considered responsive to this Request for Proposals, proposals must comply with all the requirements set forth in this RFP. Proposals that fail to comply will be declared non-responsive and eliminated from the review process.

**7.1 FORMAT OF PROPOSALS**

Proposals shall be prepared according to the following requirements:

- proposals shall be typewritten and printed on paper which measures 8 1/2 by 11 inches; the smallest allowable type size is 11 points, excluding charts and graphs;
- proposals shall be bound in a manner which allows for the easy removal of individual pages or sections, but which also ensures that proposals shall arrive intact;
- pages shall be numbered in a manner that clearly demonstrates compliance with page limits;
- the name of the organization submitting the proposal shall be noted on each page;
- proposals shall be organized and numbered in a manner which facilitates reference to this RFP and its requirements;
- proposals shall not exceed the page limits set in Section 7A, and
- attachments are allowable only where noted; and when they are allowed, they are excluded from the established page limit.

**7.2 WRITING STYLE FOR PROPOSALS**

Proposals shall be written in a style that assists readers to understand the commitments that the Bidder is willing to make to Iowa Plan Eligible Persons and to the Departments.

- Responses to each section shall be wholly contained within that section and any attachments as allowed.
- Responses shall identify and address both mental health and substance abuse service provision.
- It is the Bidder's responsibility to provide correct and accurate information throughout the Bidder's proposal. This shall include, but is not limited to, names, addresses, telephone numbers, and e-mail addresses where requested.

**7.3 TRANSMITTAL LETTER (not to exceed three (3) pages)**

40 The transmittal letter shall be in the form of a standard business letter and be written on the  
41 letterhead of the Bidder submitting the proposal. An individual authorized to legally bind the  
42 Bidder must sign the letter. The transmittal letter shall be addressed to:

43 Jennifer Vermeer, Director  
44 Iowa Medicaid Enterprise  
45 Department of Human Services  
46 100 Army Post Road  
47 Des Moines, Iowa 50315  
48

49 The transmittal letter shall include the Bidder's:

- 50 • the name, title, signature, address and telephone number of the Chief Executive Officer or  
51 other individual authorized to legally bind the Bidder;
- 52 • the name, address, electronic mail address, fax number, and telephone number of the  
53 Bidder's representative to contact regarding all contractual and technical matters  
54 concerning this Proposal;
- 55 • the name, address, electronic mail address, and telephone number of the Bidder's  
56 representative to contact regarding scheduling and other arrangements;
- 57 • a statement identifying the Bidder's form of business, i.e., corporation, partnership, etc.;
- 58 • a statement acknowledging receipt of any amendments to this RFP and the Departments'  
59 responses to questions submitted by the Bidder which have been received by the Bidder;  
60 if no amendments or responses, a statement to that effect;
- 61 • a statement indicating that the Bid Proposal is predicated upon the acceptance of all terms  
62 and conditions stated in the RFP. The Bidder shall indicate that it will meet all  
63 requirements of the RFP.
- 64 • a statement indicating that the Bidder has submitted the Mandatory Requirements and  
65 Disqualification Checklist with the transmittal letter;
- 66 • a statement of certification of independence and no conflict of interest in providing scope  
67 of work required under this RFP;
- 68 • any request for confidential treatment of information, including the specific statutory  
69 basis supporting the request and an explanation of why disclosure of the information is  
70 not in the best interest of the public. The transmittal letter shall also contain the name,  
71 address, electronic mail address, and telephone number of the individual authorized to  
72 respond to the Departments about the confidential nature of the information;
- 73 • a statement of affirmative action that the Bidder does not discriminate in its employment  
74 practices with regard to race, color, religion, sex, marital status, political affiliation,  
75 national origin or disability, and
- 76 • the following assurances:
  - 77 • a statement that the Bidder will furnish the mental health and substance abuse  
78 services required by Enrollees as promptly as is appropriate and that the services  
79 provided will meet the Departments' quality standards;
  - 80 • a statement that the percentage of the Medicaid capitation payment designated for the  
81 Claim Fund is payment in full for all required and covered services plus any optional  
82 or other services provided to Iowa Plan Enrollees by the Contractor; that any costs

- 83 for services in excess of the capitation payment are the sole responsibility of the  
84 Contractor;
- 85 • a statement that the percentage of the capitation payment designated for the Medicaid  
86 Administrative Fund is payment in full for all required administrative services related  
87 to Iowa Plan Enrollees; that any costs for administrative services in excess of the  
88 capitation payment are the sole responsibility of the Contractor;
  - 89 • a statement that the IDPH payment designated for the IDPH Administrative Fund is  
90 payment in full for all IDPH-related administrative services required of the  
91 Contractor in this RFP;
  - 92 • a statement that the Bidder agrees to place programs at risk for the costs of services to  
93 IDPH Participants;
  - 94 • a statement acknowledging that liquidated damages may be imposed for failure to  
95 perform as set forth in this RFP;
  - 96
  - 97 • a statement acknowledging that the contract will be performance-based and both  
98 incentives and disincentives may apply to the Contractor's performance as set forth  
99 in this RFP, and
  - 100
  - 101 • a statement that the Bidder will meet all provisions set forth in the Bidder's proposal.
  - 102

#### 103 **7.4 BID BOND REQUIRED**

104  
105 Each Bidder, as a mandatory part of its proposal, shall submit a bid bond or a certified check in  
106 favor of, or made payable to, the State of Iowa in the amount of \$100,000.00.

107  
108 The bid security of all Bidders shall be retained until after the award of the contract is made. The  
109 bid security of the successful Bidder shall be retained until the contract is executed. If a Bidder  
110 fails to enter into a contract, the forfeiture of the bid security will be kept by the Department.

#### 111 112 **7.5 REQUIRED ADDENDA**

113  
114 Attachment 7 to the RFP includes required addenda for all contracts with the state of Iowa and  
115 required certifications that must be fully completed, signed by the Bidder, referenced in the  
116 Transmittal Letter and included in the Bid proposal.

117  
118

118

1

2

3

4

5

6

7

8

**SECTION 7A**

**REQUIRED CONTENT OF PROPOSALS**

**7A.1 ELEMENTS OF THE PROPOSAL**

The proposal shall include the following elements and have the corresponding page limits, excluding requested attachments:

- Programmatic Overview (**150 pages**)
- Outline of Corporate Organization and Experience (**15 pages**)
- Outline of Project Staffing and Organization (**10 pages**)
- Completed copy of the Budget Worksheet (provided in Section 7A.5) and accompanying narrative (**3 pages**)

If a page limit is imposed for any of the above elements, it will be noted in the section associated with each element.

**7A.2 PROGRAMMATIC OVERVIEW (not to exceed 150 pages)**

The responses contained in the Programmatic Overview will form the basis for the services the Contractor will perform.

**7A.2.1 Executive Summary**

The Executive Summary shall condense and highlight the Contractor's proposal to provide readers and evaluators a broad understanding of the approach the Bidder is proposing for operating the Iowa Plan. It should highlight the ways in which the Bidder's approach enhances Iowans' opportunity to receive effective and appropriate mental health and substance abuse services in a manner that is consistent with the philosophy, values and goals of the Iowa Plan.

**7A.2.2 Enrollees 65 and Older**

Describe the Bidder's experience in treating individuals aged 65 and older. Please provide information on:

- other states in which the Bidder provides or has provided such coverage;
- particular challenges the Bidder has encountered in serving this population;
- any recommended additions to the provider network to better serve those aged 65 and older, and
- a proposed transition plan to ensure continuity of care while enrolling the population into the Iowa Plan, including a communication plan.

**7A.2.3 Coordination and Integration of Services**

41

42

43

44 **(Sections 4.1, 4A, 4B, and 5A of this RFP)**  
45

46 a) Describe what strategies the Bidder would employ to ensure the coordination and integration  
47 of service delivery for Eligible Persons who receive services through the Iowa Plan. In particular,  
48 please describe how the Bidder will improve integration of services for:  
49

- 50 • Eligible Persons with concurrent mental health and substance abuse conditions
- 51 • Eligible Persons with concurrent medical and mental health and/or substance abuse  
52 conditions;
- 53 • Eligible Persons with mental health and/or substance abuse conditions who are  
54 involved with the adult correctional system;
- 55 • Enrollees with concurrent mental health needs and mental retardation, and
- 56 • Eligible Persons with mental health and/or substance abuse conditions who are  
57 involved with the child welfare/juvenile justice.

58  
59 Include background information, research data, and your experience in other states on how best to  
60 structure coordination and integration. Describe lessons learned and how they will be applied in  
61 Iowa.  
62

63 **7A.2.4 Rehabilitation, Recovery, and Strength-Based Approach to Services**  
64 **(Sections 4.A.2 and 4.B.2 of this RFP)**  
65

66 a) Describe the Bidder's experience in providing behavioral health services through a recovery-  
67 oriented approach and detail the model that the Bidder would implement under the Iowa Plan to  
68 promote this approach to care, recognizing the priority that the Departments are placing on  
69 effecting change in this area during the Contract period. The description should specifically  
70 address what approach it will take with respect to:  
71

- 72 • Contractor interactions with Eligible Persons;
- 73 • service system planning and design, and
- 74 • provider adoption of a rehabilitation, recovery and strength-based approach to  
75 services.

76  
77 **7A.2.5 Person-Centered Care**  
78

79 a) Describe the Bidder's philosophy of how best to involve Eligible Persons in the planning of  
80 their care. The description should include:  
81

- 82 • how the Bidder intends to ensure Eligible Person and, as appropriate, family  
83 members, participation in treatment planning, and
- 84 • a description of any instances in which it employed such strategies with each of these  
85 populations under other contracts, with documentation of any related measurements  
86 of effectiveness.

87  
88 b) Provide the names, telephone numbers and email addresses of two references who can be  
89 contacted to confirm the effectiveness of the Bidder's performance.  
90

91  
92 **7A.2.6 Covered Services, Required Services, Optional Services**  
93 **(Sections 4A.3, 4A.4 and 4B.3 of this RFP)**

- 94  
95 a) Describe the Bidder's strategy to ensure statewide capacity for required services  
96  
97 b) Describe any additional existing service gaps, by region, which the Bidder has identified in  
98 preparing this proposal, and the basis on which the Bidder has made this determination. Describe  
99 how the Bidder would address those gaps and provide an implementation timeline showing the  
100 dates for the introduction of any new services that the Bidder would provide, by region.

101  
102 The Bidder shall minimally address:

- 103     • Level I Sub-acute Facility services delivery  
104     • 24 hour mental health stabilization services, noting that past attempts to do so for the  
105 Iowa Plan have not proven successful, and  
106     • Substance abuse peer support/recovery coaching.  
107  
108 c) Describe the process by which integrated mental health services and supports will be  
109 authorized for Enrollees and who will be allowed to authorize them. Include any parameters that  
110 would be implemented to guide the authorization of integrated services and supports. The Bidder  
111 should provide examples of any past experience with the provision of such services.

112  
113 d) Describe how the Bidder will incorporate evidence-based practice into its management of the  
114 Iowa Plan and how that will impact the services offered through the Iowa Plan during the term of  
115 the Contract.

116  
117 e) Should the Bidder anticipate that it will elect not to provide, reimburse for, or provide coverage  
118 of, a counseling or referral service because of an objection on moral or religious grounds,  
119 describe services that it will not provide.

120  
121 **7A.2.7 Organization of Utilization Management Staff**  
122 **(Section 5A.1 of this RFP)**  
123

124 a) Describe the Bidder's proposed organization of Utilization Management Staff. The description  
125 should include:

- 126  
127     • the number of Utilization Management staff which the Bidder proposes, their  
128 credentials and expertise, and the rationale behind the number and the mix of  
129 expertise the Bidder has determined would be necessary;  
130     • a discussion of what the precise roles of each of the different types of Utilization  
131 Management staff would be;  
132     • the way in which the Bidder proposes to ensure maximum coordination between  
133 Utilization Management staff and local service delivery systems, and  
134     • the method by which the Bidder would ensure continuity of Utilization Management  
135 for Eligible Persons who make frequent use of the delivery system.

136  
137 b) Provide the names, telephone numbers, and e-mail addresses of three of the Bidder's clients for  
138 which it has organized its Utilization Management staff to maximize coordination with local  
139 service delivery systems and who can be contacted to confirm the effectiveness of the Bidder's  
140 performance.

141  
142 **7A.2.8 Utilization Management**

**(Sections 5A.5 of this RFP)**

143  
144  
145  
146  
147  
148  
149  
150  
151  
152  
153  
154  
155  
156  
157  
158  
159  
160  
161  
162  
163  
164  
165  
166  
167  
168  
169  
170  
171  
172  
173  
174  
175  
176  
177  
178  
179  
180  
181  
182  
183  
184  
185  
186  
187  
188  
189  
190  
191  
192

- a) Attach to the proposal a complete copy of any Utilization Management Guidelines that the Bidder would use in authorizing mental health services. Also, attach any guidelines the Bidder would use in applying ASAM criteria for the authorization or retrospective monitoring of substance abuse services. The attachment(s) must be clearly numbered and labeled. The pages in the attachments(s) will not be counted in the page limit established for this section of the proposal.
- b) Describe how the Utilization Management Guidelines would generally be applied to authorize or retrospectively review services. Specifically address how the Bidder would both manage the appropriateness of treatment duration and the potentially high volumes of service requests.
- c) Discuss any special issues in applying the UM Guidelines for:
- i. substance abuse services for pregnant and parenting women;
  - ii. substance abuse services provided to Enrollees in PMICs;
  - iii. mental health inpatient services provided to Enrollee children in state mental health institutes;
  - iv. Eligible Persons with concurrent need for both mental health and substance abuse treatment, and
  - v. Assertive Community Treatment (ACT).
- d) List each Medicaid mental health or substance abuse service or level of care for which the Bidder would not require prior authorization.
- i. Describe a quality improvement related circumstance that would lead the Bidder to request Departments approval to require prior authorization for a service that does not usually require authorization.
- e) Discuss how the Bidder would self-evaluate both the clinical effectiveness and administrative efficiency of these authorization processes. Describe in what circumstances, if any, the Bidder would consider waiving prospective utilization review for certain providers based on a provider's past performance.
- f) Describe how the Bidder would operationalize the state's concept of "psychosocial necessity" in the authorization process for mental health services and "service need" in the authorization process for substance abuse services. Contrast this to the Bidder's use of a stricter "medical necessity" approach with clients under other contracts, or, if not applicable, describe how, in the Bidder's understanding, the authorization process approaches differ.
- g) Describe the process the Bidder would implement for the administrative authorization of services. Include the way in which the Bidder would allow for authorization for services provided during all the months of enrollment even if Medicaid eligibility is determined after the initiation of services.
- h) Describe how the Bidder would provide Intensive Clinical Management to certain Iowa Plan Enrollees, and the relationship of those activities to Targeted Case Management.
- i) Describe how the Bidder would provide 24 hour crisis management, and provide examples of how that service has been provided in other states.

193  
194  
195  
196  
197  
198  
199  
200  
201  
202  
203  
204  
205  
206  
207  
208  
209  
210  
211  
212  
213  
214  
215  
216  
217  
218  
219  
220  
221  
222  
223  
224  
225  
226  
227  
228  
229  
230  
231  
232  
233  
234  
235  
236  
237  
238  
239  
240  
241  
242

**7A.2.9 Required Elements of Individual Service Coordination and Treatment Planning  
(Sections 1.9 and 5A.5 of this RFP)**

- a) Describe the 24-hour crisis and referral service that the Bidder would make available to Iowa Plan Eligible Persons. The description should include a discussion of:
- how the Bidder would ensure the availability of clinicians with expertise in providing mental health and substance abuse services to children, and
  - how the 24-hour crisis and referral service would interface with the emergency crisis service system.
- b) Describe the Bidder’s process for identifying those Eligible Persons who have demonstrated the need for a high level of services or who are at risk of high utilization of services. Describe how the Bidder would initiate ongoing treatment planning and coordination with the Iowa Plan Eligible Persons and all others appropriate for planning the Eligible Person’s treatment.
- c) Describe the program the Bidder would implement in conjunction with officers of the courts to assure that court-ordered treatment complies with substance abuse criteria and therefore is reimbursable through the Iowa Plan.
- d) Describe how the Bidder would actively promote and ensure coordination by Iowa Plan network providers with Enrollee’s primary care physicians
- describe how the Bidder will assess network provider compliance with such care coordination requirements, and
  - provide results of monitoring efforts conducted for other clients of the Bidder to verify that coordination had been occurring effectively. Information provided should include the names of the programs and the names and telephone numbers and e-mail addresses of three references that can be contacted to verify the description submitted by the Bidder.

**7A.2.10 Children in Transition**

Describe the Bidder’s experience in transitioning children from inpatient settings (including inpatient hospital and PMIC-like entities) and provide successful strategies for putting in place appropriate discharge placement from such settings.

**7A.2.11 Appeal Process  
(Section 5B.2 of this RFP)**

a) Describe the process the Bidder would put in place for the review of Enrollee appeals, including which staff would be involved. Provide a flowchart that depicts the process and time frames the Bidder would employ, from the receipt of a request through each phase of the review to notification of disposition.

**7A.2.12 Grievance and Complaint Processes  
(Sections 5B.1 and 5B.3 of this RFP)**

243

244 a) Describe the processes the Bidder would put in place for the review of Enrollee grievances and  
245 Eligible Persons complaints.

246

247 **7A.2.13 Requirements for the Provider Network**

248 **(Section 5C.1 of this RFP)**

249

250 a) Describe how the Bidder would ensure that the provider network is adequate and that access is  
251 maintained or increased to meet the needs of Iowa Plan Eligible Persons. Where there are  
252 potential issues of lack of capacity within the Bidder's network, please describe the steps the  
253 Bidder would take to increase capacity. Provide examples from current contracts of how the  
254 Bidder has ensured network adequacy in states with a shortage of psychiatrists or other specific  
255 behavioral health professionals.

256

257 b) Describe proposed strategies to bring services to underserved communities, including but not  
258 limited to:

259

- 260 • the use of telehealth and distance treatment options, and
- 261 • provision of child psychiatric consultation services to primary care clinicians.

262

263 c) Describe the Bidder's experience under other contracts to ensure delivery of services to these  
264 populations when provider network capacity was initially found to be inadequate. Include the  
265 names of the programs and provide the names, telephone numbers and e-mail addresses of three  
266 references who can be contacted to verify the description submitted by the Bidder.

267

268 d) Describe the Bidder's experience in implementing Medicaid managed behavioral health  
269 programs in which the Bidder successfully promoted the development of:

270

- 271 • psychiatric rehabilitation services;
- 272 • mental health self-help and peer support groups, and
- 273 • peer education services.

274

275 Provide the names of the programs and provide the names, telephone numbers and e-mail  
276 addresses of three references that can be contacted to verify the description submitted by the  
277 Bidder.

278

279 e) Describe the Bidder's experience with contracts that include SAPT Block Grant funding.  
280 Provide the names, telephone numbers and email addresses of two references that can be  
281 contacted to verify the description submitted by the Bidder.

282

283 f) Describe the Bidder's experience contracting with networks of comparable or greater size  
284 than those of the Iowa Plan within the timeframe afforded by this procurement. Provide the  
285 names of the programs and provide the names, telephone numbers and e-mail addresses of three  
286 references that can be contacted to verify the description submitted by the Bidder.

287

288 **7A.2.14 Network Management**

289 **(Section 5C.5 of this RFP)**

290

291 a) Describe how the Bidder would actively manage quality of care provided by network providers  
292 of all covered services. The description should include:

- 293
- 294
- 295
- 296
- 297
- 298
- 299
- 300
- 301
- 302
- 303
- 304
- 305
- 306
- 307
- 308
- 309
- 310
- 311
- 312
- 313
- the Bidder’s proposed methodology for conducting provider profiling, including as examples, the content of the report for providers of inpatient mental health services to children; providers of outpatient mental health services to adults, and providers of substance abuse services. The Bidder shall specify the frequency of report distribution, and a timeline for developing and implementing provider profiles for all provider and service types;
  - the explicit steps the Bidder would take with each profiled provider following the production of each profile report, including a description of how the Bidder would generate and facilitate improvement in the performance of each profiled provider;
  - the process and timeline the Bidder proposes for periodically assessing provider progress on its implementation of strategies to attain improvement goals;
  - examples of how the Bidder has used provider profiling to improve services delivered by a provider, or provider type in a managed care program;
  - a description of how the Bidder would reward providers who demonstrate continued excellence and/or significant performance improvement over time, and how the Bidder would share “best practice” methods or programs with providers of similar programs in its network, and
  - a description of how the Bidder would penalize providers who demonstrate continued unacceptable performance or performance that does not improve over time.

314 b) Describe any comparable network management activities performed by the Bidder for other  
315 state clients.

316

317 c) Provide copies of provider profiles that the Bidder has employed for two clients, and describe  
318 measurable performance improvement achieved as a result of such efforts.

319

320 d) Describe the Bidder’s plan to assure the accuracy of I-SMART data submitted by the providers  
321 of substance abuse services (Section 4B.5).

322

323 **7A.2.15 Quality Assessment and Performance Improvement Program**  
324 **(Section 5D of this RFP)**

325

326 a) Describe the Bidder’s experience in using data-driven evaluation of organization-wide  
327 initiatives to improve the health status of covered populations. Provide quantified, statistically  
328 significant evidence of:

- 329
- 330
- 331
- 332
- 333
- 334
- 335
- improved mental health quality – process measures;
  - improved substance abuse quality – process measures;
  - improved mental health quality – functional or clinical outcome measures;
  - improved substance abuse quality – functional or clinical outcome measures;
  - improved mental health quality – consumer-reported outcome measures, and
  - improved substance abuse quality – consumer-reported outcome measures.

336

337 Include the names of the programs and provide the names, telephone numbers and e-mail  
338 addresses of three references that can be contacted to verify the description submitted by the  
339 Bidder.

340

341 c) Describe the Bidder’s experience with implementing instruments in publicly funded managed  
342 care programs that assess changes in functional status and/or recovery. Specify the tools, the

343 populations and subpopulations of consumers with whom the tools were applied, the size of the  
344 sampled groups, the nature of the findings, and what was done with the captured information.  
345

346 d) Describe how the Bidder would involve Eligible Persons and family members in the quality  
347 assessment and performance improvement program  
348

349 e) Describe the way in which the Bidder would utilize state pharmacy data to:

- 350 • identify utilization that deviates from clinical practice guidelines for schizophrenia  
351 and major depression, and
- 352 • identify those Enrollees whose utilization of controlled substances warrants  
353 intervention either because of multiple prescribers, excessive quantities or  
354 prescribing that is inconsistent with the clinical profile of the Enrollee.

355 f) Identify what the Bidder believes to be the greatest opportunities for quality improvement in  
356 public managed behavioral health programs like the Iowa Plan. Discuss the approaches the  
357 Bidder would pursue to realize two such opportunities in Iowa.  
358

359 h) Describe the Bidder's experience in adapting policies or procedures based on input from  
360 publicly funded consumers and from advocacy groups. Describe the measured impact of the  
361 changes based on quality assessment studies, feedback from affected groups, or other data.  
362

363 Include the names of the programs and provide the names, telephone numbers and e-mail  
364 addresses of consumer advocacy groups that can be contacted to verify the description submitted  
365 by the Bidder.  
366

367 i) Describe the process by which the Bidder would conduct retrospective monitoring of all  
368 substance abuse service providers in accordance with Section 5.D.1.2. The description should  
369 include:

- 370 • the source of the evaluation tool with which the Bidder would assess the  
371 appropriateness of clinical services delivered, and
- 372 • what actions the Bidder would propose to take with a provider who it has determined  
373 does not deliver services or follow contract guidelines appropriately, both in the  
374 event of an initial finding and of a repeated finding.  
375

376 g) Provide a copy of a 2008 QA plan that the Bidder developed for a publicly funded client.  
377

378 **7A.2.16 Prevention and Early Intervention**  
379 **(Section 4A.4.2 of this RFP)**  
380

381 a) Describe the strategy that the Bidder will invoke in order to increase access to and utilization  
382 of prevention and early intervention services. Describe the Bidder's experience in implementing  
383 such strategies under other contracts. Describe the measured impact of such programs in terms of  
384 changes in the process and outcomes of care.  
385

386 Include the names of the programs and provide the names, telephone numbers and e-mail  
387 addresses of three references that can be contacted to verify the description submitted by the  
388 Bidder.  
389

390 **7A.2.17 Management Information System**  
391 **(Section 6.4 of this RFP)**

392

393 a) Describe in detail the management information system the Bidder would implement for the  
394 Iowa Plan. The description should emphasize the way in which the MIS system would function  
395 to gather required data and produce required reports as well as providing detail on hardware  
396 capabilities.

397

398 b) Describe adaptations to the Bidder's MIS which would be made to allow reimbursement for  
399 covered, required and optional services provided even if the Enrollee's Medicaid eligibility and  
400 Iowa Plan enrollment effective date were determined subsequent to the Eligible Person's month  
401 of application.

402

403 c) Describe the process the Bidder would put into place to ensure appropriate allocation of  
404 reimbursement in the following situations:

405

406 • services were being provided to a person who was an Enrollee and whose Medicaid  
407 eligibility terminated and the person then, during the same treatment episode, became  
408 a IDPH Participant, and

409 • services were being provided to a person who was an IDPH Participant receiving  
410 services and, during the same treatment episode, became an Enrollee.

411

412 Provide as references the name, telephone number and e-mail addresses of three publicly funded  
413 clients that can be contacted to discuss the Bidder's MIS performance under similar contracts.

414

#### 415 **7A.2.18 Financial Requirements**

416 **(Section 6.6 of this RFP)**

417

418 a) Disclose the financial instruments the Bidder would use to meet the requirements of all fund  
419 and accounts required in Section 6.6. Disclose the source of the capital required.

420

421 b) Demonstrate that the Bidder's organization is in sound financial condition and/or that  
422 appropriate corrective measures are being taken to address and resolve any identified financial  
423 problems. The Bidder must attach the most recent two (2) years of independently certified audited  
424 financial statements of the Bidder's organization as well as the most recent two years of financial  
425 statements for the Bidder's parent company, if applicable. These financial statements are not  
426 included in the page limit established for this section.

427

428 c) Discuss what impact the recent declines in the stock market have had on the Bidder's  
429 financial stability, how the Bidder has responded, and any implications for the Bidder's ability to  
430 meet the requirements of this RFP.

431

#### 432 **7A.2.19 Claims Payment by the Contractor**

433 **(Section 6.7 of this RFP)**

434

435 a) Describe the process the Bidder would implement to ensure compliance with the required time  
436 frames for claims processing. The Bidder may suggest more restrictive time frames than those  
437 required in Section 6.7 of this RFP for the processing of claims that the Bidder wishes to  
438 implement.

439

440 b) Describe the Bidder's experience in implementing contracts in which the claims payment  
441 process supported the accurate and timely payment of claims as of the first day of operations.

442 Include the names of the programs, the number of covered lives in each, and provide the names,  
443 telephone numbers and e-mail addresses of three references that can be contacted to verify the  
444 description submitted by the Bidder.

445

446 **7A.2.20 Fraud and Abuse**  
447 **(Section 6.8 of this RFP)**  
448

449 a) Describe how the Bidder will comply with the Departments' Fraud and Abuse requirements  
450 and provide examples of how your internal controls successfully work to prevent such Fraud and  
451 Abuse.

452

453 **7A.3 CORPORATE ORGANIZATION AND EXPERIENCE (not to exceed 15 pages)**  
454

455 This section of the proposal shall include details of the Bidder's organization, its size and  
456 resources, management strategy, and corporate experience relevant to the Iowa Plan.

457

458 a) The Bidder shall provide the following information on all current publicly funded managed  
459 behavioral health care contracts:

460

- 461 • contract size: average monthly covered lives and annual revenues;
- 462 • contract start date and duration;
- 463 • general description of covered population and services (e.g., Medicaid, SAPT Block  
464 Grant, state-funded population for mental health and/or substance abuse services,  
465 state hospital, etc.);
- 466 • client name and mailing address, and
- 467 • a contact person and his or her telephone number and e-mail address

468

469 Letters of support or endorsement from any individual, organization, agency, interest group or  
470 other entity are not to be included in this section or in response to any part of this RFP.

471

472 **7A.3.1 Organizational Information**  
473

474 a) Attach lists and organizational charts showing any and all owners, voting and non-voting  
475 members of the Board of Directors, officers and executive management staff, including CEO,  
476 COO, CFO, Medical Director, UM Director, QM/QI/QA Director and MIS Director or equivalent  
477 functional personnel. Also provide the curriculum vitae for the aforementioned executive  
478 management staff. If the Bidder is a wholly or partly owned subsidiary or partnership, describe  
479 the legal, financial, organizational and operational arrangements and relationships between the  
480 Bidder and its parent(s) and any other related organizations; include an organizational chart. If the  
481 Bidder has subsidiaries, describe the legal, financial, organizational and operational arrangements  
482 and relationships between the Bidder and its subsidiaries; include an organizational chart.

483

484 Attachments should be clearly marked and shall not be counted within the allowed page limit.

485

486 **7A.3.2 Disclosure of Financial or Related Party Interest**  
487

488 a) The Bidder (and if the bid involves a partnership or another type of joint venture, all Bidders)  
489 must disclose any, and all, legal, financial, contractual or related party interests which the  
490 Bidder(s) shares with any Iowa provider or group of Iowa providers. This interest must be  
491 disclosed for the entire corporate structure of which the Bidder(s) may be a part. This disclosure

492 must include, but is not limited to, partnerships, joint venture agreements, affiliations and/or  
493 strategic alliances.

494

495 b) Should the Bidder or any partners have any legal, financial, contractual or related party  
496 interests with an Iowa provider or group of Iowa providers to be reimbursed through the Iowa  
497 Plan, the Bidder must demonstrate both (1) an organizational structure and (2) policies and  
498 procedures which would prevent the opportunity for, or an actual practice which allows, a  
499 situation in which the Contractor gains any financial benefit from any policy or practice related to  
500 network recruitment, referral, reimbursement, service authorization, monitoring and oversight, or  
501 any other practice which might bring financial gain.

502

503 The Bidder may attach articles of incorporation, bylaws, partnership agreements, articles of  
504 organization, and any operating agreement if the Bidder believes such information would  
505 substantiate the mechanism(s) by which it proposes to prevent any preferential treatment to those  
506 entities with which it shares a financial or related party interest. The attachment should be clearly  
507 marked and shall not be counted within the allowed page limit.

508

509 Situations that might indicate an attempt to assure financial gain include, but are not limited to:

510

- 511 • a change of the distribution of referrals or reimbursement among providers  
512 within a level of care;
- 513 • referral by the Contractor to only those providers with whom the Contractor  
514 shares an organizational relationship;
- 515 • preferential financial arrangements by the Contractor with those providers with  
516 whom the Contractor shares an organizational relationship;
- 517 • different requirements for credentialing, privileging, profiling or other network  
518 management strategies for those providers with whom the Contractor shares an  
519 organizational relationship;
- 520 • distribution of community reinvestment moneys in a way which gives preference  
521 to providers with whom the Contractor shares an organizational relationship, and
- 522 • substantiated complaints by Eligible Persons of limitations on their access to  
523 participating providers of their choice within an approved level of care.

524

### 525 **7A.3.3 Disclosure of Legal Actions**

526

527 a) The Bidder must disclose all relevant information related to the following questions or must  
528 make a statement that there is no applicable information. If the current corporate configuration is  
529 related to mergers, the information requested should be provided for all components of the  
530 merged entities:

531

- 532 • During the last five years, has the Bidder or any subcontractor identified in this  
533 proposal had a contract for services terminated for convenience, non-performance,  
534 non-allocation of funds, or any other reason for which termination occurred before  
535 completion of all obligations under the initial contract provisions? If so, provide full  
536 details related to the termination.
- 537 • During the last five years, has the Bidder been subject to default or received notice of  
538 default or failure to perform on a contract? If so, provide full details related to the  
539 default including the other party's name, address, and telephone number.
- 540 • During the last five years, describe any damages, penalties, disincentives assessed or  
541 payments withheld, or anything of value traded or given up by the Bidder under any

542 of its existing or past contracts as it relates to services performed that are similar to  
543 the services contemplated by the RFP and the resulting Contract. Indicate the reason  
544 for and the estimated cost of that incident to the Bidder.

- 545 • During the last five years, list and summarize pending or threatened litigation,  
546 administrative or regulatory proceedings, or similar matters that could affect the  
547 ability of the Bidder to perform the services contemplated in this RFP.
- 548 • During the last five years, have any irregularities been discovered in any of the  
549 accounts maintained by the Bidder on behalf of others? If so, describe the  
550 circumstances of irregularities or variances and disposition of resolving the  
551 irregularities or variances.
- 552 • The Bidder shall also state whether it or any owners, officers, primary partners, staff  
553 providing services or any owners, officers, primary partners, or staff providing  
554 services of any subcontractor who may be involved with providing the services  
555 contemplated in this RFP, have ever had a founded child or dependent adult abuse  
556 report, or been convicted of a felony.

557  
558 Failure to disclose these matters may result in rejection of the Bid Proposal or in  
559 termination of any subsequent contract. This is a continuing disclosure requirement.  
560 Any such matter commencing after submission of a Bid Proposal, and with respect to the  
561 successful Bidder after the execution of a contract shall be disclosed in a timely manner  
562 in a written statement to the Departments. For purposes of this subsection, timely means  
563 within thirty days from the date of conviction, regardless of appeal rights.  
564

565 **7A.4 PROJECT ORGANIZATION AND STAFFING (not to exceed 10 pages; excluding**  
566 **the curriculum vitae)**

567  
568 The proposal must include the following information:

569  
570 **7A.4.1 An Organizational Chart Which Demonstrates:**

- 571
- 572 • the Bidder's corporate structure, and
- 573 • the reporting relationship which staff assigned to the Iowa Plan would have with  
574 other parts of the Bidder's corporate structure.

575  
576 **7A.4.2 A Chart or Other Presentation Which Clearly Shows:**

- 577
- 578 • every position which would be working on the Iowa Plan;
- 579 • the name, qualifications and curriculum vitae (the curriculum vitae will be excluded  
580 from the page length limit for this section) of the individual who would be based  
581 within Iowa with management responsibility for the operation of the Iowa Plan;
- 582 • the reporting relationships between all positions;
- 583 • the credentials required of individuals to be hired for each clinical and management  
584 position, and
- 585 • the office locations of each individual.

586  
587 **7A.4.3 A Chart or Other Presentation Which Clearly Shows:**

- 588
- 589 • the subcontractors (including consultants, but excluding network providers) who  
590 would be working on the Iowa Plan;
- 591 • the responsibilities of those subcontractors;

- 592                   • special skills of those subcontractors, and  
593                   • the location of the office of each subcontractor from which it will provide its  
594                   subcontracted services.  
595

#### 596 **7A.4.4 Financial Information**

597 The Bidder shall provide the following information:

- 599                   • audited financial statements from independent auditors for the last three years.  
600                   Bidders who do not have financial statements shall provide a detailed explanation of  
601                   why they are not available and shall provide alternatives that are acceptable to the  
602                   Departments.  
603                   • Provide a minimum of three written financial references including contract  
604                   information.  
605

#### 606 **7A.5 BUDGET WORKSHEET AND DESCRIPTION (not to exceed 3 pages)**

607  
608 Bidders are **not** asked to submit a cost proposal. Bidders must understand that the rates have  
609 already been set and Bidders must accept them as is for the first contract year. Payment rates are  
610 provided as **Attachments to Section 9**. The Bidder is required to complete the attached budget  
611 worksheet to assist the Department's understanding of how the Bidder proposes to influence  
612 changes in care delivery and financing within the Iowa Plan. In addition, the Bidder shall provide  
613 a narrative describing:  
614

- 615                   • the Medicaid capitation payment allocations between the Medicaid Claims Fund and the  
616                   Medicaid Administrative Fund in the Proposal Pricing Tables. Bidders should note that  
617                   the percent of the Medicaid capitation payment allocated to the Medicaid Administrative  
618                   Fund, including profit, cannot exceed 13.5%;  
619                   • the percentage of the IDPH payment that the Bidder proposes to allocate to the IDPH  
620                   Administrative Fund. Bidders should note that the percent of the IDPH payment allocated  
621                   to the IDPH Administrative Fund, including profit, cannot exceed 3.5% of available  
622                   IDPH Iowa Plan funding, and  
623                   • how the Bidder proposes using the Community Reinvestment Account (Section 9  
624                   describes the requirements pertaining to the Community Reinvestment Account).  
625

626 A description of the payments to the Contractor can be found in Section 9.  
627

#### 628 **7A.6 REQUIRED CERTIFICATIONS**

629  
630 The Bidder must include the following documents and certifications:

- 631                   • RFP Certifications and Mandatory Guarantee  
632                   • Release of Information  
633                   • Mandatory Requirements and Reasons for Disqualification  
634

634  
635  
636  
637  
638  
639

**BUDGET WORKSHEET  
FOR  
THE IOWA PLAN FOR BEHAVIORAL HEALTH**

**BIDDER NAME:**

Services	7-1-09 through 6-30-10			7-1-10 through 6-30-11		
	Utilization Per 1000 Enrollees	Av. Cost Per Unit	PMPM Total Cost	Utilization Per 1000 Enrollees	Av. Cost Per Unit	PMPM Total Cost
<b>MENTAL HEALTH SERVICES</b>						
<b>Covered Mental Health Services</b>						
Ambulance						
Emergency room						
Outpatient hospital care						
Partial hospitalization						
Inpatient hospital care						
Day treatment						
Psychiatric physician services						
Dual Diagnoses						
Services by non-psychiatric physicians						
Psychologist services						
MHI services for those under 21 and 65 and older						
Community mental health center services						
Targeted Case Management						
Medication management and counseling						
Medication compliance management						
Home health agency services						
Screenings						

Services	7-1-09 through 6-30-10			7-1-10 through 6-30-11		
	Utilization Per 1000 Enrollees	Av. Cost Per Unit	PMPM Total Cost	Utilization Per 1000 Enrollees	Av. Cost Per Unit	PMPM Total Cost
Mobile crisis services						
Mobile counseling services						
ACT						
EPSDT-required						
Second Opinion						
<b>Required Mental Health Services</b>						
Case consultation						
Licensed social worker services						
Integrated MH services & supports						
Psychiatric rehabilitation						
Focused case management						
Peer support						
Community support						
Level of functioning assessments						
MHI services to adults						
Others (specify)						

640

640

<b>MEDICAID-FUNDED SUBSTANCE ABUSE SERVICES</b>						
<b>Services</b>	<b>7-01-09 through 6-30-10</b>			<b>7-01-10 through 6-30-11</b>		
	<b>Utilization Per 1000 Enrollees</b>	<b>Av. Cost Per Unit</b>	<b>PMPM Total Cost</b>	<b>Utilization Per 1000 Enrollees</b>	<b>Av. Cost Per Unit</b>	<b>PMPM Total Cost</b>
<b>COVERED AND REQUIRED SUBSTANCE ABUSE SERVICES</b>						
Outpatient (Level I)						
Intensive outpatient, Partial hospitalization (all Level II)						
Residential, Halfway House (all Level III), Substance Abuse PMIC						
Medically- managed inpatient (Level IV) and detoxification						
Testing for alcohol/drug						
Emergency Room						
Ambulance						
Other (Specify)						

641

642

642  
643  
644  
645  
646

**PROPOSAL FOR DISTRIBUTION OF THE  
MEDICAID CAPITATION PAYMENT  
FOR ADMINISTRATIVE SERVICES**

<b>Category</b>	<b>Restrictions, if Any Imposed by DHS</b>	<b>Bidder's Proposal</b>
Percentage of capitation payment required for administrative services including profit, if applicable (Medicaid Administrative Fund)	Shall not exceed 13.5% of the total capitation payment	

647  
648  
649  
650  
651  
652  
653  
654

**PROPOSAL FOR THE DISTRIBUTION OF FUNDS  
FOR THE ADMINISTRATION OF  
SUBSTANCE ABUSE SERVICES PROVIDED THROUGH  
THE IOWA DEPARTMENT OF PUBLIC HEALTH**

<b>Category</b>	<b>Restrictions, if any Proposed by IDPH</b>	<b>Bidder's Proposal</b>
Percentage required for administrative services including profit, if applicable (IDPH Administrative Fund)	For the first and second contract years, shall not exceed 3.5% of available IDPH Iowa Plan funding. For the third and subsequent contract years, shall not exceed 3% of available IDPH Iowa Plan funding available, with an additional .5% available to the Contractor as an incentive with the incentive performance measures determined by IDPH.	

655  
656

656

657

## SECTION 8

658

# EVALUATION OF PROPOSALS

659

660

661

662

663

### **8.1 EVALUATION FOR COMPLETENESS AND COMPLIANCE**

664

665

666

667

All proposals received by the closing deadline will be evaluated for compliance with the rules for format and content established in this RFP. Those that are determined to comply will be provided to the Evaluator Panel. If the Departments determine that a proposal does not comply, the Bidder will be notified.

668

669

670

A proposal will not be considered to be in compliance unless the Departments also received a Letter of Intent to Bid from the entity submitting the proposal, as required in Section 2.6.

671

672

### **8.2 EVALUATION PANEL**

673

674

675

676

677

The Departments intend to conduct a comprehensive, fair and impartial evaluation of bid proposals received in response to this RFP. In making this determination, the Departments will be represented by an Evaluation Panel. The Evaluation Panel will independently review each proposal and will then meet as a group to discuss the proposals and arrive at a total score for each proposal.

678

### **8.3 DESIGN FOR THE EVALUATION PROCESS**

679

The Evaluation Process will be conducted in the following manner:

680

681

- Each proposal will be evaluated and scored according to the criteria identified below. The Panel is entitled to rescore throughout the evaluation process.

682

683

- At the conclusion of the evaluation process, the proposals will be ranked from highest to lowest based on the total score.

684

685

686

687

688

689

- The proposal that receives the most points in accordance with the evaluation criteria will be recommended to the Directors of DHS and IDPH. The Directors will consider the recommendation of the evaluation panel and the evaluation report in making a final decision for award of the contract. However, the Departments reserve the right to cancel the RFP at any time prior to the execution of a written contract if it is in the Departments' best interest.

690

691

### **8.4 EVALUATION CRITERIA**

692

Total points available will be divided among the evaluation criteria as follows:

693

694	<b>Total</b>	<b>100%</b>
695	Programmatic Overview	60%
696	Corporate Organization and Experience	15%
697	Project Organization and Staffing	15%
698	Budget Worksheet and Narrative	10%
699		

700 **8.5 ORAL PRESENTATIONS**

701 The Departments may request Oral Presentation from those Bidders that have demonstrated to the  
702 Evaluation Panel their ability to satisfy the requirements of the RFP. The Evaluation Panel,  
703 through the Issuing Officer, will notify each Bidder if oral presentations are required and arrange  
704 for a presentation of their respective systems or services. Oral Presentations will take place at a  
705 State office location to be determined and Bidders are expected to have all designated “Key  
706 Personnel” on hand. The determination order and schedule for the presentations is at the sole  
707 discretion of the Departments. The presentation may include slides, graphics and other media  
708 selected by the Bidder to illustrate the Bid Proposal. The presentation will be limited to one hour  
709 and should only include information that was a part of the Bid Proposal and should not materially  
710 change the information contained in the Bid Proposal. At their option, the Departments may  
711 require site visits by select State staff to a Bidder’s current client site in order to view current  
712 systems or services operations.

713 **8.6 EVALUATION PANEL RECOMMENDATIONS**

714 The Evaluation Panel shall issue a formal recommendation to the Directors of the Departments  
715 for consideration. That recommendation shall be based on all information received through the  
716 evaluation process and shall provide the Panel’s assessment of the Bidder or Bidders that will  
717 provide the greatest benefit to the taxpayers of this state. This recommendation may include, but  
718 is not limited to, the name of one or more Bidders recommended for selection or a  
719 recommendation that no Bidder be selected. The Directors shall make the final determination  
720 based on all information received through the evaluation process and the Evaluation Panel’s  
721 formal recommendation.

722 **8.7 BIDDER ACCEPTANCE OF EVALUATION DESIGN**

723 By submitting a proposal in response to this RFP, the Bidder certifies that it accepts the  
724 evaluation design as fair and reasonable.

725

725

726

727

728

729

**SECTION 9**

**SAMPLE CONTRACTUAL TERMS AND  
CONDITIONS**

730

731

732

733

734

*The Departments intend that the following contract terms will be included in the contract between the Departments and the successful Bidder. The terms below are not intended to be a complete listing of all contract terms, but are provided to enable Bidders to better evaluate the costs associated with the resulting contract.*

735

736

737

**CONTRACT DECLARATIONS & EXECUTION**

RFP #	Contract #
Med 09-010	
Title of Contract	

738

739

740

741

742

743

This Contract must be signed by all parties before the Contractor provides any Deliverables. The Departments are not obligated to make payment for any Deliverables provided by or on behalf of the Contractor before the Contract is executed by all parties. This Contract is entered into by the following parties:

<b>Iowa Department of Human Services</b>	
<b>Principal Address (“Notice Address”) of Iowa Dept. of Human Services (DHS):</b> Iowa Department of Human Services Attn: Cynthia Tracy 100 Army Post Rd. Des Moines, IA 50315	<b>DHS Contract Manager Name/Address:</b> Cynthia Tracy Iowa Medicaid Enterprise 100 Army Post Rd. Des Moines, IA 50315 Phone: 515-725-1145 Fax #: 515-725-1360 E-Mail: ctracy@dhs.state.ia.us
<b>Iowa Department of Public Health</b>	
<b>Principal Address (“Notice Address”) of Iowa Dept. of Public Health (IDPH):</b> Iowa Department of Public Health Director IDPH Division of Behavioral Health Lucas State Office Bldg., 321 E. 12th St. Des Moines, IA 50319	<b>DPH Contract Manager Name and Address:</b> Kathy Stone, Director IDPH Division of Behavioral Health Lucas State Office Bldg., 321 E. 12th St. Des Moines, IA 50319 Phone: 515-281-4417 Fax: 515-281-4535 E-mail: kstone@idph.state.ia.us

744

745 The Iowa Department of Public Health and the Iowa Department of Human Services shall be  
746 referred to throughout this document in the collective as the “Departments” unless otherwise  
747 noted.  
748

<b>Contractor: (hereafter “Contractor”)</b>	
<b>Legal Name:</b>	<b>Principal Address (“Notice Address”):</b>
<b>Doing Business As Name(s):</b>	
<b>Tax ID #:</b>	<b>Organized under the laws of:</b> State of
Contractor Contract Manager Name/Address:	Phone: Fax #: E-Mail: Cell:

749

<b>Contract Information</b>		
<b>Start Date of BaseTerm:</b> 4/19/2009	<b>End Date of Base Term:</b> 6/30/2012	<b>End Date (including renewals):</b> 6/30/2015 <b>Possible Extensions:</b> 3 one-year extensions
<b>Does This Contract Include Sharing SSA Data?</b> YES		
<b>Contract Contingent on Approval of Another Agency:</b> YES (CMS)		

750

<b>Contract Financial Information</b>	
<b>Warranty Period:</b> The term of this Contract.	<b>Federal Funds Involved?</b> YES

751

<b>Insurance Requirements</b>		
<b>Type of Insurance</b>	<b>Limit</b>	<b>Amount</b>
General Liability (including contractual liability) written on occurrence basis	General Aggregate	\$2 Million
	Product/Completed Operations Aggregate	\$1 Million
	Personal Injury	\$1 Million
	Each Occurrence	\$1 Million
Automobile Liability (including any auto, hired autos, and non-owned autos)	Combined Single Limit	\$1 Million
Excess Liability, Umbrella Form	Each Occurrence	\$1 Million
	Aggregate	\$1 Million
Workers Compensation and Employer Liability	As required by Iowa law	As Required by Iowa law
Property Damage	Each Occurrence	\$1 Million
	Aggregate	\$1 Million
Professional Liability	Each Occurrence	\$2 Million
	Aggregate	\$2 Million

752

753 This Contract consists of the above information, the attached General Terms for Services  
754 Contracts, Contract Certifications, Special Terms, and all Special Contract Attachments (hereafter  
755 “Contract”). In consideration of the mutual covenants in this Contract and for other good and

756 valuable consideration, the receipt, adequacy and legal sufficiency of which are hereby  
757 acknowledged, the parties have entered into this Contract and have caused their duty authorized  
758 representatives to execute this Contract.  
759

<b>Contractor,</b>	
Signature:	
Printed Name:	
Title:	Date:

760

<b>Iowa Dept. of Public Health,</b>	
Signature:	
Printed Name: Kathy Stone	
Title: Director, Division of Behavioral Health, Iowa Department of Public Health	Date:

761

<b>Iowa Dept. of Human Services,</b>	
Signature:	
Printed Name: Eugene I. Gessow	
Title: Director, Iowa Department of Human Services	Date:

762

762 **Section 9**

763 **9.1 Special Contract Terms**

764  
765  
766  
767  
768  
769  
770  
771  
772  
773  
774  
775  
776  
777  
778  
779  
780  
781  
782  
783  
784  
785  
786  
787  
788  
789  
790  
791  
792  
793  
794  
795  
796  
797  
798  
799  
800  
801  
802  
803  
804  
805  
806  
807  
808

**9.1 (1) NATURE OF THE CONTRACT**

The contract offered under this RFP will be a risk-based contract for Medicaid mental health and substance abuse services in which the Contractor will be responsible for assuring, arranging, monitoring, and reimbursing all necessary and appropriate mental health and substance abuse services and supports for all enrolled Medicaid members as specified in this RFP.

There will be no provisions for the sharing of risk between the Contractor and the state. The Contractor shall meet the requirements of a Prepaid Health Plan as set forth in the Iowa Administrative Code 441 Chapter 88.61 and cited CFR references.

The Contractor will provide specific administrative services for the IDPH-funded delivery system. It will not bear the risk for the delivery of IDPH substance abuse services.

**9.1(2) SCOPE OF WORK.**

The Scope of Work for this Contract shall be consistent with the requirements of RFP MED-09-010 issued by the Departments.

**9.1(3) CONTRACT PAYMENT CLAUSE**

The Departments shall reimburse Contractor for work performed in accordance with the General Terms for Services Contracts and the terms of this Section.

**9.1(3)(a) Capitation Payment for Medicaid Enrollees:**

DHS has established actuarially sound capitation rates for Medicaid mental health and substance abuse services included in the Iowa Plan for such Medicaid Enrollees (“Enrollees”). These rates may change for each state fiscal year. See **Attachments to Section 9** for the Medicaid capitation payment rate for the current contract year, modified to estimate the projected rates for the first contact year by accounting for program changes specified in this RFP. Rates are recalculated for each state fiscal year of the contract. The state will release actuarially sound capitation payment rates for the first year of the contract resulting from this RFP in the Spring of 2009. There are fourteen different Medicaid per member per month capitation rates. The rates vary depending on the Medicaid Member’s age, gender and category of assistance (i.e., FMAP, SSI, those dually eligible for Medicare and Medicaid and those in Foster Care. The Foster Care rate includes members in a PMIC or MHI).

Following presentation of the rates, Contractor shall formally accept or contest the rates within 30 days.

Agreed upon rates shall be incorporated into the Contract through a formal Contract Amendment. Once Contractor accepts offered rates and the parties have executed a formal Contract Amendment, Contractor waives all claims it has or may have in the future regarding the soundness of the rates agreed to or the basis on which they were developed.

809 If the Contractor does not agree to the proposed capitation rates, DHS and Contractor  
810 shall seek to resolve any disagreements through discussions for a period of no more than  
811 30 days (the “Discussion Period”). If the parties have not agreed to the capitation rates  
812 by the end of the Discussion Period through a formal Contract Amendment, the  
813 Departments will as soon as is practicable issue a new request for proposals to replace the  
814 Contractor. Until such time as a replacement vendor is fully operational, the exiting  
815 Contractor shall continue to provide services pursuant to this Contract and shall be  
816 reimbursed based on the greater of the following:

- 817
- 818 1. The capitation rates that were in effect before Contractor’s refusal to accept new  
819 capitation rates, if those rates remain actuarially sound, or
  - 820 2. The capitation rates that were offered by DHS but contested by Contractor.
- 821

822 The total monthly capitation payment will be made based upon the list of Enrollees that is  
823 supplied to the Contractor. The payment will be made prior to the 15th day of the month  
824 of eligibility. Adjustment will be made for new and reinstated Enrollees and for persons  
825 who appear on the eligibility list but are no longer enrolled in the Iowa Plan due to an  
826 exclusionary change in their eligibility. The capitation payment constitutes payment in  
827 full.

828

829 Medicaid capitation rates will be adjusted if additional services or populations are added  
830 by DHS or if any services or populations are excluded from the scope of services.

831

832 **9.1(3)(b) Community Reinvestment Account**

833

834 a) The Contractor shall establish a Community Reinvestment Account as an account  
835 separate from other accounts required in Section 6.6 of this RFP and any other accounts  
836 that may be required by state or federal law. The Community Reinvestment Account  
837 shall be funded by the Contractor in three ways:

- 838
- 839 • at least quarterly the Contractor shall transfer into the Community Reinvestment  
840 Account 2.5% of the total capitation payment;
  - 841 • all moneys assessed by the Departments as disincentives or liquidated damages  
842 shall be paid by the Contractor to the Community Reinvestment Account, and
  - 843 • after the close of each contract year after services for that year are reimbursed, all  
844 moneys remaining in the Medicaid Claims Fund shall be transferred to the  
845 Community Reinvestment Account.
- 846

847 b) The DHS funds in the Community Reinvestment Account shall be used for  
848 Member Services and Provider Development/Customer Outreach as specified below.

- 849
- 850 1. Member Services: Up to 70% of the Community Reinvestment Accounts is for  
851 member services. These shall be additional 1915(b)(3) services to Enrollees as  
852 allowed under the cost savings aspect of the federal waiver. All such projects  
853 shall meet the prior approval of the Department and CMS. The Department, at its  
854 sole discretion, may determine that funds in this category will be used to increase  
855 provider payments so as to achieve enhanced access or maintain access as  
856 appropriate to meet the needs of its recipients.
- 857

858 2. Provider Development/Customer Outreach: Up to a maximum of 30% of the  
859 Community Reinvestment Account can be used for provider development and  
860 training, consumer and family and education, and outreach. Expenditures will be  
861 made only with the approval of the Department and CMS.  
862

863 c) Any IDPH funds assessed as disincentives or liquidated damages will be used for  
864 IDPH substance abuse services as determined by IDPH.  
865

866 d) All interest accrued in the Community Reinvestment Account belong to DHS, and  
867 shall be accounted for by the Contractor and returned to DHS within 45 days of the end  
868 of each state fiscal year.  
869

870 e) Any funds remaining in the Provider Development/Customer Outreach category  
871 will be returned upon request to the Departments at the end of each state fiscal year and  
872 upon termination or expiration of the contract. Funds remaining in the Member Services  
873 Account shall remain in the Account to be used for direct services. Funds that remain  
874 unspent or otherwise unencumbered will be returned to the Departments upon  
875 termination or expiration of the contract. However, the Departments may require that any  
876 or all funding placed into the Community Reinvestment Account be returned to the  
877 Departments upon notice. Federal matching funds will be refunded to CMS as required.  
878 The Contractor may not share in any portion of the Community Reinvestment Account  
879 for the purpose of payment of administration or overhead of the program or as a profit.  
880

881 **9.1(3)(c) Medicaid Incentive Payments**

882 In addition to the capitation payments, DHS has allowed for a maximum of \$1,000,000 in  
883 incentive payments per contract year to be paid to the Contractor based upon the  
884 Contractor’s attainment of certain performance indicators. The incentive payments will  
885 be awarded as follows in the first year of the contract and will be renegotiated in  
886 subsequent years of the contract.  
887

Indicator	
1. Quality of Care: Mental Health Readmission	10%
2. Quality of Care: Community Tenure	10%
3. Service Array: Integrated Services and Supports	10%
4. Quality of Care: ER Utilization	20%
5. Quality of Care: Follow-up After Hospitalization for Mental Illness	10%
6. Quality of Care: Follow-up After Hospitalization for Substance Abuse Treatment	10%
7. Quality of Care: Treatment of the Dually Diagnosed	20%
8. Network Management	10%

888 The DHS Director will annually distribute the incentive payment if performance  
889 indicators selected by the Director for the contract year for incentive-based pay are met  
890 according to the specifications pursuant to each performance indicator. The weight given  
891 to each performance indicator will be determined at the outset of each contract year by  
892 DHS. Indicators to which incentive payments will be attached for the first Contract Year  
893 and the specifications describing how performance will be assessed relative to each  
894 indicator are included in **Attachments to Section 9**.  
895  
896

897 The amount of incentive payment earned by the Contractor will be calculated after  
898 receipt of the independent audit required in Section 6.5.3.1 which shall be no sooner than  
899 6 months following the end of the contract year. Determination of the Contractor's level  
900 of achievement shall be at the sole discretion of DHS.

901  
902 In making the \$1,000,000 available as incentive payments to the Iowa Plan Contractor,  
903 DHS does not guarantee that any or all of the available payments will be paid to the  
904 Contractor. The amount of the incentive payments paid to the Contractor shall be  
905 dependent upon the level of performance demonstrated by the Contractor. The specific  
906 portion of the \$1,000,000 tied to each performance indicator shall be negotiated between  
907 the Contractor and the Departments.

908  
909 Incentive payments earned by the Contractor shall not be included in calculations of  
910 either the Medicaid Claims Fund or the Medicaid Administrative Fund required under the  
911 terms of the contract.

912

913 **9.1(3)(d) Payment for IDPH Substance Abuse Services**

914

915 IDPH will establish the monthly payment amount. In general, funding for IDPH  
916 substance abuse services will be the monthly pro-rated amount of the IDPH substance  
917 abuse budget dedicated for the Iowa Plan contract. In Iowa Plan contract year 2008-  
918 2009, IDPH provided \$25,457,269 for Iowa Plan funding. Distribution of the payment  
919 amount to the IDPH-funded substance abuse treatment providers is based on a formula  
920 that will be established through consultation with IDPH. See **Attachments to Section 9**  
921 for information about IDPH funding included in the Iowa Plan.

922

923 IDPH will pay the agreed-upon payment rate upon receipt of an invoice for incurred  
924 expense. Every reasonable effort will be made to make payment within 15 days of receipt  
925 of an invoice. Payment of this rate constitutes payment in full. Payment may be adjusted  
926 based on the Contractor's performance. See the **Attachments to Section 9** for  
927 performance indicators with financial disincentives. The payment rate may be adjusted  
928 dependent upon state and block grant funding.

929 **9.1(3)(e) Payment for Persons Who Use Methamphetamine**

930 In 2001 the Iowa State Legislature voted to allocate funds annually toward enhancement  
931 of treatment services provided to Iowans who use Methamphetamine ("Meth Funding").  
932 The funding was intended to increase the length of stay for clients reporting use of  
933 methamphetamine. There was no addition to the minimum IDPH Participant numbers  
934 (see on-line resource room for minimum client numbers). In Iowa Plan contract year  
935 2008-2009, IDPH Iowa Plan funding included \$1,139,568 in Meth Funding. IDPH shall  
936 pay the Contractor the annual Meth Funding allocation in twelve equal payments over the  
937 contract year providing:

938 • funds shall be contracted to IDPH-funded providers to maintain increased lengths of  
939 stay. There shall be no corresponding expectation of an increase in the required  
940 minimum IDPH Participant client numbers, and

941 • Meth funding requirements shall be monitored through I-SMART reporting and other  
942 monitoring methods that may be developed. A system shall be developed and  
943 maintained to identify expenditures of Meth Funding, as well as, services provided to  
944 IDPH Participants receiving Meth Funding. The monitoring of these expenditures

945 and services shall be done separately from the monitoring of all other services and  
946 funding provided through the Iowa Plan IDPH-funded substance abuse services  
947 contract.

948 The Contractor must ensure that providers receiving Meth Funding must meet the  
949 requirements outlined in Section 4B.3.2

950 **9.1(3)(f) Certification**

951 Data submitted by the Contractor that results in state payments to the Contractor, must be  
952 certified. This includes encounter data and the annual performance indicator report.

953  
954 The Contractor's Chief Operating Officer, Financial Officer, or an individual who has  
955 delegated authority to sign for, and who reports directly to the Contractor's Chief  
956 Operating Officer or Financial Officer, must attest, based on best knowledge,  
957 information, and belief as to the accuracy, completeness and truthfulness of the  
958 documents and data.

959  
960 The Contractor must submit the certification concurrently with the certified data and  
961 documents.

962  
963 **9.1(4) REMEDIES IN THE EVENT OF CONTRACTOR'S FAILURE TO PERFORM**

964  
965 **9.1(4)(a) Liquidated Damages**

966  
967 Liquidated damages may be assessed against the Contractor for the following:

- 968  
969 a) Upon failure to attain or retain accredited status as required by the terms of the  
970 contract liquidated damages of 1% of each month's capitation payment for each  
971 month of non-compliance shall be assessed.  
972 b) Upon failure to comply with the pre-implementation deadlines discussed in Section  
973 6.2 regarding the requisite activities to be performed during the pre-implementation  
974 and preliminary implementation of the contract, the liquidated damages assessed  
975 shall equal \$5000 per day;  
976 c) Upon failure to begin full operation of the Iowa Plan on January 1, 2010, liquidated  
977 damages assessed shall equal \$150,000 for each month implementation is delayed.  
978 The amount of damages may be prorated if necessary.  
979 d) Upon failure to provide adequate management of contract funds, the liquidated  
980 damages assessed shall equal 5% of the annual IDPH payment that there has been  
981 failure to comply with SAMHSA block grant requirements.

982  
983 **9.1(4)(b) Medicaid Performance Indicators with Disincentives**

984  
985 In addition to the general contractual expectations, there are other specific levels of  
986 performance that must be maintained by the Contractor at all times. Disincentives will  
987 apply if the Contractor fails to perform at the minimum levels specified. A list of  
988 performance indicators that include disincentives is provided in the **Attachments to**  
989 **Section 9**. An example of the Performance Indicator incentive and disincentive  
990 methodology is also provided in the **Attachments to Section 9**. Additional disincentives  
991 will be assessed for lack of or lateness of reports specified in Section 6.5 as follows:  
992

- 993 • Disincentives will be assessed at \$500 per report for reports that are not  
994 submitted by the due date for the first month or reporting period a report is not  
995 submitted. If the Contractor is out of compliance a second month or reporting  
996 period, a disincentive payment of \$1,000 will be assessed per report. Failure by  
997 the Contractor to submit the necessary report(s) for a third reporting period shall  
998 result in an additional \$1,000 disincentives for each report or the departments  
999 may terminate the contract in accordance with standards specified herein;
- 1000 • Additional disincentives will be assessed for lack of or lateness of correcting  
1001 encounter data as specified in Section 6.5.1. Disincentives are assessed as \$500  
1002 for the first month in that all corrections to the monthly encounter data  
1003 submission are not finalized within 45 days from the date the initial error report  
1004 for the month was sent to the Contractor or 59 days from the date the initial  
1005 encounter data were due. If the Contractor is out of compliance a second month,  
1006 a disincentive payment of \$1,000 will be assessed. Failure by provider to submit  
1007 the necessary encounter date in accordance with standards established in Section  
1008 6.5.1 for a third reporting period shall result in an additional \$1,000 per month  
1009 disincentives or the departments may terminate the contract in accordance with  
1010 standards specified herein.

1011

#### 1012 **9.1(4)(c) IDPH Performance Indicators with Disincentives**

1013

1014 In addition to the general contractual expectations, there are other specific levels of  
1015 performance that must be maintained by the Contractor at all times. Disincentives will  
1016 apply if the Contractor fails to perform at the minimum levels specified. A list of  
1017 performance indicators that will include disincentives is provided in the **Attachments to**  
1018 **Section 9**. An example of the Performance Indicator incentive and disincentive  
1019 methodology is also provided in the **Attachments to Section 9**. In addition, disincentives  
1020 will be assessed at \$500 per report for reports that are not submitted by the due date for  
1021 the first month or reporting period a report is not submitted. If the Contractor is out of  
1022 compliance a second month or reporting period, a disincentive payment of \$1,000 will be  
1023 assessed per report. Failure by the Contractor to submit the necessary report(s) for a third  
1024 reporting period shall result in an additional \$1,000 disincentives for each report or the  
1025 departments may terminate the contract in accordance with standards specified herein.

1026

#### 1027 **9.1(4)(d) Cost Sharing Prohibited (Enrollees only)**

1028

1029 The Contractor shall not require co-payment or cost sharing by any Enrollee for any of  
1030 the services covered under the contract. The Contractor must ensure that Enrollee cost  
1031 sharing is not imposed by any provider reimbursed for services through the Iowa Plan.  
1032 The Contractor will further assure that providers will accept negotiated rates as full  
1033 payment of services provided under the Contract and will not charge Enrollees for  
1034 services if payment is denied by the Contractor due to the provider's failure to adhere to  
1035 contractual requirements in the provider's contract with the Contractor. The Departments  
1036 reserve the right to assess a penalty against the Contractor for failure to comply with this  
1037 requirement. In the event the Contractor or a provider imposes a co-payment or cost  
1038 sharing, upon notice the amount imposed shall be remitted by the Contractor to the  
1039 Departments.

1040

1041 The Contractor shall not charge, or permit those who provide services to Iowa Plan  
1042 Enrollees to charge, Enrollees for missed appointments.

1043  
1044  
1045  
1046  
1047  
1048  
1049  
1050  
1051  
1052  
1053  
1054  
1055  
1056  
1057  
1058  
1059  
1060  
1061  
1062  
1063  
1064  
1065  
1066  
1067  
1068  
1069  
1070  
1071  
1072  
1073  
1074  
1075  
1076  
1077  
1078  
1079  
1080  
1081  
1082  
1083  
1084  
1085  
1086  
1087  
1088  
1089  
1090  
1091

**9.1(5) FRAUD AND ABUSE**

The Contractor shall diligently safeguard against the potential for, and promptly investigate reports of, suspected fraud and abuse by employees, subcontractors, providers, and others with whom the Contractor does business. The Contractor shall provide the Departments with the Contractor’s policies and procedures on handling fraud and abuse.

9.1(5)(a) The Contractor shall have in place a method to verify whether services reimbursed by the Contractor were actually furnished to Eligible Persons as billed by providers.

9.1(5)(b) The Contractor must report within two working days to the appropriate Department any evidence indicating the possibility of fraud and abuse by any member of the provider network. The Contractor also shall provide the Departments with an annual update of surveillance activity, including corrective actions taken.

9.1(5)(c) The Contractor shall have administrative and management arrangements or procedures, and a mandatory compliance plan, that are designed to guard against fraud and abuse and include the following:

- written policies, procedures, and standards of conduct consistent with all applicable federal and state laws pertaining to fraud and abuse;
- the designation of a compliance officer and a compliance committee that are accountable to senior management;
- effective training and education for the compliance officer and the staff;
- effective lines of communication between the compliance officer and staff;
- enforcement of standards through well-publicized disciplinary guidelines;
- provision for internal monitoring and auditing, and
- provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the contract services.

9.1(5)(d) The Contractor may not knowingly have a relationship with the following:

- a. an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549, or
- b. an individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1) of the regulation.

For the purposes of this section, “Relationship” is defined as follows:

- a director, officer, or partner of the Contractor;

- 1092 • a person with beneficial ownership of five percent or more of the
- 1093 Contractor's equity, or
- 1094 • a person with an employment, consulting or other arrangement with the
- 1095 Contractor under its contract with the State.
- 1096
- 1097 9.1(5)(e) The Contractor shall notify the State of any person or corporation that has
- 1098 5% or more ownership or controlling interest in the Contractor.
- 1099
- 1100 9.1(5)(f) The Contractor shall not expend Medicaid funds for providers excluded by
- 1101 Medicare, Medicaid, or SCHIP, as notified by DHS, except for emergency
- 1102 services.
- 1103
- 1104 9.1(5)(g) The Contractor must require each individually contracted physician to have a
- 1105 unique identifier.
- 1106
- 1107 9.1(5)(h) The Contractor shall report fraud and abuse information to DHS. The report
- 1108 will include the following to the extent such information is available:
- 1109
- 1110 • the number of complaints of fraud and abuse made to DHS that warrant
- 1111 preliminary investigation, and
- 1112 • for each complaint which warrants investigation, the following
- 1113 information: name-ID number; source of complaint; type of provider;
- 1114 nature of complaint; approximate dollars involved; disposition of the
- 1115 case.
- 1116
- 1117 9.1(5)(i) The Contractor shall document that safeguards at least equal to federal
- 1118 safeguards (at 41 USC 423, section 27) are in place.
- 1119

#### 1120 **9.1(6) CONTRACT PERFORMANCE DISPUTES AND APPEALS**

1121  
1122 The contract is not subject to arbitration. Any performance issues related to services provided to  
1123 Enrollees shall be identified in writing and submitted to the state Medicaid Director. Any  
1124 performance issues related to IDPH Participants receiving substance abuse services shall be  
1125 identified in writing and submitted to the Director of the IDPH Division of Behavioral Health. All  
1126 disputes concerning Enrollees or Medicaid services shall be decided by the state Medicaid  
1127 Director. All disputes concerning IDPH Participants and substance abuse services shall be  
1128 decided by the IDPH Director of the Division of Behavioral Health. The state Medicaid Director  
1129 and the Director of the IDPH Division of Behavioral Health shall consult and issue a joint  
1130 decision on issues that relate to Medicaid substance abuse services. Decisions shall be issued in  
1131 writing with copies to the Contractor and the Department Directors.

1132  
1133 The Directors' decision shall be final unless within five (5) days from the date of service of such  
1134 copy the Contractor files a written appeal with the Department Directors.

1135  
1136 In connection with any appeal proceedings under this subsection, the Contractor and the  
1137 Departments shall be afforded an opportunity to present written argument or evidence relative to  
1138 the appeal.

1139  
1140 The appropriate Director shall render a decision within ten (10) days after the appeal is filed. A  
1141 decision by a Director shall be final for purposes of Iowa Code Chapter 17A. Pending a final

1142 determination of any dispute, the Contractor shall proceed diligently with the performance of the  
1143 contract and in accordance with the Director's decision.  
1144

1145 **9.1(7) CHANGES OF KEY IOWA PLAN PERSONNEL**  
1146

1147 The name(s) and title(s) of the Contractor's contact person or persons shall be specified in the  
1148 contract. This person(s) will be responsible, with designated staff of the Departments, for  
1149 communication and coordination between the Contractor and the Departments. The Contractor  
1150 also is required to provide to the Departments the names of key on-site staff (see Section 6.1).  
1151 The Departments reserve the right to approve key personnel hired by the Contractor.  
1152

1153 If, for any reason, substitution or elimination of a contact person or any key staff person becomes  
1154 necessary, the Contractor shall provide written notification to the Departments. The Contractor  
1155 shall notify the Departments in writing within five (5) working days of any change of key  
1156 personnel. Such written notification shall include the proposed successor's name and curriculum  
1157 vitae.  
1158

1159 The Departments further reserve the right to approve the transfer of responsibility from any  
1160 interim staff to regular on-site staff hired by the Contractor.  
1161

1162 **9.1(8) MAINTENANCE OF LOCAL FUNDING FOR SUBSTANCE ABUSE SERVICES**  
1163 **(IDPH Participants only)**  
1164

1165 The Contractor shall assist network providers in developing other sources of financial support for  
1166 program activities, including the following activities:  
1167

- 1168 (1) recover, to the maximum extent feasible, third-party revenues to which the  
1169 Contractor is entitled as a result of services provided;
- 1170 (2) garner all other available federal, state, local and private funds, and
- 1171 (3) charge IDPH Participants according to their ability to pay for the services pro-  
1172 vided, based on the sliding fee schedule developed. The sliding fee schedule  
1173 shall be developed by IDPH and the Contractor using standardized guidelines  
1174 provided by IDPH. Variances from these guidelines must have prior written  
1175 IDPH approval. IDPH Participant billing and collection procedures shall be  
1176 consistent with those established and provided by the IDPH. Services funded  
1177 partially or completely by IDPH shall not be denied to a person because of the  
1178 inability of the person or group to pay a fee for the service. Factors of indi-  
1179 vidual/immediate family income and family size are to be used in developing the  
1180 sliding fee schedule.  
1181

1182 **9.1(9) DISALLOWABLE EXPENSES (IDPH Participants only)**  
1183

1184 Contract funds can be expended only for services and activities covered in the contract. Unless  
1185 specifically allowed by special condition, IDPH contract funds may not be expended for:  
1186

- 1187 • purchase of land or construction of building or improvements thereon, or payment of
- 1188 real estate mortgages or taxes;
- 1189 • purchase of major medical equipment;
- 1190 • costs related to political activity;
- 1191 • any bonus, commission or fee paid by the Contractor for the purpose of applying for
- 1192 or obtaining a IDPH contract;
- 1193 • distribution of sterile needles for the hypodermic injection of any legal drug or
- 1194 distributing bleach for the purpose of cleansing needles for such hypodermic
- 1195 injection;
- 1196 • carrying out testing for the etiologic agent for acquired immune deficiency syndrome
- 1197 unless such testing is accompanied by appropriate pre-test and post-test counseling.
- 1198 • any salary in excess of \$125,000 per year;
- 1199 • cost of services that are paid for by another organization or individual;
- 1200 • inpatient hospital treatment;
- 1201 • satisfying the requirement for expenditures of non-federal funds as a condition for the
- 1202 receipt of federal funds;
- 1203 • subcontracting for treatment services by organizations other than government or
- 1204 private non-profit entities, and
- 1205 • payments to intended recipients of health services.

1206

1207 **9.1(10) PAYMENT OF LAST RESORT (IDPH Participants only)**

1208

1209 IDPH funds, as provided by the contract are to be used as “payment of last resort,” i.e., all other  
1210 available funds must be used prior to billing funds available through the contract.

1211

1212 **9.1(11) NON-SUPPLANTING REQUIREMENT (IDPH Participants only)**

1213

1214 Federal funds made available under the contract shall be used to supplement and increase the  
1215 level of state, local and other non-federal funds that would in the absence of such federal funds be  
1216 made available for the programs and activities for which funds are provided and will in no event  
1217 take the place of state, local and other non-federal funds.

1218

1219 **9.1(12) PUBLICATIONS, COPYRIGHTS AND RIGHTS IN DATA AND PATENTS**

1220

1221 The Departments shall be and remain the owner of all data and records provided to the Contractor  
1222 and all reports prepared by the Contractor. The Departments’ data and records will not be  
1223 utilized by the Contractor for any purpose other than that of rendering services to the Department  
1224 under the Contract, nor will the data and records be disclosed, sold, assigned or leased to third  
1225 parties or otherwise disposed of by the Contractor without the prior approval to do so by the  
1226 Departments.

1227

1228 The Department shall own all work products developed or furnished in connection with the  
1229 Contract by the Contractor or any subcontractor (the “Work Product”), all such Work Product  
1230 shall be considered a work made for hire. If any Work Product is not considered a work made for  
1231 hire under applicable law, the Contractor shall make an exclusive, perpetual royalty-free  
1232 assignment of all Contractor’s rights, title and interest in such Work Product, including U.S. and

1233 foreign patents, copyrights and trade secrets. With regard to work performed by the Contractor's  
1234 subcontractors, the Contractor shall provide for the irrevocable assignment of rights to the  
1235 Department, without additional consideration of all Work Product of the subcontractors. The  
1236 Contractor shall give the Department and any person designated by the Department, all assistance  
1237 reasonably requested by the Department to perfect the Department's ownership of all Work  
1238 Product, including the execution and delivery of documents assigning title to such Work Product  
1239 to the Department. The Contractor shall not publish or attempt to transfer to third parties any  
1240 Work Product without the Department's prior written approval.

1241

1242 Any publications shall contain an acknowledgment of the Departments' contract support and if  
1243 funded by IDPH payment, of SAMHSA support. A copy of any such publication shall be  
1244 furnished to the Departments at no cost.

1245

1246 **9.1(13) LEGALIZED ALIENS (IDPH Participants only)**

1247

1248 The Contractor shall submit the State Legalization Impact Assistance Grant (SLIAG) Quarterly  
1249 Expenditure Report form and Claim Voucher for reimbursement to network providers who  
1250 provided services to Eligible Legalized Aliens (ELA). Quarterly reports shall be submitted to the  
1251 Iowa Department of Public Health, Family and Community Health Division, Lucas State Office  
1252 Building, Des Moines, Iowa 50319-0075, by the 15th of the month following each quarter (i.e.,  
1253 October 15, January 15, April 15 and July 15).

1254

1255 **9.1(14) NOT-FOR-PROFIT/FOR-PROFIT STATUS**

1256

1257 The Contractor selected to implement the Iowa Plan may be organized as either a for-profit or  
1258 not-for profit organization. Any treatment program funded by IDPH funds must be a not-for-  
1259 profit organization.

1260

1261 **9.1(15) COORDINATION OF SERVICES (IDPH Participants only)**

1262

1263 The Contractor shall ensure that a local health care provider or nonprofit health care organization  
1264 seeking grant moneys administered by IDPH shall provide documentation that the provider or  
1265 organization has coordinated its services with other local entities providing similar services  
1266 including the local board of health.

1267

1268 **9.1(16) PRIORITY IN SUBSTANCE ABUSE TREATMENT**

1269

1270 The Contractor shall ensure that priority in treatment must be given to those individuals with the  
1271 greatest clinical need. In establishing clinical need, priority must be given to substance abuse  
1272 which results in the highest personal and social cost as measured by severity of personal and  
1273 social consequences, and the number of abusers. Preference in admissions to treatment is as  
1274 follows: (1) pregnant women injecting drug users, (2) pregnant substance abusers (3) injecting  
1275 drug users, (4) all others. Admission to treatment of pregnant women must be accomplished  
1276 within 48 hours and intravenous (IV) drug users within 14 days of the individual seeking  
1277 treatment. If the Contractor is unable to admit the pregnant women or IV drug user within the  
1278 required time due to insufficient capacity, the Department is to be notified immediately, using

1279 procedures established by the IDPH. In addition, IDPH is to be notified when treatment program  
1280 networks reach 90% capacity for these two populations.

1281

1282 **9.1(17) SUBSTANCE ABUSE INTERIM SERVICES (IDPH Participants only)**

1283

1284 If, after notifying the IDPH that admission to treatment of pregnant women can not be  
1285 accomplished within 48 hours or IV drug users within 14 days of the individual seeking  
1286 treatment, it is determined that no provider has capacity, interim services are to be provided.  
1287 Interim services to IV drug users shall include counseling and education about HIV and TB,  
1288 about the risks of transmission to sexual partners and infants, about the relationship between IV  
1289 use and communicable diseases, and about steps that can be taken to ensure that HIV  
1290 transmission does not occur and, if necessary, referral for HIV and TB treatment services. The  
1291 Contractor shall establish a waiting list, which includes a unique patient identifier, for individuals  
1292 awaiting treatment for IV drug use, including those receiving interim services. For pregnant  
1293 women this shall also include prenatal care referral and education regarding the effects of alcohol  
1294 and drug use on the fetus.

1295

1296 **9.1(18) IOWA RESIDENCE (IDPH Participants only)**

1297

1298 Services under the contract are for Iowa residents only. The primary place of residence at the  
1299 time of treatment must be in Iowa. If a place of residence is not maintained while receiving  
1300 residential or halfway house services, the most recent place of residence will be considered when  
1301 determining residence.

1302

1303 **9.1(19) OUTREACH SERVICES-IV DRUG (IDPH Participants only)**

1304

1305 The Contractor shall ensure that providers providing services to IV drug users shall perform  
1306 outreach activities. The providers shall select, train and supervise outreach workers. They shall  
1307 encourage individuals needing IV treatment to undergo treatment and provide awareness about  
1308 the relationship between IV drug use and communicable disease. The provider shall use outreach  
1309 models that are applicable to the local situation and use an approach that can be expected to be  
1310 reasonably effective.

1311

1312 **9.1(20) TUBERCULOSIS (TB) SERVICES (IDPH Participants Only)**

1313

1314 The Contractor shall make available TB services directly or through a collaborative agreement  
1315 with another local agency.

1316

1317 The Contractor shall implement infection control procedures and protocols provided by the  
1318 Departments. All programs shall test for TB in the following populations:

1319

- 1320 1) all persons in residential treatment and halfway houses, and  
1321 2) recipients of outpatient services who are: a) IV drug users, or, b) persons who are in a  
1322 close relationship with IV drug users and, c) any others who may be at high risk for  
1323 tuberculosis, such as those with an unexplained persistent cough or the homeless.

1324

1325 **9.1(21) HIV/SERVICES**

1326

1327 Early intervention services for HIV disease to individuals will be undertaken voluntarily by, and  
1328 with the informed consent of, the individual. Undergoing such services is not to be required as a  
1329 condition of receiving treatment services for substance abuse or any other service.

1330

1331 **9.1(22) COORDINATION OF ACTIVITIES**

1332

1333 The Contractor shall make every reasonable effort to link Eligible Persons with needed  
1334 wraparound services such as criminal justice, education, vocational rehabilitation and  
1335 employment. Written referral and/or collaborative agreements are to be maintained.

1336

1337 **9.1(23) SERVICES AND EDUCATION TO EMPLOYEES**

1338

1339 The provider network shall offer continuing education to staff providing treatment services or  
1340 activities. This shall include education on confidentiality requirements and information on  
1341 disciplinary action relating to the requirements.

1342

1343 **9.1(24) SUBSTANCE ABUSE LICENSE REQUIREMENTS**

1344

1345 It shall be the responsibility of the Contractor to ensure that any substance abuse treatment  
1346 program providing substance abuse treatment/rehabilitation services to IDPH Participants has a  
1347 license from IDPH in accordance with Iowa Code, Chapter 125, and Iowa Administrative Code,  
1348 Section 643, Chapter 3, for the provision of treatment services.

1349

1350 It shall be the responsibility of the Contractor to ensure that any substance abuse treatment  
1351 program providing substance abuse treatment services to Enrollees has a license from the Iowa  
1352 Department of Public Health in accordance with Iowa Code, Chapter 125, and Iowa  
1353 Administrative Code, Section 643, Chapter 3, for the provision of treatment services, or is a  
1354 hospital-based substance abuse treatment program which is exempt from licensure in accordance  
1355 with Iowa Code Chapter 125.13.2(a).

1356

1357 **9.1(25) ELIGIBLE PERSONS' ACCESS TO SUBSTANCE ABUSE SERVICES**

1358

1359 Equal access to treatment must be provided regardless of age, sex, ethnicity, sexual orientation,  
1360 cognitive or physical functioning, English speaking proficiency or involvement in the legal  
1361 system.

1362

1363 Access to treatment shall be ensured to any Eligible Person who meets admission criteria for  
1364 treatment, regardless of prior alcohol/other drug treatment or education, clinical history or other  
1365 considerations.

1366

1367 **9.1(26) SCREENING INSTRUMENT FOR SUBSTANCE ABUSE SERVICES**

1368

1369 Any screening instruments used by the Contractor shall be developed in accordance with the  
1370 placement criteria and shall be approved by the Departments prior to implementation.

1371

1372 **9.1(27) CERTIFIED ALCOHOL AND DRUG COUNSELOR**

1373

1374 The Contractor shall accept Certified Alcohol and Drug Counselor (CADC) certification from the  
1375 Iowa Board of Certification as a credentialing criteria for practitioners employed by a licensed  
1376 substance abuse treatment program.

1377

1378 **9.1(28) SUBCONTRACTORS**

1379

1380 **9.1(28)(a) General Requirements Pertaining to Subcontracts**

1381

- 1382 a) All subcontracts must fulfill the requirements of 42 CFR 438.6 that are  
1383 appropriate to the service or activity delegated under the subcontract.  
1384 b) The Contractor is responsible for any functions and responsibilities that it  
1385 delegates to any subcontractor.  
1386 c) The Contractor must evaluate the prospective subcontractor's ability to perform  
1387 the activities to be delegated.  
1388 d) The subcontract must be a written agreement between the Contractor and a  
1389 subcontractor that specifies the activities and report responsibilities delegated to  
1390 the subcontractor; and provide for revoking delegation or imposing other  
1391 sanctions if the subcontractor's performance is inadequate.  
1392 e) The Contractor must periodically review and monitor the subcontractor's  
1393 performance on an ongoing basis. Review and monitoring periods will be based  
1394 on the activities of the subcontract and agreed to by the State, consistent with  
1395 industry standards or State Limited Service Organization (LSO) laws and  
1396 regulations as specified in rules at 191 Iowa Administrative Code Chapter 41.  
1397 f) If the Contractor identifies deficiencies or areas for improvement, the  
1398 subcontractor must take corrective action.  
1399 g) The Departments shall have the right to request the removal of a subcontractor  
1400 for good cause.

1401

1402 **9.1(28)(b) Subcontracts for the Provision of Treatment Services and Supports**

1403

1404 The Departments reserve the right to approve or disapprove any subcontracts entered into  
1405 by the Contractor for the purpose of completing the provisions of the contract prior to  
1406 entering into subcontracts. A subcontract shall not affect the payment by the State to the  
1407 Contractor or the distribution of payments. All restrictions, obligations, and  
1408 responsibilities which apply to the principal Contractor shall also apply to the  
1409 subcontractors.

1410

1411 If the Contractor wishes to delegate either clinical or administrative responsibilities to a  
1412 direct service provider, the Departments reserve the right to limit the direct clinical  
1413 services for which that provider can be reimbursed

1414

1415 None of the substance abuse treatment program networks relating to the contract shall be  
1416 subcontracted to another organization or individual without specific prior written  
1417 approval by the Departments. To obtain approval, the Contractor shall submit to the  
1418 Departments the proposed contract or written agreement between the parties.

1419

1420 If during the course of the subcontract period the Contractor or subcontractor wishes to  
1421 change or revise the subcontract, prior written approval from the Departments is required.  
1422

1423 The Contractor shall maintain a written code of standards of conduct governing the  
1424 performance of its employees engaged in the award and administration of any  
1425 subcontract. No employee, officer or agent of the Contractor or subcontractor shall  
1426 participate in the selection or in the award or administration of a contract if a conflict of  
1427 interest, real or apparent would be involved. See also the Code of Federal Regulations  
1428 Title 45 Part 92.36.  
1429

1430 The Contractor is contractually obligated to have no subcontracts containing any  
1431 provision which provides incentive, monetary or otherwise, for the withholding of care  
1432 determined necessary under the Contractor's criteria of psychosocial necessity or other  
1433 utilization management criteria as required or approved by the Departments.  
1434

1435 **9.1(28)(c) Restrictions Regarding Physician Incentives in Subcontracts for the**  
1436 **Provision of Treatment Services and Supports**  
1437

1438 The Contractor may not operate a Physician Incentive Plan (PIP) unless the Contractor  
1439 notifies the Departments and receives written authorization to operate the PIP, and then,  
1440 only if no specific payment can be made directly or indirectly under a PIP to a provider  
1441 or provider group as an inducement to reduce or limit medically necessary services  
1442 furnished to an individual.  
1443

1444 A PIP must provide for compliance with the requirements set forth in 42 CFR 422.208  
1445 and 422.210. In addition, should the Contractor operate a PIP, it must:  
1446

- 1447 • upon request from the Departments, report adequate information specified in the  
1448 PIP regulations to the Departments to allow for adequate monitoring;
- 1449 • report type of incentive arrangement, e.g., withhold, bonus, capitation;
- 1450 • report percent of withhold or bonus (if applicable);
- 1451 • report panel size, and if patients are pooled, the approved method used;
- 1452 • if a provider/group is put at substantial financial risk for services not provided by  
1453 a provider/group, ensure adequate stop-loss protection to individual providers  
1454 and conduct annual Enrollee surveys; if the entity is at substantial financial risk,  
1455 show proof that the provider/group has adequate stop loss coverage, including  
1456 amount and type of stop-loss;
- 1457 • provide information on its PIP to any Enrollee upon request (this includes the  
1458 right to adequate and timely information on a PIP), and
- 1459 • if required to conduct a member survey, disclose survey results to the State and,  
1460 upon request, to members.  
1461

1462 **9.1(28)(d) Utilization of Minority Business Enterprises**  
1463

1464 It is the policy of the state that minority business enterprises shall have the maximum  
1465 practical opportunity to participate in the performance of government contracts. In  
1466 implementing the contract, the Contractor agrees to use its best efforts to carry out this

1467 policy in the award of its subcontracts to the fullest extent consistent with the efficient  
1468 performance of the contract.

1469

1470 **9.1(28)(e) Utilization of Small Business**

1471

1472 The State encourages the use of small businesses in the performance of government  
1473 contracts. In implementing the contract, the Contractor agrees to undertake the maximum  
1474 amount of subcontracting to small businesses that is consistent with the efficient  
1475 performance of the contract.

1476

1477 **9.1 (4) Monitoring Clause:** See Section 6.5 of this RFP.

1478

1479

1480

1481 **9.1 (5) Review Clause:** See Section 6.5 of this RFP.

1482

1483

1484

1485

1486

1486

## 9.2 General Terms for Services Contracts

1487

### 9.2 (1) Definitions.

1488

a. **“Acceptance”** means that the Departments have determined that one or more Deliverables satisfy the Departments’ Acceptance Tests. Final Acceptance means that the Departments have determined that all Deliverables satisfy the Departments’ Acceptance Tests. Non-acceptance means that the Departments have determined that one or more Deliverables have not satisfied the Departments’ Acceptance Tests.

1493

b. **“Acceptance Criteria”** means the Specifications, goals, performance measures, testing results and/or other criteria designated by the Departments and against which the Deliverables may be evaluated for purposes of Acceptance or Non-acceptance thereof.

1496

c. **“Acceptance Tests” or “Acceptance Testing”** mean the tests, reviews and other activities that are performed by or on behalf of Departments to determine whether the Deliverables meet the Acceptance Criteria or otherwise satisfy the Departments, as determined by the Departments in their sole discretion.

1499

1500

d. **“Departments”** means the Iowa Department of Human Services and the Iowa Department of Public Health, collectively.

1501

1502

e. **“Bid Proposal” or “Proposal”** means the Contractor’s proposal submitted in response to the RFP.

1503

1504

f. **“Contract”** means the collective documentation memorializing the terms of the agreement between the Departments and the Contractor identified on the Contract Declarations & Execution Page(s) and includes the signed Contract Declarations & Execution Page(s), the Special Terms, these General Terms for Services Contracts, any Special Contract Attachments, and all other addenda to the Contract Declarations & Execution Page(s).

1509

g. **“Contractor”** means the entity or individual providing services under this Contract.

1510

1511

h. **“Declarations & Execution Page(s)”** means the document that contains basic information about the Contract and incorporates by reference these General Terms for Services Contracts, the Special Terms, and all other addenda to the Contract Declarations and Executions Page(s).

1513

1514

i. **“Deficiency”** means a defect, flaw, anomaly, failure, omission, interruption of service, or other problem of any nature whatsoever with respect to a Deliverable, including, without limitation, any failure of a Deliverable to conform to or meet an applicable specification. Deficiency also includes the lack of something essential or necessary for completeness or proper functioning of a Deliverable.

1519

1520

j. **“Deliverables”** all of the goods, products, services, work, work product, items, materials and property to be created, developed, produced, delivered, performed or provided by or on behalf of, or made available through, Contractor (or any agent, contractor or subcontractor of Contractor) in connection with this Contract.

1522

1523

k. **“Documentation”** means any and all technical information, commentary, explanations, design documents, system architecture documents, database layouts, test materials, training materials, guides, manuals, worksheets, notes, work papers, and all other information, documentation and materials related to or used in conjunction with the Deliverables, in any medium, including hard copy, electronic, digital, and magnetically or optically encoded media.

1526

1527

l. **“RFP”** means the Request for Proposals or Request for Bids (and any Addenda thereto) identified on the Contracts Declarations and Execution Page(s) that was issued to solicit the Deliverables that are subject to the Contract.

1529

1530

1531

m. **“Special Contract Attachments”** means any attachment to this Contract indicated on the Contract Declarations & Execution Page(s).

1532

1533           **n. “Special Terms”** means the Section of the Contract entitled “Special Terms” that  
1534 contains terms specific to this Contract, including but not limited to the Scope of Work, contract  
1535 payment terms, and any amendments to these General Terms and Conditions for Services  
1536 Contracts. If there is a conflict between the General Terms for Services Contracts and the Special  
1537 Terms, the Special Terms shall prevail.

1538           **o. “Specifications”** means all specifications, requirements, technical standards,  
1539 performance standards, representations and other criteria related to the Deliverables stated or  
1540 expressed in this Contract, the Documentation, the RFP, and the Proposal. Specifications shall  
1541 include the Acceptance Criteria and any specifications, standards or criteria stated or set forth in  
1542 any applicable state, federal, foreign and local laws, rules and regulations. The Specifications are  
1543 incorporated into this Contract by reference as if fully set forth in this Contract.

1544           **p. “State”** means the State of Iowa, the Departments, and all State of Iowa agencies,  
1545 departments, boards, and commissions, and when this Contract is available to political  
1546 subdivisions, any political subdivisions of the State of Iowa.

1547  
1548 **9.2 (2) Duration of Contract.** The term of the Contract shall begin and end on the dates specified  
1549 on the Contract Declarations & Execution Page(s), unless extended or terminated earlier in  
1550 accordance with the termination provisions of this Contract. The Departments may, in their sole  
1551 discretion, exercise any applicable extension by giving the Contractor written notice of the  
1552 extension decision at least sixty (60) days prior to the expiration of the initial term or renewal  
1553 term.

1554  
1555 **9.2 (3) Scope of Work.** The Contractor shall provide Deliverables that comply with and conform  
1556 to the Specifications.

1557  
1558 **9.2 (4) Compensation**

1559           **a. Pricing.** The Contractor will be compensated in accordance with the payment terms  
1560 outlined in the Contract Payment Terms and Scope of Work described in the Special Terms.

1561           The Contractor shall submit, on the frequency established on the Contract Declarations &  
1562 Execution Page(s) an invoice for Deliverables rendered in accordance with this Contract. The  
1563 invoice shall comply with all applicable rules concerning payment of such claims. The  
1564 Departments shall verify the Contractor’s performance of the Deliverables outlined in the invoice  
1565 before making payment. The Departments shall pay all approved invoices in arrears and in  
1566 conformance with Iowa Code § 8A.514. The Departments may pay in less than sixty (60) days,  
1567 but an election to pay in less than sixty (60) days shall not act as an implied waiver of Iowa Code  
1568 § 8A.514.

1569           Unless otherwise agreed in writing by the parties, the Contractor shall not be entitled to  
1570 receive any other payment or compensation from the State for any Deliverables provided by or on  
1571 behalf of the Contractor under this Contract. The Contractor shall be solely responsible for paying  
1572 all costs, expenses and charges it incurs in connection with its performance under this Contract.

1573           **b. Withholding Payments.** In addition to pursuing any other remedy provided herein or  
1574 by law, the Departments may withhold compensation or payments to Contractor, in whole or in  
1575 part, without penalty to the Departments or work stoppage by Contractor, in the event that the  
1576 Departments (individually or collectively) determine that: (1) Contractor has failed to perform  
1577 any of its duties or obligations as set forth in this Contract; or (2) any Deliverable has failed to  
1578 meet or conform to any applicable Specifications or contains or is experiencing a Deficiency. No  
1579 interest shall accrue or be paid to Contractor on any compensation or other amounts withheld or  
1580 retained by the Departments under this Contract.

1581           **c. Setoff Against Sums Owed by the Contractor.** In the event that Contractor owes the  
1582 State any sum under the terms of this Contract, any other contract or agreement, pursuant to a

1583 judgment, or pursuant to any law, the State may, in its sole discretion, set off any such sum  
1584 against: (1) any sum invoiced by, or owed to, Contractor under this Contract, or (2) any sum or  
1585 amount owed by the State to Contractor, unless otherwise required by law. The Contractor agrees  
1586 that this provision constitutes proper and timely notice under any applicable laws governing  
1587 setoff.

1588

1589 **9.2 (5) Termination.**

1590 **a. Termination for Cause by the Departments.** The Departments may terminate this  
1591 Contract upon written notice for the breach by Contractor of any material term, condition or  
1592 provision of this Contract, if such breach is not cured within the time period specified in the  
1593 Departments' notice of breach or any subsequent notice or correspondence delivered by the  
1594 Departments to Contractor, provided that cure is feasible. In addition, the Departments may  
1595 terminate this Contract effective immediately without penalty and without advance notice or  
1596 opportunity to cure for any of the following reasons:

1597 (1) Contractor furnished any statement, representation, warranty or certification in  
1598 connection with this Contract, the RFP or the Proposal that is false, deceptive, or materially  
1599 incorrect or incomplete;

1600 (2) Contractor or any of Contractor's officers, directors, employees, agents, subsidiaries,  
1601 affiliates, contractors or subcontractors has committed or engaged in fraud, misappropriation,  
1602 embezzlement, malfeasance, misfeasance, or bad faith;

1603 (3) Contractor or any parent or affiliate of Contractor owning a controlling interest in  
1604 Contractor dissolves;

1605 (4) Contractor terminates or suspends its business;

1606 (5) Contractor's corporate existence or good standing in Iowa is suspended, terminated,  
1607 revoked or forfeited, or any license or certification held by Contractor related to Contractor's  
1608 performance under this Contract is suspended, terminated, revoked, or forfeited;

1609 (6) Contractor has failed to comply with any applicable international, federal, state  
1610 (including, but not limited to Iowa Code chapter 8F), or local laws, rules, ordinances, regulations  
1611 or orders when performing within the scope of this Contract;

1612 (7) The Departments determine or believes the Contractor has engaged in conduct that:  
1613 (a) has or may expose the Departments or the State to material liability, or (b) has caused or may  
1614 cause a person's life, health or safety to be jeopardized;

1615 (8) Contractor infringes or allegedly infringes or violates any patent, trademark,  
1616 copyright, trade dress or any other intellectual property right or proprietary right, or Contractor  
1617 misappropriates or allegedly misappropriates a trade secret;

1618 (9) Contractor fails to comply with any applicable confidentiality laws, privacy laws, or  
1619 any provisions of this Contract pertaining to confidentiality or privacy; or

1620 (10) Any of the following has been engaged in by or occurred with respect to Contractor  
1621 or any corporation, shareholder or entity having or owning a controlling interest in Contractor:

1622 **1.** Commencing or permitting a filing against it which is not discharged within ninety  
1623 (90) days, of a case or other proceeding seeking liquidation, reorganization, or other relief with  
1624 respect to itself or its debts under any bankruptcy, insolvency, or other similar law now or  
1625 hereafter in effect; or filing an answer admitting the material allegations of a petition filed against  
1626 it in any involuntary case or other proceeding commenced against it seeking liquidation,  
1627 reorganization, or other relief under any bankruptcy, insolvency, or other similar law now or  
1628 hereafter in effect with respect to it or its debts; or consenting to any such relief or to the  
1629 appointment of or taking possession by any such official in any voluntary case or other  
1630 proceeding commenced against it seeking liquidation, reorganization, or other relief under any  
1631 bankruptcy, insolvency, or other similar law now or hereafter in effect with respect to it or its  
1632 debts;

1633           2. Seeking or suffering the appointment of a trustee, receiver, liquidator, custodian or  
1634 other similar official of it or any substantial part of its assets;

1635           3. Making an assignment for the benefit of creditors;

1636           4. Failing, being unable, or admitting in writing the inability generally to pay its debts or  
1637 obligations as they become due or failing to maintain a positive net worth and such additional  
1638 capital and liquidity as is reasonably adequate or necessary in connection with Contractor's  
1639 performance of its obligations under this Contract; or

1640           5. Taking any action to authorize any of the foregoing.

1641           The Departments' right to terminate this Contract shall be in addition to and not exclusive  
1642 of other remedies available to the Departments, and the Departments shall be entitled to exercise  
1643 any other rights and pursue any remedies, in law, at equity, or otherwise.

1644           **b. Termination Upon Notice.** Following a thirty (30) day written notice, the  
1645 Departments may terminate this Contract in whole or in part without penalty and without  
1646 incurring any further obligation to Contractor. Termination can be for any reason or no reason at  
1647 all.

1648           **c. Termination Due to Lack of Funds or Change in Law.** Notwithstanding anything in  
1649 this Contract to the contrary, and subject to the limitations set forth below, the Departments shall  
1650 have the right to terminate this Contract without penalty and without any advance notice as a  
1651 result of any of the following:

1652           (1) The legislature or governor fail in the sole opinion of the Departments to appropriate  
1653 funds sufficient to allow the Departments to either meet its obligations under this Contract or to  
1654 operate as required and to fulfill its obligations under this Contract; or

1655           (2) If funds are de-appropriated, reduced, not allocated, or receipt of funds is delayed, or  
1656 if any funds or revenues needed by the Departments to make any payment hereunder are  
1657 insufficient or unavailable for any other reason as determined by the Departments in their sole  
1658 discretion; or

1659           (3) If the Departments' authorization to conduct its business or engage in activities or  
1660 operations related to the subject matter of this Contract is withdrawn or materially altered or  
1661 modified; or

1662           (4) If the Departments' duties, programs or responsibilities are modified or materially  
1663 altered; or

1664           (5) If there is a decision of any court, administrative law judge or an arbitration panel or  
1665 any law, rule, regulation or order is enacted, promulgated or issued that materially or adversely  
1666 affects the Departments' ability to fulfill any of its obligations under this Contract.

1667           The Departments shall provide Contractor with written notice of termination pursuant to  
1668 this section.

1669           **d. Limitation of the State's Payment Obligations.** In the event of termination of this  
1670 Contract for any reason by either party (except for termination by the Departments pursuant to  
1671 Section 2.2(5)(a), the Departments shall pay only those amounts, if any, due and owing to  
1672 Contractor hereunder for Deliverables actually and satisfactorily provided in accordance with the  
1673 provisions of this Contract up to and including the date of termination of this Contract and for  
1674 which the Departments are obligated to pay pursuant to this Contract; provided however, that in  
1675 the event the Departments terminate this Contract pursuant to Section 2.2(5)(c), the Departments'  
1676 obligation to pay Contractor such amounts and other compensation shall be limited by, and  
1677 subject to, legally available funds. Payment will be made only upon submission of invoices and  
1678 proper proof of Contractor's claim. Notwithstanding the foregoing, this Section 2.2(5)(d) in no  
1679 way limits the rights or remedies available to the Departments and shall not be construed to  
1680 require the Departments to pay any compensation or other amounts hereunder in the event of  
1681 Contractor's breach of this Contract or any amounts withheld by the Departments in accordance

1682 with the terms of this Contract. The Departments shall not be liable, under any circumstances, for  
1683 any of the following:

1684 (1) The payment of unemployment compensation to Contractor's employees;

1685 (2) The payment of workers' compensation claims, which occur during the Contract or  
1686 extend beyond the date on which the Contract terminates;

1687 (3) Any costs incurred by Contractor in its performance of the Contract, including, but  
1688 not limited to, startup costs, overhead or other costs associated with the performance of the  
1689 Contract;

1690 (4) Any damages or other amounts associated with the loss of prospective profits,  
1691 anticipated sales, goodwill, or for expenditures, investments or commitments made in connection  
1692 with this Contract;

1693 (5) Any taxes Contractor may owe in connection with the performance of this Contract,  
1694 including, but not limited to, sales taxes, excise taxes, use taxes, income taxes or property taxes.

1695 **e. Contractor's Termination Duties.** Upon receipt of notice of termination or upon  
1696 request of the Departments, Contractor shall:

1697 1. Cease work under this Contract and take all necessary or appropriate steps to limit  
1698 disbursements and minimize costs, and furnish a report within thirty (30) days of the date of  
1699 notice of termination, describing the status of all work performed under the Contract and such  
1700 other matters as the Departments may require.

1701 2. Immediately cease using and return to the Departments any property or materials,  
1702 whether tangible or intangible, provided by the Departments (individually or collectively) to  
1703 Contractor.

1704 3. Cooperate in good faith with the Departments and their employees, agents and  
1705 independent contractors during the transition period between the notification of termination and  
1706 the substitution of any replacement service provider.

1707 4. Immediately return to the Departments any payments made by the Departments for  
1708 Deliverables that were not rendered or provided by Contractor.

1709 5. Immediately deliver to the Departments any and all Deliverables for which the  
1710 Departments have made payment (in whole or in part) that are in the possession or under the  
1711 control of the Contractor or its agents or subcontractors in whatever stage of development and  
1712 form of recordation such property is expressed or embodied as that time.

1713 **f. Termination for Cause by Contractor.** Contractor may only terminate this Contract  
1714 for the breach by the Departments of any material term, condition or provision of this Contract, if  
1715 such breach is not cured within sixty (60) days of the Departments' receipt of Contractor's  
1716 written notice of breach.

1717

1718 **9.2 (6) Confidential Information.**

1719 **a. Access to Confidential Information.** The Contractor's employees, agents and  
1720 subcontractors may have access to confidential information maintained by the Departments to the  
1721 extent necessary to carry out its responsibilities under the Contract. The Contractor shall presume  
1722 that all information received pursuant to this Contract is confidential unless otherwise designated  
1723 by the Departments. The Contractor shall provide to the Departments a written description of its  
1724 policies and procedures to safeguard confidential information. Policies of confidentiality shall  
1725 address, as appropriate, information conveyed in verbal, written, and electronic formats. The  
1726 Contractor must designate one individual who shall remain the responsible authority in charge of  
1727 all data collected, used, or disseminated by the Contractor in connection with the performance of  
1728 the Contract. The Contractor shall provide adequate supervision and training to its agents,  
1729 employees and subcontractors to ensure compliance with the terms of this Contract. The private  
1730 or confidential information shall remain the property of the Departments at all times.

1731           **b. No Dissemination of Confidential information.** No confidential information  
1732 collected, maintained, or used in the course of performance of the Contract shall be disseminated  
1733 by Contractor except as authorized by law and only with the prior written consent of the  
1734 Departments, either during the period of the Contract or thereafter. Any data supplied by the  
1735 Departments to the Contractor or created by the Contractor in the course of the performance of  
1736 this Contract shall be considered the property of the Departments. The Contractor must return any  
1737 and all data collected, maintained, created or used in the course of the performance of the  
1738 Contract in whatever form it is maintained promptly at the request of the Departments. The  
1739 Contractor may be held civilly or criminally liable for improper disclosure of confidential  
1740 information.

1741           **c. Subpoena.** In the event that a subpoena or other legal process is served upon the  
1742 Contractor for records containing confidential information, the Contractor shall promptly notify  
1743 the Departments and cooperate with the Departments in any lawful effort to protect the  
1744 confidential information.

1745           **d. Reporting of Unauthorized Disclosure.** The Contractor shall immediately report to  
1746 the Departments any unauthorized disclosure of confidential information.

1747           **e. Survives Termination.** The Contractor's obligations under this section shall survive  
1748 termination or expiration of this Contract.

1749  
1750 **9.2 (7) Indemnification.**

1751           **a. By the Contractor.** The Contractor agrees to indemnify and hold harmless the State  
1752 and its officers, appointed and elected officials, board and commission members, employees,  
1753 volunteers and agents (collectively the "Indemnified Parties"), from any and all costs, expenses,  
1754 losses, claims, damages, liabilities, settlements and judgments (including, without limitation, the  
1755 reasonable value of the time spent by the Attorney General's Office, and the costs, expenses and  
1756 attorneys' fees of other counsel retained by the Indemnified Parties directly or indirectly related  
1757 to, resulting from, or arising out of this Contract, including but not limited to any claims related  
1758 to, resulting from, or arising out of:

1759           (1) Any breach of this Contract;

1760           (2) Any negligent, intentional or wrongful act or omission of the Contractor or any agent  
1761 or subcontractor utilized or employed by the Contractor;

1762           (3) The Contractor's performance or attempted performance of this Contract, including  
1763 any agent or subcontractor utilized or employed by the Contractor;

1764           (4) Any failure by the Contractor to make all reports, payments and withholdings  
1765 required by federal and state law with respect to social security, employee income and other  
1766 taxes, fees or costs required by the Contractor to conduct business in the State of Iowa;

1767           (5) Any claim of misappropriation of a trade secret or infringement or violation of any  
1768 intellectual property rights, proprietary rights or personal rights of any third party, including any  
1769 claim that any Deliverable or any use thereof (or the exercise of any rights with respect thereto)  
1770 infringes, violates or misappropriates any patent, copyright, trade secret, trademark, trade dress,  
1771 mask work, utility design, or other intellectual property right or proprietary right of any third  
1772 party.

1773           **b. Survives Termination.** Contractor's duties and obligations under this section shall  
1774 survive the termination of this Contract and shall apply to all acts or omissions taken or made in  
1775 connection with the performance of this Contract regardless of the date any potential claim is  
1776 made or discovered by the Departments or any other Indemnified Party.

1777  
1778 **9.2 (8) Insurance.**

1779           **a. Insurance Requirements.** The Contractor, and any subcontractor, shall maintain in  
1780 full force and effect, with insurance companies licensed by the State of Iowa, at the Contractor's

1781 expense, insurance covering its work during the entire term of this Contract and any extensions or  
1782 renewals thereof. The Contractor's insurance shall, among other things, be occurrence based and  
1783 shall insure against any loss or damage resulting from or related to the Contractor's performance  
1784 of this Contract regardless of the date the claim is filed or expiration of the policy. The State of  
1785 Iowa and the Departments shall be named as additional insureds or loss payees, or the Contractor  
1786 shall obtain an endorsement to the same effect, as applicable.

1787 **b. Types and Amounts of Insurance Required.** Unless otherwise requested by the  
1788 Departments in writing, the Contractor shall cause to be issued insurance coverages insuring the  
1789 Contractor and/or subcontractors against all general liabilities, product liability, personal injury,  
1790 property damage, and (where applicable) professional liability in the amount specified on the  
1791 Contract Declarations and Execution Page for each occurrence. In addition, the Contractor shall  
1792 ensure it has any necessary workers' compensation and employer liability insurance as required  
1793 by Iowa law.

1794 **c. Certificates of Coverage.** Contractor shall maintain all insurance policies required by  
1795 this Contract in full force and effect during the entire term of this Contract and any extensions or  
1796 renewals thereof, and shall not permit such policies to be canceled or amended except with the  
1797 advance written approval of the Departments. The Contractor shall submit certificates of the  
1798 insurance, which indicate coverage and notice provisions as required by this Contract, to the  
1799 Departments upon execution of this Contract. The certificates shall be subject to approval by the  
1800 Departments. The insurer shall state in the certificate that no cancellation of the insurance will be  
1801 made without at least a thirty (30) day prior written notice to the Departments. Approval of the  
1802 insurance certificates by the Departments shall not relieve the Contractor of any obligation under  
1803 this Contract.

1804 **d. Waiver of Subrogation Rights.** The Contractor shall obtain a waiver of any  
1805 subrogation rights that any of its insurance carriers might have against the State. The waiver of  
1806 subrogation rights shall be indicated on the certificates of insurance coverage supplied to the  
1807 State.

1808

1809 **9.2(9) Project Management & Reporting.**

1810 **a. Project Manager.** At the time of execution of this Contract, each party shall designate,  
1811 in writing, a Project Manager to serve until the expiration of this Contract or the designation of a  
1812 substitute Project Manager. During the term of this Contract, each Project Manager shall be  
1813 available to meet monthly, unless otherwise mutually agreed, to review and plan the Deliverables  
1814 being provided under this Contract.

1815 **b. Review Meetings.** During the review meetings the Project Managers shall discuss  
1816 progress made by the Contractor in the performance of this Contract. Each party shall provide a  
1817 status report, as desired by a Project Manager, listing any problem or concern encountered since  
1818 the last meeting. Records of such reports and other communications issued in writing during the  
1819 course of Contract performance shall be maintained by each party.

1820 **c. Reports.** At the next scheduled meeting after which any party has identified in writing  
1821 a problem, the party responsible for resolving the problem shall provide a report setting forth  
1822 activities undertaken, or to be undertaken, to resolve the problem, together with the anticipated  
1823 completion dates of such activities. Any party may recommend alternative courses of action or  
1824 changes that will facilitate problem resolution. For as long as a problem remains unresolved,  
1825 written reports shall identify:

1826 (1) Any event not within the control of the Contractor or the Departments that accounts  
1827 for the problem;

1828 (2) Modifications to the Contract agreed to by the parties in order to remedy or solve the  
1829 identified problem;

1830 (3) Damages incurred as a result of any party's failure to perform its obligations under  
1831 this Contract; and

1832 (4) Any request or demand by one party that another party believes is not included within  
1833 the terms of this Contract.

1834 **d. Problem Reporting Omissions.** The Departments' acceptance of a problem report  
1835 shall not relieve the Contractor of any obligation under this Contract or waive any other remedy  
1836 under this Contract or at law or equity that the Departments may have. The Departments' failure  
1837 to identify the extent of a problem or the extent of damages incurred as a result of a problem shall  
1838 not act as a waiver of performance or damages under this Contract. Where other provisions of this  
1839 Contract require notification of an event in writing, the written report shall be considered a valid  
1840 notice under this Contract provided the parties required to receive notice are notified.

1841 **e. Change Order Procedure.** The Departments may at any time request a modification  
1842 to the Scope of Work using a change order. The following procedures for a change order shall be  
1843 followed:

1844 (1) **Written Request.** The Departments shall specify in writing the desired modifications  
1845 to the same degree of specificity as in the original Scope of Work.

1846 (2) **The Contractor's Response.** The Contractor shall submit to the Departments a firm  
1847 cost proposal for the requested change order within five (5) business days of receiving the change  
1848 order request.

1849 (3) **Acceptance of the Contractor Estimate.** If the Departments accept the cost proposal  
1850 presented by the Contractor, the Contractor shall provide the modified Deliverable subject to the  
1851 cost proposal included in the Contractor response. The Contractor's provision of the modified  
1852 Deliverables shall be governed by the terms and conditions of this Contract.

1853 (4) **Adjustment to Compensation.** The parties acknowledge that a change order for this  
1854 Contract may or may not entitle the Contractor to an equitable adjustment in the Contractor's  
1855 compensation or the performance deadlines under this Contract.

1856  
1857 **9.2 (10) Legislative Changes.** The Contractor expressly acknowledges that the contracted  
1858 Deliverables are subject to legislative change by either the federal or state government. Should  
1859 either legislative body enact measures which alter the project, the Contractor shall not hold the  
1860 Departments liable in any manner for the resulting changes. The Departments shall use best  
1861 efforts to provide a thirty (30) day written notice to the Contractor of any legislative change.  
1862 During the thirty (30) day period, the parties shall meet and make a good faith effort to agree  
1863 upon changes to the Contract to address the legislative change. Nothing in this subsection shall  
1864 affect or impair the Departments' right to terminate the Contract pursuant to the termination  
1865 provisions.

1866  
1867 **9.2 (11) Intellectual Property.**

1868 **a. Ownership and Assignment of Other Deliverables.** Contractor agrees that the State  
1869 and Departments shall become the sole and exclusive owners of all Deliverables. Contractor  
1870 hereby irrevocably assigns, transfers and conveys to the State and the Departments all right, title  
1871 and interest in and to all Deliverables and all intellectual property rights and proprietary rights  
1872 arising out of, embodied in, or related to such Deliverables, including copyrights, patents,  
1873 trademarks, trade secrets, trade dress, mask work, utility design, derivative works, and all other  
1874 rights and interests therein or related thereto. Contractor represents and warrants that the State  
1875 and the Departments shall acquire good and clear title to all Deliverables, free from any claims,  
1876 liens, security interests, encumbrances, intellectual property rights, proprietary rights, or other  
1877 rights or interests of Contractor or of any third party, including any employee, agent, contractor,  
1878 subcontractor, subsidiary or affiliate of Contractor. The Contractor (and Contractor's employees,  
1879 agents, contractors, subcontractors, subsidiaries and affiliates) shall not retain any property

1880 interests or other rights in and to the Deliverables and shall not use any Deliverables, in whole or  
1881 in part, for any purpose, without the prior written consent of the Departments and the payment of  
1882 such royalties or other compensation as the Departments deem appropriate. Unless otherwise  
1883 requested by Departments, upon completion or termination of this Contract, Contractor will  
1884 immediately turn over to the Departments all Deliverables not previously delivered to the  
1885 Departments, and no copies thereof shall be retained by Contractor or its employees, agents,  
1886 subcontractors or affiliates, without the prior written consent of the Departments.

1887 **b. Waiver.** To the extent any of Contractor's rights in any Deliverables are not subject to  
1888 assignment or transfer hereunder, including any moral rights and any rights of attribution and of  
1889 integrity, Contractor hereby irrevocably and unconditionally waives all such rights and  
1890 enforcement thereof and agrees not to challenge the State's rights in and to the Deliverables.

1891 **c. Further Assurances.** At the Departments' request, Contractor will execute and deliver  
1892 such instruments and take such other action as may be requested by the Departments to establish,  
1893 perfect or protect the State's rights in and to the Deliverables and to carry out the assignments,  
1894 transfers and conveyances set forth in Section 2.2(11)(a).

1895 **d. Publications.** Prior to completion of all services required by this Contract, Contractor  
1896 shall not publish in any format any final or interim report, document, form or other material  
1897 developed as a result of this Contract without the express written consent of the Departments.  
1898 Upon completion of all services required by this Contract, Contractor may publish or use  
1899 materials developed as a result of this Contract, subject to confidentiality restrictions, and only  
1900 after the Departments have had an opportunity to review and comment upon the publication. Any  
1901 such publication shall contain a statement that the work was done pursuant to a contract with the  
1902 Departments and that it does not necessarily reflect the opinions, findings and conclusions of the  
1903 Departments.

1904  
1905 **9.2 (12) Warranties.**

1906 **a. Construction of Warranties Expressed in this Contract with Warranties Implied**  
1907 **by Law.** Warranties made by the Contractor in this Contract, whether: (a) this Contract  
1908 specifically denominates the Contractor's promise as a warranty; or (b) the warranty is created by  
1909 the Contractor's affirmation or promise, by a description of the Deliverables to be provided, or by  
1910 provision of samples to the Departments, shall not be construed as limiting or negating any  
1911 warranty provided by law, including without limitation, warranties that arise through course of  
1912 dealing or usage of trade. The warranties expressed in this Contract are intended to modify the  
1913 warranties implied by law only to the extent that they expand the warranties applicable to the  
1914 Deliverables provided by the Contractor. The provisions of this section apply during the term of  
1915 this Contract and any extensions or renewals thereof.

1916 **b. Contractor represents and warrants that:**

1917 (1) all Deliverables shall be wholly original with and prepared solely by Contractor; or it  
1918 owns, possesses, holds, and has received or secured all rights, permits, permissions, licenses and  
1919 authority necessary to provide the Deliverables to the Departments hereunder and to assign, grant  
1920 and convey the rights, benefits, licenses and other rights assigned, granted or conveyed to the  
1921 Departments hereunder or under any license agreement related hereto without violating any rights  
1922 of any third party;

1923 (2) Contractor has not previously and will not grant any rights in any Deliverables to any  
1924 third party that are inconsistent with the rights granted to the Departments herein; and

1925 (3) the Departments shall peacefully and quietly have, hold, possess, use and enjoy the  
1926 Deliverables without suit, disruption or interruption.

1927 **c. Contractor represents and warrants that:**

1928 (1) the Deliverables (and all intellectual property rights and proprietary rights arising out  
1929 of, embodied in, or related to such Deliverables); and

1930 (2) the Departments' use of, and exercise of any rights with respect to, the Deliverables  
1931 (and all intellectual property rights and proprietary rights arising out of, embodied in, or related to  
1932 such Deliverables), do not and will not, under any circumstances, misappropriate a trade secret or  
1933 infringe upon or violate any copyright, patent, trademark, trade dress or other intellectual  
1934 property right, proprietary right or personal right of any third party. Contractor further represents  
1935 and warrants there is no pending or threatened claim, litigation or action that is based on a claim  
1936 of infringement or violation of an intellectual property right, proprietary right or personal right or  
1937 misappropriation of a trade secret related to the Deliverables. Contractor shall inform the  
1938 Departments in writing immediately upon becoming aware of any actual, potential or threatened  
1939 claim of or cause of action for infringement or violation or an intellectual property right,  
1940 proprietary right, or personal right or misappropriation of a trade secret. If such a claim or cause  
1941 of action arises or is likely to arise, then Contractor shall, at the Departments' request and at the  
1942 Contractor's sole expense:

1943 1. Procure for the Departments the right or license to continue to use the Deliverable at  
1944 issue;

1945 2. Replace such Deliverable with a functionally equivalent or superior Deliverable free of  
1946 any such infringement, violation or misappropriation;

1947 3. modify or replace the affected portion of the Deliverable with a functionally equivalent  
1948 or superior Deliverable free of any such infringement, violation or misappropriation; or

1949 4. accept the return of the Deliverable at issue and refund to the Departments all fees,  
1950 charges and any other amounts paid by the Departments with respect to such Deliverable. In  
1951 addition, Contractor agrees to indemnify, defend, protect and hold harmless the State and its  
1952 officers, directors, employees, officials and agents as provided in the Indemnification section of  
1953 this Contract, including for any breach of the representations and warranties made by Contractor  
1954 in this section. The foregoing remedies shall be in addition to and not exclusive of other remedies  
1955 available to the Departments and shall survive termination of this Contract.

1956 d. Contractor represents and warrants that the Deliverables (in whole and in part) shall:

1957 (1) be free from material Deficiencies; and

1958 (2) meet, conform to and operate in accordance with all Specifications and in accordance  
1959 with this Contract during the Warranty Period, as defined in the Contract Special Terms. During  
1960 the Warranty Period Contractor shall, at its expense, repair, correct or replace any Deliverable  
1961 that contains or experiences material Deficiencies or fails to meet, conform to or operate in  
1962 accordance with Specifications within five (5) business days of receiving notice of such  
1963 Deficiencies or failures from the Departments or within such other period as the Departments  
1964 specify in the notice. In the event Contractor is unable to repair, correct or replace such  
1965 Deliverable to the Departments' satisfaction, Contractor shall refund the fees or other amounts  
1966 paid for the Deliverables and for any services related thereto. The foregoing shall not constitute  
1967 an exclusive remedy under this Contract, and the Departments shall be entitled to pursue any  
1968 other available contractual, legal or equitable remedies. Contractor shall be available at all  
1969 reasonable times to assist the Departments with questions, problems and concerns about the  
1970 Deliverables, to inform the Departments promptly of any known Deficiencies in any  
1971 Deliverables, repair and correct any Deliverables not performing in accordance with the  
1972 warranties contained in this Contract, notwithstanding that such Deliverable may have been  
1973 accepted by the Departments, and provide the Departments with all necessary materials with  
1974 respect to such repaired or corrected Deliverable.

1975 e. Contractor represents, warrants and covenants that all services to be performed under  
1976 this Contract shall be performed in a professional, competent, diligent and workmanlike manner  
1977 by knowledgeable, trained and qualified personnel, all in accordance with the terms and  
1978 Specifications of this Contract and the standards of performance considered generally acceptable  
1979 in the industry for similar tasks and projects. In the absence of a Specification for the

1980 performance of any portion of this Contract, the parties agree that the applicable specification  
1981 shall be the generally accepted industry standard. So long as the Departments notify Contractor of  
1982 any services performed in violation of this standard, Contractor shall re-perform the services at no  
1983 cost to the Departments, such that the services are rendered in the above-specified manner, or if  
1984 the Contractor is unable to perform the services as warranted, Contractor shall reimburse the  
1985 Departments any fees or compensation paid to Contractor for the unsatisfactory services.

1986 **f.** Contractor represents and warrants that the Deliverables will comply with any  
1987 applicable federal, state, foreign and local laws, rules, regulations, codes, and ordinances in effect  
1988 during the term of this Contract, including applicable provisions of Section 508 of the  
1989 Rehabilitation Act of 1973, as amended, and all standards and requirements established by the  
1990 Architectural and Transportation Barriers Access Board and the Iowa Department of  
1991 Administrative Services, Information Technology Enterprise.

1992 **g.** Obligations Owed to Third Parties. The Contractor represents and warrants that all  
1993 obligations owed to third parties with respect to the activities contemplated to be undertaken by  
1994 the Contractor pursuant to this Contract are or will be fully satisfied by the Contractor so that the  
1995 Departments will not have any obligations with respect thereto.

1996  
1997 **9.2 (13). Acceptance Testing.** Except as otherwise specified in the Scope of Work, all  
1998 Deliverables shall be subject to the Departments' Acceptance Testing and Acceptance, unless  
1999 otherwise specified in the Statement of Work. Upon completion of all work to be performed by  
2000 Contractor with respect to any Deliverable, Contractor shall deliver a written notice to the  
2001 Departments certifying that the Deliverable meets and conforms to applicable Specifications and  
2002 is ready for the Departments to conduct Acceptance Tests; provided, however, that Contractor  
2003 shall pretest the Deliverable to determine that it meets and operates in accordance with applicable  
2004 Specifications prior to delivering such notice to the Departments. At the Departments' request,  
2005 Contractor shall assist the Departments in performing Acceptance Tests at no additional cost to  
2006 the Departments. Within a reasonable period of time after the Departments have completed its  
2007 Acceptance Testing, the Departments shall provide Contractor with written notice of Acceptance  
2008 or Non-acceptance with respect to each Deliverable that was evaluated during such Acceptance  
2009 Testing. If the Departments determine that a Deliverable satisfies its Acceptance Tests, the  
2010 Departments shall provide Contractor with notice of Acceptance with respect to such Deliverable.  
2011 If the Departments determine that a Deliverable fails to satisfy its Acceptance Tests, the  
2012 Departments shall provide Contractor with notice of Non-acceptance with respect to such  
2013 Deliverable. In the event the Departments provide notice of Non-acceptance to Contractor with  
2014 respect to any Deliverable, Contractor shall correct and repair such Deliverable and submit it to  
2015 the Departments within ten (10) days of Contractor's receipt of notice of Non-acceptance so that  
2016 the Departments may re-conduct their Acceptance Tests with respect to such Deliverable. In the  
2017 event the Departments determine, after re-conducting its Acceptance Tests with respect to any  
2018 Deliverable that Contractor has attempted to correct or repair pursuant to this section, that such  
2019 Deliverable fails to satisfy its Acceptance Tests, then the Departments shall have the continuing  
2020 right, at their sole option, to: (i) require Contractor to correct and repair such Deliverable within  
2021 such period of time as the Departments may specify in a written notice to Contractor; (ii) refuse  
2022 to accept such Deliverable without penalty and without any obligation to pay any fees or other  
2023 amounts associated with such Deliverable (or receive a refund of any fees or amounts already  
2024 paid with respect to such Deliverable); (iii) accept such Deliverable on the condition that any fees  
2025 or other amounts payable with respect thereto shall be reduced or discounted to reflect, to the  
2026 Departments' satisfaction, the Deficiencies present therein and any reduced value or functionality  
2027 of such Deliverable or the costs likely to be incurred by the Departments to correct such  
2028 Deficiencies; or (iv) terminate this Contract and/or seek any and all available remedies, including  
2029 damages. Notwithstanding the provisions of Section 9.2(5)(a) of this Contract, the Departments

2030 may terminate this Contract pursuant to this section without providing Contractor with any notice  
2031 or opportunity to cure provided for in Section 9.2(5)(a). The Departments' right to exercise the  
2032 foregoing rights and remedies, including termination of this Contract, shall remain in effect until  
2033 Acceptance Tests are successfully completed to the Departments' satisfaction and the  
2034 Departments have provided Contractor with written notice of Final Acceptance. If the  
2035 Departments determine that all Deliverables satisfy its Acceptance Tests, the Departments shall  
2036 provide Contractor with notice of Final Acceptance with respect to such Deliverables.  
2037 Contractor's receipt of any notice of Acceptance, including Final Acceptance, with respect to any  
2038 Deliverable(s) shall not be construed as a waiver of any of the Departments' rights to enforce the  
2039 terms of this Contract or require performance in the event Contractor breaches this Contract or  
2040 any Deficiency is later discovered with respect to such Deliverable(s).

2041

2042 **9.2 (14) Contract Administration.**

2043 **a. Independent Contractor.** The status of the Contractor shall be that of an independent  
2044 contractor. The Contractor, its employees, agents and any subcontractors performing under this  
2045 Contract are not employees or agents of the State or any agency, division or department of the  
2046 State simply by virtue of work performed pursuant to this Contract. Neither the Contractor nor its  
2047 employees shall be considered employees of the Departments or the State for federal or state tax  
2048 purposes simply by virtue of work performed pursuant to this Contract. The Departments will not  
2049 withhold taxes on behalf of the Contractor (unless required by law).

2050 **b. Incorporation of Documents.** To the extent this Contract arises out of an RFP, the  
2051 parties acknowledge that the Contract consists of these contract terms and conditions as well as  
2052 the RFP and the Bid Proposal. The RFP and the Bid Proposal are incorporated into the Contract  
2053 by reference, except that no objection or amendment by the Contractor to the provisions of the  
2054 RFP shall be incorporated by reference into the Contract unless the Departments have explicitly  
2055 accepted the Contractor's objection or amendment in writing. If there is a conflict between the  
2056 Contract, the RFP and the Bid Proposal, the conflict shall be resolved according to the following  
2057 priority, ranked in descending order: (1) the Contract; (2) the RFP; (3) the Bid Proposal.

2058 **c. Intent of References to Bid Documents.** The references to the parties' obligations,  
2059 which are contained in this Contract, are intended to supplement or clarify the obligations as  
2060 stated in the RFP and the Bid Proposal. The failure of the parties to make reference to the terms  
2061 of the RFP or the Bid Proposal in this Contract shall not be construed as creating a conflict and  
2062 will not relieve the Contractor of the contractual obligations imposed by the terms of the RFP and  
2063 the Contractor's Bid Proposal. The contractual obligations of the Departments cannot be implied  
2064 from the Bid Proposal.

2065 **d. Compliance with the Law.** The Contractor, its employees, agents, and subcontractors  
2066 shall comply with all applicable federal, state, and local laws, rules, ordinances, regulations and  
2067 orders when providing Deliverables under this Contract, including without limitation, all laws  
2068 that pertain to the prevention of discrimination in employment and in the provision of services.  
2069 For employment, this would include equal employment opportunity and affirmative action, and  
2070 the use of targeted small businesses as subcontractors or suppliers. The Contractor may be  
2071 required to provide a copy of its affirmative action plan, containing goals and time specifications,  
2072 and non-discrimination and accessibility plans and policies regarding services to clients. Failure  
2073 to comply with this provision may cause this contract to be cancelled, terminated or suspended in  
2074 whole or in part and the Contractor may be declared ineligible for future state contracts or be  
2075 subject to other sanctions as provided by law or rule. The Contractor, its employees, agents and  
2076 subcontractors shall also comply with all federal, state and local laws regarding business permits  
2077 and licenses that may be required to carry out the work performed under this Contract. The  
2078 Contractor may be required to submit its affirmative action plan to the Department of  
2079 Management to comply with the requirements of 541 Iowa Administrative Code chapter 4. If all

2080 or a portion of the funding used to pay for the Deliverables is being provided through a grant  
2081 from the Federal Government, Contractor acknowledges and agrees that pursuant to applicable  
2082 federal laws, regulations, circulars and bulletins, the awarding agency of the Federal Government  
2083 reserves certain rights including, without limitation a royalty-free, non-exclusive and irrevocable  
2084 license to reproduce, publish or otherwise use, and to authorize others to use, for Federal  
2085 Government purposes, the Deliverables developed under this Contract and the copyright in and to  
2086 such Deliverables.

2087 **e. Procurement.** Contractor shall use procurement procedures that comply with all  
2088 applicable federal, state, and local laws and regulations.

2089 **f. Non-Exclusive Rights.** This Contract is not exclusive. The Departments reserve the  
2090 right to select other contractors to provide Deliverables similar or identical to those described in  
2091 the Scope of Work during the term of this Contract.

2092 **g. Compliance with Iowa Code Chapter 8F.** N/A

2093 **h. Amendments.** This Contract may be amended in writing from time to time by mutual  
2094 consent of the parties. Amendments to the General Terms for Services Contracts may appear in  
2095 the Special Terms.

2096 **i. Third Party Beneficiaries.** There are no third party beneficiaries to this Contract. This  
2097 Contract is intended only to benefit the State and the Contractor.

2098 **j. Use of Third Parties.** The Departments acknowledge that the Contractor may contract  
2099 with third parties for the performance of any of the Contractor's obligations under this Contract.  
2100 The Contractor shall notify the Departments in writing of all subcontracts relating to Deliverables  
2101 to be provided under this Contract prior to the time the subcontract(s) become effective. The  
2102 Departments reserve the right to review and approve all subcontracts. The Contractor may enter  
2103 into these contracts to complete the project provided that the Contractor remains responsible for  
2104 all Deliverables provided under this Contract. All restrictions, obligations and responsibilities of  
2105 the Contractor under this Contract shall also apply to the subcontractors and the Contractor shall  
2106 include in all of its subcontracts a clause that so states. The Departments shall have the right to  
2107 request the removal of a subcontractor from the Contract for good cause.

2108 **k. Choice of Law and Forum.** The laws of the State of Iowa shall govern and determine  
2109 all matters arising out of or in connection with this Contract without regard to the conflict of law  
2110 provisions of Iowa law. Any and all litigation commenced in connection with this Contract shall  
2111 be brought and maintained solely in Polk County District Court for the State of Iowa, Des  
2112 Moines, Iowa, or in the United States District Court for the Southern District of Iowa, Central  
2113 Division, Des Moines, Iowa, wherever jurisdiction is appropriate. This provision shall not be  
2114 construed as waiving any immunity to suit or liability including without limitation sovereign  
2115 immunity in State or Federal court, which may be available to the Departments or the State of  
2116 Iowa.

2117 **l. Assignment and Delegation.** Contractor may not assign, transfer or convey in whole  
2118 or in part this Contract without the prior written consent of the Departments. For the purpose of  
2119 construing this clause, a transfer of a controlling interest in the Contractor shall be considered an  
2120 assignment. The Contractor may not delegate any of its obligations or duties under this Contract  
2121 without the prior written consent of the Departments. The Contractor may not assign, pledge as  
2122 collateral, grant a security interest in, create a lien against, or otherwise encumber, any payments  
2123 that may or will be made to the Contractor under this Contract.

2124 **m. Integration.** This Contract represents the entire Contract between the parties. The  
2125 parties shall not rely on any representation that may have been made which is not included in this  
2126 Contract.

2127 **n. Headings or Captions.** The paragraph headings or captions used in this Contract are  
2128 for identification purposes only and do not limit or construe the contents of the paragraphs.

2129           **o. Not a Joint Venture.** Nothing in this Contract shall be construed as creating or  
2130 constituting the relationship of a partnership, joint venture, (or other association of any kind or  
2131 agent and principal relationship) between the parties hereto. Each party shall be deemed to be an  
2132 independent contractor contracting for services and acting toward the mutual benefits expected to  
2133 be derived herefrom. No party, unless otherwise specifically provided for herein, has the  
2134 authority to enter into any contract or create an obligation or liability on behalf of, in the name of,  
2135 or binding upon another party to this Contract.

2136           **p. Joint and Several Liability.** If the Contractor is a joint entity, consisting of more than  
2137 one individual, partnership, corporation or other business organization, all such entities shall be  
2138 jointly and severally liable for carrying out the activities and obligations of this Contract, and for  
2139 any default of activities and obligations.

2140           **q. Supersedes Former Contracts or Agreements.** This Contract supersedes all prior  
2141 contracts or agreements between the Departments and the Contractor for the Deliverables to be  
2142 provided in connection with this Contract.

2143           **r. Waiver.** Except as specifically provided for in a waiver signed by duly authorized  
2144 representatives of the Departments and the Contractor, failure by either party at any time to  
2145 require performance by the other party or to claim a breach of any provision of the Contract shall  
2146 not be construed as affecting any subsequent right to require performance or to claim a breach.

2147           **s. Notice.** Any and all notices, designations, consents, offers, acceptances or any other  
2148 communication provided for herein shall be given in writing by registered or certified mail, return  
2149 receipt requested, by receipted hand delivery, by Federal Express, courier or other similar and  
2150 reliable carrier which shall be addressed to each party's contract manager as set forth on the  
2151 Contract Declarations & Execution Page(s). Each such notice shall be deemed to have been  
2152 provided:

- 2153           (1) At the time it is actually received; or,  
2154           (2) Within one day in the case of overnight hand delivery, courier or services such as  
2155 Federal Express with guaranteed next day delivery; or,  
2156           (3) Within five (5) days after it is deposited in the U.S. Mail in the case of registered U.S.  
2157 Mail. From time to time, the parties may change the name and address of a party designated to  
2158 receive notice. Such change of the designated person shall be in writing to the other party and as  
2159 provided herein.

2160           **t. Cumulative Rights.** The various rights, powers, options, elections and remedies of any  
2161 party provided in this Contract, shall be construed as cumulative and not one of them is exclusive  
2162 of the others or exclusive of any rights, remedies or priorities allowed either party by law, and  
2163 shall in no way affect or impair the right of any party to pursue any other equitable or legal  
2164 remedy to which any party may be entitled.

2165           **u. Severability.** If any provision of this Contract is determined by a court of competent  
2166 jurisdiction to be invalid or unenforceable, such determination shall not affect the validity or  
2167 enforceability of any other part or provision of this Contract.

2168           **v. Time is of the Essence.** Time is of the essence with respect to the Contractor's  
2169 performance of the terms of this Contract. Contractor shall ensure that all personnel providing  
2170 Deliverables to the Departments are responsive to the Departments' requirements and requests in  
2171 all respects.

2172           **w. Authorization.** Contractor represents and warrants that:

- 2173           (1) It has the right, power and authority to enter into and perform its obligations under  
2174 this Contract, and (2) It has taken all requisite action (corporate, statutory or otherwise) to  
2175 approve execution, delivery and performance of this Contract, and this Contract constitutes a  
2176 legal, valid and binding obligation upon itself in accordance with its terms.

2177 **x. Successors in Interest.** All the terms, provisions, and conditions of the Contract shall  
2178 be binding upon and inure to the benefit of the parties hereto and their respective successors,  
2179 assigns and legal representatives.

2180 **y. Records Retention and Access.** The Contractor shall maintain accurate, current, and  
2181 complete records of the financial activity of this Contract which sufficiently and properly  
2182 document and calculate all charges billed to the Departments throughout the term of this Contract  
2183 and for a period of at least five (5) years following the date of final payment or completion of any  
2184 required audit (whichever is later). If any litigation, claim, negotiation, audit or other action  
2185 involving the records has been started before the expiration of the five (5) year period, the records  
2186 must be retained until completion of the action and resolution of all issues which arise from it, or  
2187 until the end of the regular five (5) year period, whichever is later. The Contractor shall permit  
2188 the Departments, the Auditor of the State or any other authorized representative of the State and  
2189 where federal funds are involved, the Comptroller General of the United States or any other  
2190 authorized representative of the United States government, to access and examine, audit, excerpt  
2191 and transcribe any directly pertinent books, documents, papers, electronic or optically stored and  
2192 created records or other records of the Contractor relating to orders, invoices or payments or any  
2193 other documentation or materials pertaining to this Contract, wherever such records may be  
2194 located. The Contractor shall not impose a charge for audit or examination of the Contractor's  
2195 books and records. Based on the audit findings, the Departments reserve the right to address the  
2196 Contractor's board or other managing entity regarding performance and expenditures. When state  
2197 or federal law or the terms of this Contract require compliance with OMB Circular A-87, A-110,  
2198 or other similar provision addressing proper use of government funds, the Contractor shall  
2199 comply with these additional records retention and access requirements:

2200 (1) Records of financial activity shall include records that adequately identify the source  
2201 and application of funds. When the terms of this Contract require matching funds, cash  
2202 contributions made by the Contractor and third party in-kind (property or service) contributions  
2203 must be verifiable from the Contractor's records. These records must contain information  
2204 pertaining to contract amount, obligations, unobligated balances, assets, liabilities, expenditures,  
2205 income and third-party reimbursements.

2206 (2) The Contractor shall maintain accounting records supported by source documentation  
2207 that may include but are not limited to cancelled checks, paid bills, payroll, time and attendance  
2208 records, and contract award documents.

2209 (3) The Contractor, in maintaining project expenditure accounts, records and reports,  
2210 shall make any necessary adjustments to reflect refunds, credits, underpayments or overpayments,  
2211 as well as any adjustments resulting from administrative or compliance reviews and audits. Such  
2212 adjustments shall be set forth in the financial reports filed with the Departments.

2213 (4) The Contractor shall maintain a sufficient record keeping system to provide the  
2214 necessary data for the purposes of planning, monitoring and evaluating its program.

2215 (5) The Contractor shall retain all medical records for a period of six (6) years from the  
2216 last date of service for each patient; or in the case of a minor patient or client, for a period  
2217 consistent with that established by Iowa Code § 614.1(9). Client records, which are non-medical,  
2218 must be maintained for a period of five (5) years.

2219 **z. Audits.** Local governments and non-profit subrecipient entities that expend \$500,000  
2220 or more in a year in federal awards (from all sources) shall have a single audit conducted for that  
2221 year in accordance with the provisions of OMB Circular A-133 "Audit of States, Local  
2222 Governments, and Non-Profit Organizations." A copy of the final audit report shall be submitted  
2223 to the Departments if either the schedule of findings and questioned costs or the summary  
2224 schedule of prior audit findings includes any audit findings related to federal awards provided by  
2225 the Departments. If an audit report is not required to be submitted per the criteria above, the  
2226 subrecipient must provide written notification to the Departments that the audit was conducted in

2227 accordance with Government Auditing Standards and that neither the schedule of findings and  
2228 questioned costs nor the summary schedule of prior audit findings includes any audit findings  
2229 related to federal awards provided by the Departments. See A-133 Section 21 for a discussion of  
2230 subrecipient versus vendor relationships. Contractor shall provide the Departments with a copy of  
2231 any written audit findings or reports, whether in draft or final form, within 24 hours following  
2232 receipt by the Contractor. The requirements of this paragraph shall apply to the Contractor as well  
2233 as any subcontractors.

2234 **a.a. Qualifications of Staff.** The Contractor shall be responsible for assuring that all  
2235 persons, whether they are employees, agents, subcontractors or anyone acting for or on behalf of  
2236 the Contractor, are properly licensed, certified or accredited as required under applicable state law  
2237 and the Iowa Administrative Code. The Contractor shall provide standards for service providers  
2238 who are not otherwise licensed, certified or accredited under state law or the Iowa Administrative  
2239 Code.

2240 **b.b. Solicitation.** The Contractor represents and warrants that no person or selling agency  
2241 has been employed or retained to solicit and secure this Contract upon an agreement or  
2242 understanding for commission, percentage, brokerage or contingency excepting bona fide  
2243 employees or selling agents maintained for the purpose of securing business.

2244 **c.c. Obligations Beyond Contract Term.** This Contract shall remain in full force and  
2245 effect to the end of the specified term or until terminated pursuant to this Contract. All obligations  
2246 of the Departments and the Contractor incurred or existing under this Contract as of the date of  
2247 expiration or termination will survive the termination or expiration of this Contract.

2248 **d.d. Counterparts.** The parties agree that this Contract has been or may be executed in  
2249 several counterparts, each of which shall be deemed an original and all such counterparts shall  
2250 together constitute one and the same instrument.

2251 **e.e. Delays or Potential Delays of Performance.** Whenever the Contractor encounters  
2252 any difficulty which is delaying or threatens to delay the timely performance of this Contract,  
2253 including but not limited to potential labor disputes, the Contractor shall immediately give notice  
2254 thereof in writing to the Departments Contract Managers with all relevant information with  
2255 respect thereto. Such notice shall not in any way constitute a basis for an extension of the delivery  
2256 schedule or be construed as a waiver by the Departments or the State of any rights or remedies to  
2257 which either is entitled bylaw or pursuant to provisions of this Contract. Failure to give such  
2258 notice, however, may be grounds for denial of any request for an extension of the delivery  
2259 schedule because of such delay. Furthermore, Contractor will not be excused from failure to  
2260 perform that is due to a force majeure unless and until the Contractor provides notice pursuant to  
2261 this provision.

2262 **f.f. Delays or Impossibility of Performance Based on a Force Majeure.** Neither party  
2263 shall be in default under the Contract if performance is prevented, delayed or made impossible to  
2264 the extent that such prevention, delay, or impossibility is caused by a “force majeure.” The term  
2265 “force majeure” as used in this Contract includes an event that no human foresight could  
2266 anticipate or which if anticipated, is incapable of being avoided. Circumstances must be abnormal  
2267 and unforeseeable, so that the consequences could not have been avoided through the exercise of  
2268 all due care, such as acts of God, war, civil disturbance and other similar causes. The delay or  
2269 impossibility of performance must be beyond the control and without the fault or negligence of  
2270 the parties. “Force majeure” does not include: financial difficulties of the Contractor or any  
2271 parent, subsidiary, affiliated or associated company of Contractor; claims or court orders that  
2272 restrict Contractor’s ability to deliver the Deliverables contemplated by this Contract; strikes;  
2273 labor unrest; or supply chain disruptions. If delay results from a subcontractor’s conduct,  
2274 negligence or failure to perform, the Contractor shall not be excused from compliance with the  
2275 terms and obligations of the Contract unless the subcontractor or supplier is prevented from  
2276 timely performance by a “force majeure” as defined in this Contract. If a “force majeure” delays

2277 or prevents the Contractor's performance, the Contractor shall immediately use its best efforts to  
2278 directly provide alternate, and to the extent possible, comparable performance. Comparability of  
2279 performance and the possibility of comparable performance shall be determined solely by the  
2280 Departments. The party seeking to exercise this provision and not perform or delay performance  
2281 pursuant to a "force majeure" shall immediately notify the other party of the occurrence and  
2282 reason for the delay. The parties shall make every effort to minimize the time of nonperformance  
2283 and the scope of work not being performed due to the unforeseen events. Dates by which  
2284 performance obligations are scheduled to be met will be extended only for a period of time equal  
2285 to the time lost due to any delay so caused.

2286 **g.g. Conflict of Interest.** Contractor represents, warrants, and covenants that no  
2287 relationship exists or will exist during the Contract period between the Contractor and the  
2288 Departments that is a conflict of interest. No employee, officer or agent of the Contractor or  
2289 subcontractor shall participate in the selection or in the award or administration of a subcontract if  
2290 a conflict of interest, real or apparent, exists. The provisions of Iowa Code chapter 68B shall  
2291 apply to this Contract. If a conflict of interest is proven to the Departments, the Departments may  
2292 terminate this Contract, and the Contractor shall be liable for any excess costs to the Departments  
2293 as a result of the conflict of interest. The Contractor shall establish safeguards to prevent  
2294 employees, consultants, or members of governing bodies from using their positions for purposes  
2295 that are, or give the appearance of being, motivated by the desire for private gain for themselves  
2296 or others with whom they have family, business, or other ties. The Contractor shall report any  
2297 potential, real, or apparent conflict of interest to the Departments.

2298 **h.h. Certification regarding sales and use tax.** By executing this Contract, the  
2299 Contractor certifies it is either (a) registered with the Iowa Department of Revenue, collects, and  
2300 remits Iowa sales and use taxes as required by Iowa Code chapter 423; or (b) not a "retailer" or a  
2301 "retailer maintaining a place of business in this state" as those terms are defined in Iowa Code  
2302 subsections 423.1(42) & (43). The Contractor also acknowledges that the Departments may  
2303 declare the Contract void if the above certification is false. The Contractor also understands that  
2304 fraudulent certification may result in the Departments or their representative filing for damages  
2305 for breach of contract.

2306 **i.i. Right to Address the Board of Directors or Other Managing Entity.** The  
2307 Departments reserve the right to address the Contractor's board of directors or other managing  
2308 entity of the Contractor regarding performance, expenditures and any other issue as appropriate.  
2309 The Departments determine appropriateness.

2310 **j.j. Repayment Obligation.** In the event that any State and/or federal funds are deferred  
2311 and/or disallowed as a result of any audits or expended in violation of the laws applicable to the  
2312 expenditure of such funds, the Contractor shall be liable to the Departments for the full amount of  
2313 any claim disallowed and for all related penalties incurred. The requirements of this paragraph  
2314 shall apply to the Contractor as well as any subcontractors.

2315 **k.k. Further Assurances and Corrective Instruments.** The parties agree that they will,  
2316 from time to time, execute, acknowledge and deliver, or cause to be executed, acknowledged and  
2317 delivered, such amendments hereto and such further instruments as may reasonably be required  
2318 for carrying out the expressed intention of this Contract.

2319 **l.l. Reporting Requirements.** If this Contract permits other State agencies and political  
2320 subdivisions to make purchases off of the Contract, the Contractor shall keep a record of the  
2321 purchases made pursuant to the Contract and shall submit a report to the Departments on a  
2322 quarterly basis. The report shall identify all of the State agencies and political subdivisions  
2323 making purchases off of this Contract and the quantities purchased pursuant to the Contract  
2324 during the reporting period.

2325 **m.m. Immunity from Liability.** Every person who is a party to the Contract is hereby  
2326 notified and agrees that the State, the Departments, and all of their employees, agents, successors,

2327 and assigns are immune from liability and suit for or from Contractor's and/or subcontractors'  
2328 activities involving third parties and arising from the Contract.

2329 **n.n. Public Records.** The laws of the State require procurement records to be made  
2330 public unless otherwise provided by law.

2331 **o.o. Use of Name or Intellectual Property.** Contractor agrees it will not use the  
2332 Departments and/or State's name or any of their intellectual property, including but not limited  
2333 to, any State, state agency, board or commission trademarks or logos in any manner, including  
2334 commercial advertising or as a business reference, without the expressed prior written consent of  
2335 the Departments and/or the State.

2336 **p.p. Taxes.** The State is exempt from Federal excise taxes, and no payment will be made  
2337 for any taxes levied on Contractor's employee's wages. The State is exempt from State and local  
2338 sales and use taxes on the Deliverables.

2339 **q.q. No Minimums Guaranteed.** The Contract does not guarantee any minimum level of  
2340 purchases or any minimum amount of compensation.

2341

2341

## CONTRACT CERTIFICATIONS

2342

### CERTIFICATION OF COMPLIANCE WITH PRO-CHILDREN ACT OF 1994

2343

2344

2345

2346

2347

2348

2349

2350

2351

2352

2353

2354

Contractor must comply with Public Law 103-227, Part C Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act). This Act requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the Deliverables are funded by federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees, and contracts. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities (other than clinics) where WIC coupons are redeemed.

2355

2356

2357

2358

2359

The Contractor further agrees that the above language will be included in any subawards that contain provisions for children's services and that all subgrantees shall certify compliance accordingly. Failure to comply with the provisions of this law may result in the imposition of a civil monetary penalty of up to \$1000 per day.

2360

### CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION --LOWER TIER COVERED TRANSACTIONS

2361

2362

2363

By signing and submitting this document, the Contractor is providing the certification set out below:

2364

2365

2366

2367

2368

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 Contractor 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.

2369

2370

2371

2372

2. The Contractor shall provide immediate written notice to the person to whom this document is submitted if at any time the Contractor learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.

2373

2374

2375

2376

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 document is submitted for assistance in obtaining a copy of those regulations.

2377

2378

2379

2380

2381

2382

4. The Contractor agrees by submitting this document 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 Departments or agency with which this transaction originated.

2383

2384

2385

2386

5. The Contractor further agrees by submitting this document 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.

2387

2388

2389

2390

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

2391 method and frequency by which it determines the eligibility of its principals. A participant may,  
2392 but is not required to, check the List of Parties Excluded from Federal Procurement and  
2393 Nonprocurement Programs.

2394 **7.** Nothing contained in the foregoing shall be construed to require establishment of a  
2395 system of records in order to render in good faith the certification required by this clause. The  
2396 knowledge and information of a participant is not required to exceed that which is normally  
2397 possessed by a prudent person in the ordinary course of business dealings.

2398 **8.** Except for transactions authorized under paragraph 4 of these instructions, if a  
2399 participant in a covered transaction knowingly enters into a lower tier covered transaction with a  
2400 person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred,  
2401 ineligible, or voluntarily excluded from participation in this transaction, in addition to other  
2402 remedies available to the federal government, the Departments or agency with which this  
2403 transaction originated may pursue available remedies, including suspension and/or debarment.

2404 **a.** The Contractor certifies, by submission of this document, that neither it nor its  
2405 principals is presently debarred, suspended, proposed for debarment, declared ineligible, or  
2406 voluntarily excluded from participation in this transaction by any federal department or agency.

2407 **b.** Where the Contractor is unable to certify to any of the statements in this certification,  
2408 such Contractor shall attach an explanation to this document.

2409

2410 **CERTIFICATION REGARDING LOBBYING**

2411 The undersigned certifies, to the best of his or her knowledge and belief, that:

2412 **1.** No federal appropriated funds have been paid or will be paid on behalf of the sub-  
2413 grantee to any person for influencing or attempting to influence an officer or employee of any  
2414 federal agency, a Member of the Congress, an officer or employee of the Congress, or an  
2415 employee of a Member of Congress in connection with the awarding of any federal contract, the  
2416 making of any federal grant, the making of any federal loan, the entering into of any cooperative  
2417 agreement, or the extension, continuation, renewal, amendment, or modification of any federal  
2418 contract, grant loan or cooperative agreement.

2419 **2.** If any funds other than federal appropriated funds have been paid or will be paid to any  
2420 person for influencing or attempting to influence an officer or employee of any federal agency, a  
2421 Member of the Congress, or an employee of a Member of Congress in connection with this  
2422 Contract, grant, loan, or cooperative agreement, the applicant shall complete and submit Standard  
2423 Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

2424 **3.** The Contractor shall require that the language of this certification be included in the  
2425 award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts  
2426 under grants, loans and cooperative agreements) and that all subrecipients shall certify and  
2427 disclose accordingly.

2428 This certification is a material representation of fact upon which reliance was placed  
2429 when this transaction was made or entered into. Submission of this certification is a prerequisite  
2430 for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C.A. Any  
2431 person who fails to file the required certification shall be subject to a civil penalty of not less than  
2432 \$10,000 and not more than \$100,000 for each such failure.

2433

2434 **CERTIFICATION REGARDING DRUG FREE WORKPLACE**

2435 **1. Requirements for Contractors Who are Not Individuals.** If Contractor is not an  
2436 individual, by signing below Contractor agrees to provide a drug-free workplace by:

2437 **a.** publishing a statement notifying employees that the unlawful manufacture,  
2438 distribution, dispensation, possession, or use of a controlled substance is prohibited in the

2439 person's workplace and specifying the actions that will be taken against employees for violations  
2440 of such prohibition;

2441 **b.** establishing a drug-free awareness program to inform employees about:

2442 **(1)** the dangers of drug abuse in the workplace;

2443 **(2)** the person's policy of maintaining a drug-free workplace;

2444 **(3)** any available drug counseling, rehabilitation, and employee assistance programs; and

2445 **(4)** the penalties that may be imposed upon employees for drug abuse violations;

2446 **c.** making it a requirement that each employee to be engaged in the performance of such  
2447 contract be given a copy of the statement required by subparagraph (a);

2448 **d.** notifying the employee in the statement required by subparagraph (a), that as a  
2449 condition of employment on such contract, the employee will:

2450 **(1)** abide by the terms of the statement; and

2451 **(2)** notify the employer of any criminal drug statute conviction for a violation occurring  
2452 in the workplace no later than 5 days after such conviction;

2453 **e.** notifying the contracting agency within 10 days after receiving notice under  
2454 subparagraph (D)(ii) from an employee or otherwise receiving actual notice of such conviction;

2455 **f.** imposing a sanction on, or requiring the satisfactory participation in a drug abuse  
2456 assistance or rehabilitation program by, any employee who is so convicted, as required by 41  
2457 U.S.C. § 703; and

2458 **g.** making a good faith effort to continue to maintain a drug-free workplace through  
2459 implementation of subparagraphs (a), (b), (c), (d), (e), and (f).

2460 **2. Requirement for individuals.** If Contractor is an individual, by signing below  
2461 Contractor agrees to not engage in the unlawful manufacture, distribution, dispensation,  
2462 possession, or use of a controlled substance in the performance of the contract.

2463 **3. Notification Requirement.** Contractor shall, within 30 days after receiving notice  
2464 from an employee of a conviction pursuant to 41 U.S.C. § 701(a)(1)(D)(ii) or 41 U.S.C. §  
2465 702(a)(1)(D)(ii):

2466 **(a)** take appropriate personnel action against such employee up to and including  
2467 termination; or

2468 **(b)** require such employee to satisfactorily participate in a drug abuse assistance or  
2469 rehabilitation program approved for such purposes by a Federal, State, or local health, law  
2470 enforcement, or other appropriate agency.

2471  
2472 By signing the Contract Declarations and Execution Page, Contractor certifies that the above is  
2473 true and accurate, Contractor will fully comply with obligations herein. If any conditions within  
2474 these certifications change, the Contractor will provide written notification to the Departments  
2475 within 24 hours. Contractor has caused a duly authorized representative to execute this Contract  
2476 Certifications document concurrently with the underlying Contract.

2477

## Sample Business Associate Agreement

2477  
2478  
2479  
2480  
2481  
2482  
2483  
2484  
2485  
2486  
2487  
2488  
2489  
2490  
2491  
  
2492  
2493  
2494  
2495  
2496  
2497  
2498  
2499  
2500  
2501  
2502  
2503  
2504  
2505  
2506  
2507  
2508  
2509  
2510  
2511  
2512  
2513  
2514  
2515  
2516  
2517  
2518  
2519  
2520  
2521  
2522  
2523  
2524  
2525

THIS ADDENDUM to \_\_\_\_\_ supplements and is made a part of the Iowa Department of Human Services (“Department”) Contract (hereinafter, the "Underlying Agreement") between the Department and \_\_\_\_\_ ("the Business Associate"). This Addendum, when accepted by the Department, establishes the terms of the relationship between the Department and the Business Associate.

Whereas, the Department and the Business Associate are parties to the Underlying Agreement pursuant to which the Business Associate provides or performs certain services on behalf of or for the Department. The Department discloses to the Business Associate certain Protected Health Information ("PHI,") (as defined in 45 C.F. R. § 164.501), related to the services performed by the Business Associate for the relationship and, in connection with the provision of those services. This PHI is subject to protection under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

Whereas, the Department is a "Covered Entity" as that term is defined in the HIPAA implementing regulations, 45 C.F.R. Part 160 and Part 164, Subparts A and E, the Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule");

Whereas, Contractor provides or performs certain services on behalf of or for the Department which require the disclosure of PHI from the Department and is, therefore a "Business Associate" as that term is defined in the Privacy Rule;

Whereas, pursuant to the Privacy Rule and the Security Rule, all Business Associates of Covered Entities must agree in writing to certain mandatory provisions regarding the use and disclosure of PHI; and

Whereas, the purpose of this Addendum is to comply with the requirements of the Privacy Rule and the Security Rule, including, but not limited to, the Business Associate’s contract requirements at 45 C.F.R. §164.504(e) and 45 C.F.R. §164.314.

NOW, THEREFORE in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

1. **Definitions.** Unless otherwise provided in this Addendum, capitalized terms have the same meanings as set forth in the Privacy Rule and the Security Rule.

2. **Scope of Use and Disclosure by Business Associate of Protected Health Information.**

a. The Business Associate shall be permitted to use and disclose PHI that is disclosed to it by the Department as necessary to perform its obligations under the Underlying Agreement.

b. Unless otherwise limited herein, in addition to any other uses and/or disclosures permitted or authorized by this Addendum or required by law, the Business Associate may:

(1) Use the PHI in its possession for its proper management and administration and to fulfill any legal responsibilities of the Department

2526 (2) Disclose the PHI in its possession to a third party for the purpose of proper management and  
2527 administration or to fulfill any legal responsibilities of the Department; provided, however, that  
2528 the disclosures are required by law or Business Associate has received from the third party  
2529 written assurances that:

2530

2531 (i) The information will be held confidentially and used or further disclosed only as required by  
2532 law or for the purposes for which it was disclosed to the third party; and

2533

2534 (ii) The third party will notify the Business Associate of any instances of which it becomes aware  
2535 in which the confidentiality of the information has been breached; and

2536

2537 (iii) Disclose or use any PHI created or received by the Department under this Addendum, for  
2538 other purposes, so long as it has been de-identified and the de-identification conforms to the  
2539 requirements of the Privacy Rule.

2540

2541 **3. Obligations of Business Associate.** In connection with its use and disclosure of PHI, the  
2542 Business Associate agrees that it will:

2543

2544 a. Use or further disclose PHI only as permitted or required by this Addendum or as required by  
2545 law.

2546

2547 b. Use reasonable and appropriate safeguards to prevent use or disclosure of PHI other than as  
2548 provided for by this Addendum;

2549

2550 c. To the extent practicable, mitigate any harmful effect that is known to the Business Associate  
2551 of a use or disclosure of PHI in violation of this Addendum.

2552

2553 d. Promptly report to the Department any use or disclosure of PHI not provided for by this  
2554 Addendum of which the Business Associate becomes aware.

2555

2556 e. Require contractors or agents to whom the Business Associate provides PHI to agree to the  
2557 same restrictions and conditions that apply to the Business Associate pursuant to this Addendum.

2558

2559 f. Make available to the Secretary of Health and Human Services the Business Associate's  
2560 internal practices, books and records relating to the use and disclosure of PHI for purposes of  
2561 determining the Business Associate's compliance with the Privacy Rule, subject to any applicable  
2562 legal privileges.

2563

2564 g. Obtain consents, authorizations and other permissions from all individuals necessary or  
2565 required by laws applicable to the Business Associate to fulfill its obligations under the  
2566 Underlying Agreement and this Addendum.

2567

2568 h. Promptly comply with any changes in, or revocation of, permission by an Individual for the  
2569 Business Associate or the Department to use or disclose PHI, after receiving written notice by the  
2570 Department.

2571

2572 i. Promptly comply with any restrictions on the use and disclosure of PHI about Individuals that  
2573 the Department has agreed to, after written notice by the Departments.

2574

2575 j. Within (15) days of receiving a request from the Department, make available the information  
2576 necessary for the Department to make an accounting of disclosures of PHI about an individual.  
2577

2578 k. Within ten (10) days of receiving a written notice from the Department about a request from  
2579 the Individual, make available PHI necessary for the response to individuals' requests for access  
2580 to PHI about them in the Business Associate's possession which constitutes part of the  
2581 Department's Designated Record Set.  
2582

2583 l. Within fifteen (15) days of receiving a written notice from the Department to amend or correct  
2584 an Individual's PHI in accordance with the Privacy Rule, make the amendments or corrections to  
2585 PHI in Business Associate's possession which constitutes part of the Department's Designated  
2586 Record Set.  
2587

2588 m. Implement administrative, physical, and technical safeguards that protect the confidentiality,  
2589 integrity, and availability of the electronic PHI that it creates, maintains, or transmits on behalf of  
2590 the Department. This security requirement is effective April 20, 2005.  
2591

2592 n. Promptly report to the Department any security incident of which the Business Associate  
2593 becomes aware. This security requirement is effective April 20, 2005.  
2594

2595 **4. Obligations of the Department.** The Department agrees that it:  
2596

2597 a. Has included, and will include, in the Department's required Notice of Privacy Practices that  
2598 the Business Associate may disclose PHI for health care operations purposes.  
2599

2600 b. Has obtained, and will obtain, from Individuals authorizations and other permissions necessary  
2601 or required by laws applicable to the Department and the Business Associate to fulfill their  
2602 obligations under the Underlying Agreement and this Addendum.  
2603

2604 c. Will promptly notify Business Associate in writing of any restrictions on the use and disclosure  
2605 of PHI about Individuals that the Department has agreed to that may affect Business Associate's  
2606 ability to perform its obligations under the Underlying Agreement or this Addendum.  
2607

2608 d. Will promptly notify the Business Associate in writing of any changes in, or revocation of,  
2609 authorization by an Individual to use or disclose PHI, if such changes or revocation may affect  
2610 the Business Associate's ability to perform its obligations under the Underlying Agreement or  
2611 this Addendum.  
2612

2613 **5. Termination.**  
2614

2615 a. Termination for Cause. The Department may terminate this Addendum for cause if the  
2616 Department determines that the Business Associate, or any of its subcontractors, etc. has breached  
2617 a material term of this Addendum. The Department will allow the Business Associate an  
2618 opportunity to cure the breach. The Department shall provide written notice to the Business  
2619 Associate requesting that the breach be remedied within the period of time specified in the notice.  
2620 If the breach is not remedied by the date specified to the satisfaction of the Department, the  
2621 Department may immediately terminate this Addendum and the Underlying Agreement.  
2622

2623 b. Automatic Termination. This Addendum will automatically terminate upon the termination or  
2624 expiration of the Underlying Agreement.

2625  
2626  
2627  
2628  
2629  
2630  
2631  
2632  
2633  
2634  
2635  
2636  
2637  
2638  
2639  
2640  
2641  
2642  
2643  
2644  
2645  
2646  
2647  
2648  
2649  
2650  
2651  
2652  
2653

c. Effect of Termination.

(1) Termination of this Addendum will result in termination of the Underlying Agreement.

(2) Upon termination of this Addendum or the Underlying Agreement, unless specially required by the Department for the business associate to retain the protected health information, the Business Associate will return or destroy all PHI received from the Department, or created or received by the Business Associate on behalf of the Department, that the Business Associate still maintains and retain no copies of such PHI. If such return or destruction is not feasible, the Business Associate will extend the protections of this Addendum to the PHI and limit any further uses and disclosures. The Business Associate will provide the Department in writing the reason that will make the return or destruction of the information infeasible.

**6. Amendment.** The Department and the Business Associate agree to take such action as is necessary to amend this Addendum from time to time as is necessary for the Business Associate to comply with the requirements of the Privacy Rule and/or the Security Rule.

**7. Survival.** The obligations of the Business Associate under section 5.c.(2) of this Addendum shall survive any termination of this addendum.

**8. No Third Party Beneficiaries.** Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon a person other than the parties and their respective successors or assigns, an rights, remedies, obligations or liabilities whatsoever.

**9. Effective Date.** This Addendum shall be effective on the date the parties enter into the underlying Contract that is the subject of this Addendum.

2653

1

2

3

4

5

6

7

8

9

**ACADC:** A substance abuse professional certified by the Iowa Board of Certification as an Advanced Certified Alcohol and Drug Counselor.

10

11

12

**Action:** When pertaining to the Enrollee grievance system, means the following:

13

14

15

16

17

18

19

20

21

**Appeal:** Means a request for review of an action, as "action" is defined in this section.

22

23

24

**Appeal Process:** Means the procedure for addressing Enrollees' appeals or providers' appeals on Enrollees' behalf

25

26

27

**ASAM PPC-2R:** The American Society of Addiction Medicine's Patient Placement Criteria, Second Edition-Revised

28

29

30

31

32

33

34

35

36

**Assertive Community Treatment (ACT) Program:** A program of comprehensive outpatient services provided in the community that are directed toward the amelioration of symptoms and the rehabilitation of behavioral/functional/social deficits of Enrollees with severe and persistent mental disorders, and/or persons with complex symptomatology which require multiple mental health and supportive services to live in the community. Services are active and rehabilitative in focus, and are initiated when there is a reasonable likelihood that such services will lead to specific, observable improvements in an Enrollee's functioning and will assist him or her in maintaining community tenure.

37

38

39

**ASO:** Administrative Service Only; a non-risk contractual agreement by which a MBHO is paid to provide specific administrative services.

40

41

42

43

**Benefits:** Services and supports provided through the Iowa Plan. Also see covered services.

**Bidder:** An entity submitting a proposal to become the Iowa Plan Contractor.

- 44 **Block Grant:** See Substance Abuse & Mental Health Services Administration (SAMHSA).  
45
- 46 **CADC:** A substance abuse professional certified by the Iowa Board of Certification as a Certified  
47 Alcohol and Drug Counselor.  
48
- 49 **Capitation Payment:** The total fee that is paid monthly by DHS to the Contractor for all  
50 Enrollees, whether or not the Enrollees receive services during the payment period.  
51
- 52 **Capitation Rate:** The amount to be paid each month by DHS to the Contractor for each Enrollee,  
53 by category of assistance, by age, and by Medicaid status.  
54
- 55 **Centers for Medicare and Medicaid Services (CMS):** The unit of the United States Department  
56 of Health and Human Services that provides administration and funding for Medicare under  
57 Title XVIII and Medicaid under Title XIX of the Social Security Act.  
58
- 59 **Central Office DHS:** Any DHS employee with an office in the Hoover Building.  
60
- 61 **Certification:** The process of determining that a facility, equipment, or an individual meets the  
62 requirements of state or federal law.  
63
- 64 **Certified Alcohol and Drug Counselor (CADC):** A substance abuse professional certified by  
65 the Iowa Board of Certification.  
66
- 67 **CFR:** Code of Federal Regulations.  
68
- 69 **Claim:** 1) a bill for services or 2) a line item of service or 3) all services for one Eligible Person  
70 within a bill.  
71
- 72 **Community Support Services:** Required Medicaid services that are community-based and are  
73 the balance of support and maximizing individual independence. These services are designed to  
74 support individuals as they live and work in the community. These services address mental and  
75 functional disabilities that negatively affect integration and stability in the community. CSS staff  
76 attempt to reduce or manage symptoms and reduced functioning that result from a mental illness.  
77 Components include the following:  
78 Monitoring of mental health symptoms and functioning/reality orientation  
79 Ensuring client makes appointments and obtains medications  
80 Crisis intervention and developing of a crisis plan  
81 Communication with other providers  
82 Coordination and development of natural support systems for mental health  
83 Supportive relationships  
84 Transportation assistance  
85
- 86 **Complaint:** A formal expression, written or oral, of dissatisfaction by an IDPH Participant related  
87 to the Iowa Plan, the Contractor, IDPH-funded services or a provider in the Iowa Plan IDPH  
88 network.  
89
- 90 **Concurrent Review:** The process by which the Contractor determines the ongoing psychosocial  
91 necessity for services as they are being delivered.  
92

93 **Continuing care:** Level I service of the ASAM-PPC-2R eligible/patient placement criteria,  
94 which provides a specific period of structured therapeutic involvement designed to enhance,  
95 facilitate and promote transition from primary care to ongoing recovery. Continuing service  
96 reviews will not be required or applicable to Level I continuing care/aftercare  
97 eligibles/patients. Also, there shall not be any required frequency of review for continuing  
98 service or frequency of review of treatment plan by eligible/patient and counselor.  
99

100 **Continuing service and discharge criteria:** Means, in accordance with ASAM-PPC-2R, during  
101 the process of eligible/patient assessment, certain problems and priorities are identified as  
102 justifying admission to a particular level of care and the resolution of those problems and  
103 priorities determines when an eligible/patient can be treated at a different level of care or  
104 discharged from treatment. New problems may require services that can be provided  
105 effectively at the same level of care or may require a more intensive or less intensive level of  
106 care.  
107

108 **Continuum of care:** A structure of interlinked treatment modalities and services designed so that  
109 an individual's changing needs will be met as that individual moves through the treatment and  
110 recovery process.  
111

112 **Contract:** A formal legal document adopted by the governing authority of the program and any  
113 other organization.  
114

115 **Contract operational start date:** the day on which the Contractor begins administering the Iowa  
116 Plan as required under this RFP; the anticipated start date is January 1, 2010.  
117

118 **Contractor:** The entity with which the Departments will contract to provide services covered  
119 under the Iowa Plan to Enrollees and IDPH Participants.  
120

121 **Coordinated Services And Supports:** Individualized mental health services and supports planned  
122 jointly by the Contractor and the Enrollee, family members as applicable, and representatives of  
123 other service delivery systems; allows the Contractor flexibility to offer Enrollees services  
124 which augment and complement those provided through other funders and systems; usually  
125 provided under the supervision of mental health professionals.  
126

127 **Coordination of Benefits:** A provision which applies when a person is covered under insurance  
128 programs other than Medicaid; requires that payment of benefits be coordinated by the Contractor  
129 to eliminate over-insurance or duplication of benefits.  
130

131 **Co-payment:** A cost-sharing arrangement in which a covered person pays a specified charge for a  
132 specified service; also called co-pay.  
133

134 **Counselor:** An individual who, by virtue of education, training or experience, provides treatment,  
135 which includes advice, opinion, or instruction to an individual or in a group setting to allow an  
136 opportunity for a person to explore the person's problems related directly or indirectly to  
137 substance abuse or dependence.  
138

139 **Covered Services:** For Enrollees, those services that are included in the Medicaid State Plan. For  
140 IDPH Participants, those substance abuse treatment services which, prior to the Iowa Plan,  
141 were funded through IDPH.

142  
143  
144  
145  
146  
147  
148  
149  
150  
151  
152  
153  
154  
155  
156  
157  
158  
159  
160  
161  
162  
163  
164  
165  
166  
167  
168  
169  
170  
171  
172  
173  
174  
175  
176  
177  
178  
179  
180  
181  
182  
183  
184  
185  
186  
187  
188  
189

**Crisis Support:** Acute care services available 24 hours a day for intervention; e.g., mobile crisis, crisis telephone and emergency walk-in.

**Critical Incidents:** Those events that are dangerous to an Eligible Person or another party, which occur while an Eligible Person is actively being treated through the Iowa Plan, and which result in a significant happening, including, but not limited to: death, suicide, assault, dangerous behavior, leaving a 24-hour facility against medical advice (AMA), using drugs while in an inpatient, residential or halfway house facility, escape from a locked facility, and unauthorized departure from a 24-hour facility pursuant to a court order. Critical Incidents must be reported to the Departments.

**Culturally and environmentally specific:** Means integrating into the assessment and treatment process the ideas, customs, beliefs, and skills of a given population, as well as an acceptance, awareness, and celebration of diversity regarding conditions, circumstances and influences surrounding and affecting the development of an individual or group.

**Decategorization:** A process that combines a county, or cluster of counties, categorical state appropriations for child welfare services into a single fund; requires cooperation by area juvenile court, DHS, and county government administrators; is designed to address needs, identified by the community, at the local level; designed to improve outcomes for children and families by promoting funding flexibility and enhancing the community's ability to provide family and community-based early intervention, preventative programs. See Iowa Code section 232.188.

**Departments:** The Iowa Department of Human Services (DHS) and the Iowa Department of Public Health (IDPH).

**Detoxification:** The process of withdrawing a person from a specific psychoactive substance in a safe and effective manner.

**DHS:** The Iowa Department of Human Services.

**Discharge Planning:** The process, begun at admission, of determining an Eligible Person's continued need for treatment services and of developing a plan to address ongoing needs.

**Disenrollment:** The removal of an Enrollee from the Iowa Plan enrollment list either through loss of eligibility or some other cause.

**Distance Treatment:** The delivery of covered services through telehealth technology or other approved, non face-to-face methodology.

**Eligible Persons:** Individuals who qualify to receive mental health and substance abuse services funded through the Iowa Plan, including Enrollees and IDPH Participants.

**Emergency admission:** An admission of an Enrollee due to an emergency situation with placement screening criteria being applied as soon after admission as possible.

190 **Emergency medical condition:** A medical condition manifesting itself by acute symptoms of  
191 sufficient severity (including severe pain) that a prudent layperson, who possesses an average  
192 knowledge of health and medicine, could reasonably expect the absence of immediate medical  
193 attention to result in placing the health of the individual (or, with respect to a pregnant woman,  
194 the health of the woman or her unborn child) in serious jeopardy, serious impairments to  
195 bodily functions, or serious dysfunction of any bodily organ or part (42 CFR  
196 438.114(a)).(Enrollee only)

197  
198 **Emergency Services:** Medically necessary inpatient and outpatient covered services for Enrollees  
199 that are: furnished by a provider that is qualified to furnish these services and that are needed  
200 to evaluate or stabilize an emergency medical condition.

201  
202 **Encounter:** A face-to-face meeting or other billable service provided by a provider to an Eligible  
203 Person.

204  
205 **Enrollee (or Iowa Plan Enrollee):** All Medicaid Members who are enrolled with the Iowa Plan.  
206 All persons covered by Medicaid are covered by the Iowa Plan unless specifically excluded;  
207 Enrollees include Medicaid Members residing in a substance abuse licensed PMIC during any  
208 month they reside in the PMIC for one or more days and whose Medicaid eligibility may be  
209 gained retroactively (prior to application).

210  
211 **Evaluation:** The process to evaluate an Eligible Person's strengths, weaknesses, problems, and  
212 needs for the purpose of defining a course of treatment. This includes development of a  
213 comprehensive treatment plan.

214  
215 **Facility:** A hospital, detoxification center, institution or program licensed under Iowa Code  
216 section 125.13 providing care, maintenance and treatment for substance abusers. Facility also  
217 includes the physical areas such as grounds, buildings, or portions thereof under direct  
218 administrative control of the program.

219  
220 **Failure to provide services in a timely manner:** Failure to provide services within the  
221 timeframes required for the service accessibility standards as defined in 4A.8, 4B.6, and 5C.

222  
223 **Fee-For-Service (FFS):** A method of making payment for health services based on fees set by the  
224 DHS or another entity for defined services. Payment of the fee is based upon delivery of the  
225 defined service.

226  
227 **FIP:** Family Investment Program is the name of Iowa's Temporary Assistance for Needy Families  
228 (TANF) program (formally known as Aid to Families with Dependent Children Program). The  
229 purpose of FIP is to provide financial and other assistance to needy, dependent children and the  
230 parents or relatives with whom they live. From when Title XIX was added to the Social  
231 Security Act in 1965, to when Congress passed the Personal Responsibility and Work  
232 Opportunity Act of 1996 P.L. 104-193, policies governing FIP cash program were the general  
233 basis of eligibility for Medicaid for families, pregnant women, and children. After P.L. 104-  
234 193, Congress "delinked" Medicaid from FIP.

235  
236 **FMAP:** Family Medical Assistance Program. FMAP is the basis of Medicaid eligibility  
237 policy for coverage groups for pregnant women, families and children. Under the FMAP  
238 coverage group, and in accordance with P.L. 104-193, persons that meet the FIP eligibility

- 239 criteria in place on July 16, 1996, receive Medicaid. Medicaid eligibility is determined  
240 independently of FIP.  
241
- 242 **FTE:** Full time equivalent position.  
243
- 244 **Follow-up:** The process for determining the status of an individual who has been referred to an  
245 outside resource for services or who has been discharged from services.  
246
- 247 **Foster care:** Substitute care furnished on a 24-hour a day basis through CW/JJ. Child foster care  
248 shall include but is not limited to the provision of food, lodging, training, education,  
249 supervision and health care. Children in foster care receive behavioral health services through  
250 the Iowa Plan.
- 251 **Governing body:** The individual(s), group, or agency that has ultimate authority and  
252 responsibility for the overall operation of the facility.  
253
- 254 **Grievance:** An expression of dissatisfaction about any matter other than an action, as action is  
255 defined.  
256
- 257 **Grievance Process:** The procedure for addressing Enrollees' grievances.  
258
- 259 **Grievance System:** The system that includes a grievance process, an appeal process, and access  
260 to the State's fair hearing system. Any grievance system requirements apply to all three  
261 components of the grievance system, not just to the grievance process.  
262
- 263 **Habilitation Service:** A home and community-based service that assists a Member in acquiring,  
264 retaining and improving the self-help, socialization and adaptive skills necessary to reside  
265 successfully in the community. Services include case management, home-based habilitation,  
266 day habilitation, prevocational services and supported employment.  
267
- 268 **Healthcare Common Procedural Coding System (HCPCS):** A listing of services, procedures  
269 and supplies offered by providers; includes CPT (Current Procedural Terminology) codes,  
270 national alphanumeric codes, and local alphanumeric codes. The national codes are developed  
271 by CMS to supplement CPT codes. HCPCS codes are 5-digit codes, the first digit a letter  
272 followed by four numbers. HCPCS codes beginning with A through V are national; those  
273 beginning with W through Z are local.  
274
- 275 **High Need:** Enrollees who meet the following criteria:  
276 Medicaid Adults  
277 Covered Iowa Plan diagnosis, AND  
278 GAF score not exceeding 40 for a continuous 6-month time period based on authorization data  
279 OR,  
280 Use of community-based services such as Supported Community Living, ACT, or TCM for more  
281 than 3 months in a 6-month time period (based on claims data), AND  
282 Total claims cost during a 12-month time period exceeding \$5000, OR  
283 Within a 6-month time period, the Enrollee meets one of the following:  
284
- 40 days of Day Treatment or Intensive Outpatient

- 285 • 20 days of Partial Hospitalization
- 286 • 10 days of Sub-acute, Respite, or Inpatient
- 287 • 60 days of any of the above services
- 288 AND, Total claims cost during a 12-month period exceeding \$5000, OR
- 289 30 or more days of substance abuse Primary Residential in a 12-month time period.
- 290 Medicaid Children and Adolescents
- 291 Covered Iowa Plan Diagnosis, AND
- 292 GAF score not exceeding 50 for 3 months of a 6-month time period based on authorization data
- 293 OR
- 294 Within a 6-month time period, the Enrollee meets one of the following:
- 295 • 20 days of Day Treatment or Intensive Outpatient
- 296 • 48 Units of Outpatient
- 297 • 20 days of Partial Hospitalization
- 298 • 10 days of Sub-acute, Respite, or Inpatient
- 299 • 80 days/units of any of the above services
- 300 AND, Total claims cost during a 12-month period exceeding \$5000, OR
- 301 30 or more days of substance abuse Primary Residential in a 12-month time period.
- 302
- 303 **HMO:** Health Maintenance Organization as defined by Iowa Code section 513B.1(6).
- 304 **IAC:** Iowa Administrative Code which contains rules promulgated by the Departments.
- 305
- 306 **IBC:** Iowa Board of Certification
- 307
- 308 **IDPH:** The Iowa Department of Public Health
- 309
- 310 **IDPH Participant:** A resident of the state of Iowa with an income at or below 200 % of the
- 311 federal poverty guidelines as published by the Department of Health and Human Services who
- 312 is not a Medicaid Member who seeks Iowa Plan substance abuse treatment services funded
- 313 through the Iowa Department of Public Health, Division of Behavioral Health.
- 314
- 315 **IDPH Population:** IDPH Participants.
- 316
- 317 **Insolvency:** A financial condition that exists when an entity is unable to pay its debts as they
- 318 become due in the usual course of business, or when the liabilities of the entity exceeds its
- 319 assets.
- 320
- 321 **Intake:** The process by which additional assessment information is gathered at the time of
- 322 admission to services.
- 323
- 324 **Integrated Mental Health Services And Supports:** Individualized mental health services and
- 325 supports planned jointly by the Contractor and the Enrollee, family members, as applicable, and

326 representatives of other service delivery systems; allows the Contractor flexibility to offer  
327 Enrollees services which augment and complement those provided through other funders and  
328 systems; limited to services/supports specifically tailored to an individual Enrollee's needs at a  
329 particular point in time and are not regularly defined services otherwise offered by the  
330 Contractor.

331  
332 **Intensive Clinical Management (ICM):** the administration and provision of a set of clinical  
333 behavioral health management services delivered to an Enrollee who has a history of, or who in  
334 the best judgment of the Contractor's clinical staff, is likely to be a high utilizer of behavioral  
335 health services, or frequently in crisis by virtue of his or her diagnosis, multiple diagnoses or  
336 chronic illness.

337  
338 **Iowa Plan services:** Services inclusive of covered services, required services, and optional  
339 services made available to Eligible Persons.

340  
341 **I-SMART:** Iowa Service Management and Reporting Tool; IDPH's data system for tracking  
342 substance abuse services.

343  
344 **JCO:** Juvenile Court Officer

345  
346 **Levels of Care:** A general term that encompasses the different options for treatment that vary  
347 according to the intensity of the services offered. Each treatment option in the ASAM-PPC-2R  
348 is a level of care.

349  
350 **Level of Service:** One of the levels of substance abuse treatment services as described in the  
351 ASAM PPC-2R and the PMIC Admission and Continued Stay Criteria.

352  
353 **Licensure:** The issuance of a license by IDPH and the Iowa State Board of Health that validates  
354 the licensee's compliance with substance abuse program standards and authorizes the licensee  
355 to operate a substance abuse treatment program in the State of Iowa. This also includes deemed  
356 status in accordance with Iowa Administrative Code 643-3.18 (125).

357  
358 **Limited Service Organization (LSO):** An LSO is an organization licensed under the Department  
359 of Insurance within the state of Iowa conforming to the required regulations.

360  
361 **Management of care:** The process to ensure that the appropriate level of care is utilized, which  
362 entails implementing ASAM-PPC-2R during the placement screening, continuing service and  
363 discharge process. This includes discharge planning that begins at admission to meet the  
364 immediate, ongoing and post treatment needs of the Eligible Person.

365  
366 **Marketing:** Any communication, from the Contractor to a Medicaid Member who is not enrolled  
367 in that entity, that can reasonably be interpreted as intended to influence the recipient to enroll  
368 in the Contractor's Medicaid product, or either to not enroll in, or to disenroll from, another  
369 Medicaid managed health care program.

370  
371 **MBHO:** Managed Behavioral Healthcare Organization

372  
373 **MCO:** Managed Care Organization

374

- 375 **MH:** Mental Health  
376
- 377 **MIS:** Management Information System  
378
- 379 **Medicaid Management Information System (MMIS):** The federally mandated management  
380 information system of software, hardware, and manual procedures used to process Medicaid  
381 claims and to retrieve and produce service utilization and management information.  
382
- 383 **Medicaid:** The Medical Assistance program authorized by Title XIX of the Social Security Act  
384 and administered in Iowa under the auspices of the Department of Human Services, Bureau of  
385 Managed Care and Clinical Services to provide medical benefits to eligible low income persons  
386 needing health care. The federal and state governments share costs.  
387
- 388 **Medically Necessary Services:** Covered services that meet the criteria for psychosocial necessity  
389 or service necessity.  
390
- 391 **Medically Needy:** An eligibility category within the Medicaid program.  
392
- 393 **Medicare:** A nationwide federally administered health insurance program which covers the cost  
394 of hospitalization, medical care and some related services for Eligible Persons. Medicare has  
395 two parts: Part A (also called the supplemental medical insurance program) covers inpatient  
396 costs; Part B covers outpatient costs. Part C is Medicare Advantage. Part D is optional  
397 coverage for prescription drugs.  
398
- 399 **MediPASS:** Medicaid Patient Access to Service System: A Medicaid primary care case  
400 management program operated by the Department of Human Services.  
401
- 402 **Member:** A person covered by Medicaid as determined by DHS.  
403
- 404 **MHDS:** The DHS Division of Mental Health and Disability Services (MHDS)  
405
- 406 **NIATx:** The Network for Improvement of Addiction Treatment  
407
- 408 **NOMS:** SAMHSA National Outcomes Measures  
409
- 410 **Open Panel:** The requirement under which the Contractor shall contract with all providers  
411 who are appropriately licensed, certified or accredited, who meet the credentialing criteria,  
412 who agree to the standard contract terms, and who wish to participate, in the Enrollee  
413 provider network.  
414
- 415 **Optional Services:** Services provided at the discretion of the Contractor to provide additional  
416 assistance to Eligible Persons.  
417
- 418 **Outreach:** Activities and functions conducted to inform the public of available programs and  
419 services. In addition, outreach can include a process or series of activities that identifies Eligible  
420 Persons in need of services, engages them, and links such individuals with the most appropriate  
421 resources or service providers.  
422

423 **Peer Support:** The services provided to Eligible Persons by other mental health consumers or  
424 substance abuse recovering persons who are specifically trained to provide peer support  
425 services. Services are provided in the community in Eligible Persons' homes, workplaces and  
426 other community settings and are targeted toward the support of persons with a serious and  
427 persistent mental illness or substance abuse. Peer support services focus on individual support  
428 and counseling from the perspective of a trained peer, and may also include service  
429 coordination and advocacy activities as well as rehabilitative services. Peer support services  
430 are initiated when there is a reasonable likelihood that such services will benefit an Eligible  
431 Person's functioning and assist him or her in maintaining community tenure.

432  
433 **Performance Indicator:** A measure of an aspect of Contractor performance that is of particular  
434 interest and/or concern to the Departments. Many indicators also contain standards that the  
435 Contractor is expected to meet.

436  
437 **Performance Standard:** Within a performance indicator, the level of performance required, i.e.,  
438 95% of all claims received shall be processed within 30 days; or 1000 joint case planning  
439 sessions shall be conducted.

440  
441 **PMIC:** Psychiatric Medical Institution for Children as described in Iowa Code Chapter 135H.

442  
443 **PMIC Admission and Continued Stay Criteria:** Psychiatric Medical Institutions For Children  
444 Admission and Continued Stay Criteria For Extended Care and the Psychiatric Medical  
445 Institutions For Children Admission and Continued Stay Criteria For Sub-Acute Level of Care,  
446 whichever is applicable, as promulgated by DHS and as may be amended from time to time  
447 with approval from DHS.

448  
449 **PMIC Substance Abuse Services:** Substance abuse treatment provided by a substance abuse  
450 licensed PMIC and consistent with the nature of care provided by a PMIC as described in Iowa  
451 Code Chapter 135H.

452  
453 **Post-stabilization services:** Medically necessary covered services, related to an emergency  
454 medical condition that are provided after an Enrollee is stabilized in order to maintain the  
455 stabilized condition, or, under the circumstances described in 42 CFR 438.114(e) to improve  
456 or resolve the Enrollee's condition.

457  
458 **Practitioner:** A professional that provides behavioral health services to an Eligible Person under  
459 the Iowa Plan.

460  
461 **Prevention:** A proactive process to eliminate unnecessary disease, disability, and premature  
462 death caused by (1) acute disease, (2) chronic disease, (3) intentional or unintentional injury or  
463 disease associated with environmental, home and workplace hazards, and (4) controllable risk  
464 factors such as poor nutrition; lack of exercise; alcohol, tobacco, and other drug use;  
465 inadequate use of preventive health services; and other risk behaviors.

466  
467 **Prior Authorization:** The process of obtaining prior approval as to the appropriateness of a  
468 service or medication; prior authorization does not guarantee coverage.

469  
470 **Program:** Any partnership, corporation, association, governmental subdivision or public or  
471 private organization.

472  
473  
474  
475  
476  
477  
478  
479  
480  
481  
482  
483  
484  
485  
486  
487  
488  
489  
490  
491  
492  
493  
494  
495  
496  
497  
498  
499  
500  
501  
502  
503  
504  
505  
506  
507  
508  
509  
510  
511  
512  
513  
514  
515  
516  
517  
518  
519

**Provider:** A professional or program that provides behavioral health services to an Eligible Person under the Iowa Plan.

**Provider Profiling:** A comparison of network providers performed by the Contractor or its designee; comparison may be done on selected criteria such as compliance with clinical protocols, length of treatment, change in Eligible Person's level of functioning, client satisfaction ratings; feedback is generally given to the provider with the provider's own ratings compared to the average rating of other similar providers.

**Psychosocial Necessity:** In the context of the Iowa Plan, psychosocial necessity is an expansion of the concept of medical necessity and shall mean clinical, rehabilitative or supportive mental health services which meet all of the following conditions:

- appropriate and necessary to the symptoms, diagnoses or treatment of a covered mental health diagnosis;
- provided for the diagnosis or direct care and treatment of a mental disorder;
- within standards of good practice for mental health treatment;
- required to meet the mental health need of the Enrollee and not primarily for the convenience of the Eligible Person, the provider, or the Contractor;
- be the most appropriate type of service which would reasonably meet the need of the Enrollee in the least costly manner; after consideration of:
  - the Enrollee's clinical history including the impact of previous treatment and service interventions;
  - services being provided concurrently by other delivery systems;
  - the potential for services/supports to avert the need for more intensive treatment;
  - the potential for services/supports to allow the Enrollee to maintain functioning improvement attained through previous treatment;
  - unique circumstances which may impact the accessibility or appropriateness of particular services for an individual Enrollee (e.g., availability of transportation, lack of natural supports including a place to live), and
  - the Enrollee's choice of provider or treatment location.

**Psychiatric Rehabilitation Services:** The services designed to restore, improve, or maximize level of functioning, self-care, responsibility, independence, and quality of life and to minimize impairments, disabilities and disadvantages of persons with a disabling mental illness. Services are focused on improving personal capabilities while reducing the harmful effects of psychiatric disability and resulting in Enrollee's recovering the ability to perform a valued role in society.

**Quality Assessment and Performance Improvement (QA):** A formal set of activities to review and affect the quality of services provided. QA includes quality assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative, and support services.

**Recovery Center:** A consumer-operated entity that promotes recovery through peer support, socialization, education and training.

**Rehabilitation:** The restoration of an Eligible Person to the fullest physical, mental, social, vocational, and economic usefulness of which the Eligible Person is capable. Rehabilitation

520 may include, but is not limited to, medical treatment, psychological therapy, occupational  
521 training, job counseling, social and domestic rehabilitation and education.  
522

523 **Remedial Services:** services designed to assist a person with a mental health diagnosis to regain  
524 self-control and teach appropriate behaviors. The Iowa Plan does not cover remedial services.  
525

526 **Required Services:** Service that the Contractor must make available to Iowa Plan Eligible  
527 Persons that are not covered in the Iowa Medicaid fee-for-service program, but are appropriate  
528 and desirable services for adequately addressing the needs of people with behavioral health  
529 diagnoses. If the provider capacity for these services does not exist in an area, the Contractor  
530 is obligated to develop the capacity, thus expanding the availability of the service(s).  
531

532 **Residential Substance Abuse Treatment Services:** Addiction and chemical dependency  
533 treatment provided to medically and physically stable individuals. This is a 24 hour supervised  
534 substance abuse treatment service in a setting less intensive than an acute care hospital.  
535

536 **Risk-Based Contract:** An agreement between the DHS and the Contractor requiring the  
537 Contractor to furnish at a minimum all covered services to Enrollees for a fixed monthly  
538 payment rate paid by DHS. The Contractor is then liable for services regardless of their extent,  
539 expense, or degree.  
540

541 **Rural:** Any area that is not designated as a Metropolitan Statistical Area (MSA). See definition  
542 for urban herein.  
543

544 **SA:** Substance Abuse  
545

546 **SAPT Block Grant:** Substance Abuse Prevention and Treatment Block Grant  
547

548 **SARS:** Substance Abuse Reporting System historically used by IDPH.  
549

550 **Screening:** Means the process by which an Eligible Person is determined appropriate and eligible  
551 for admission to a particular program or level of care. The focus is on the minimum criteria  
552 necessary for appropriateness/eligibility.  
553

554 **Service Area:** IDPH-determined outpatient treatment services areas.  
555

556 **Service Authorization Request:** means an Enrollee's request for the provision of a covered or  
557 required service or a provider's request on behalf of an Enrollee.  
558

559 **Service Necessity:** The requirement that the goods and services provided or ordered must be,  
560 pursuant to the criteria of the ASAM PPC-2R or the PMIC Admission and Continued Stay  
561 Criteria, whichever is applicable:

- 562 • appropriate and necessary to the symptoms, diagnoses or treatment of a covered disorder;
- 563 • provided for the diagnosis or direct care and treatment of a covered disorder;
- 564 • within standards of good practice within the substance abuse service area;
- 565 • required to meet the need related to a covered diagnosis or disorder, and not primarily for  
566 the convenience of the Eligible Person or provider;
- 567 • be the least costly type of service which would reasonably meet the need of the Eligible  
568 Person, and

- be within the scope of the licensure of the provider.

570

571 **Shall:** Indicates a mandatory requirement or condition that must be met under the terms of the  
572 contract.

573

574 **SSI:** Supplemental Security Income: A cash assistance program administered by the United States  
575 Social Security Administration.

576

577 **Stabilized:** Means with respect to an Enrollee “emergency medical condition” that no material  
578 deterioration of the condition is likely, within reasonable medical probability, to result from or  
579 occur during the transfer of the individual from a facility.

580

581 **Sub-acute mental health service:** The provision of care to an Enrollee who does not require acute  
582 hospital services, but continues to require less intense services in a medical facility.

583

584 **Substance Abuse & Mental Health Services Administration (SAMHSA):** The unit of the  
585 United States Department of Health and Human Services that provides administration and  
586 funding for the Substance Abuse Prevention and Treatment Block Grant in accordance with 45  
587 CFR, Part 96.

588

589 **Substance Abuse License:** The requirement that all substance abuse treatment programs must be  
590 licensed by the IDPH.

591

592 **Targeted Case Management:** Individual case management services targeted to persons with  
593 chronic mental illness, mental retardation or developmental disabilities as defined in Chapter  
594 225C.20 of the Code of Iowa with standards set forth in the Iowa Administrative Code 441  
595 Chapter 24; the Contractor is responsible for TCM only for persons who have chronic mental  
596 illness.

597

598 **TCM:** Targeted Case Management.

599

600 **TCMs:** Targeted case managers. Individual case managers responsible for TCM services.

601

602 **Temporary Assistance for Needy Families (TANF):** Iowa’s welfare reform plan that provides  
603 for assistance to families.

604

605 **Third Party:** An individual, entity, or program, excluding Medicaid and Eligible Persons, that is,  
606 may be, could be, should be, or has been liable for, all or part of the cost of substance abuse  
607 treatment services.

608

609 **Time frames:** The periods of time within which the substance abuse assessment and treatment  
610 plan must be completed after admission, frequency of review of the treatment plan by the  
611 Eligible Person and counselor, and frequency of reviews for continuing service and discharge.  
612 The time frames for Levels I and III.1 shall be every 30 days; for Levels II.1, II.5, III.3 and  
613 III.5, every 7 days; and for Levels III.7 and IV, daily. For Level I continuing care/aftercare,  
614 there shall not be any required frequency of review for continuing service or frequency of  
615 review of treatment plan by Eligible Person and counselor.

616

617 **Treatment:** The broad range of planned and continuing, inpatient, outpatient, residential care  
618 services, including diagnostic evaluation, counseling, medical, psychiatric, psychological, and  
619 social service care, which may be extended to substance abusers, concerned persons, concerned  
620 family members, or significant others, and which is geared toward influencing the behavior of  
621 such individuals to achieve a state of rehabilitation.  
622

623 **Treatment days:** Days in which the treatment program is open for services or actual working  
624 days.  
625

626 **Treatment planning:** The process by which a counselor and Eligible Person identify and rank  
627 problems, establish agreed-upon goals, and decide on the treatment process and resources to be  
628 utilized.  
629

630 **Urban:** A Metropolitan Statistical Area (MSA) as defined by the federal Executive Office of  
631 Management and Budget.  
632

633 **Utilization Management Guidelines:** Guidelines developed and/or used by the Contractor and  
634 approved by the Departments which serve as a way to interpret criteria of medical necessity,  
635 service necessity, and psychosocial necessity  
636

637 **Utilization Management staff:** Those appropriately credentialed clinicians who are employed by  
638 the Contractor to authorize and/or review services based on Utilization Management  
639 Guidelines.  
640

641 **Utilization Management:** A formal assessment of the medical/psychosocial necessity, efficacy  
642 and/or appropriateness of services requested by or on behalf of an Iowa Plan Enrollee based on  
643 applicable Utilization Management Guidelines.  
644

645 **Utilization Monitoring:** Retrospective review of mental health and substance abuse services,  
646 particularly those that do not require prior authorization, to assure appropriate placement and  
647 service delivery, consistent with the applicable Utilization Management Guidelines.  
648

649 **Waiver:** The documents and request submitted by DHS to CMS requesting a waiver from certain  
650 terms and conditions of the federal Medicaid Program and the State Plan submitted by the State  
651 of Iowa.  
652

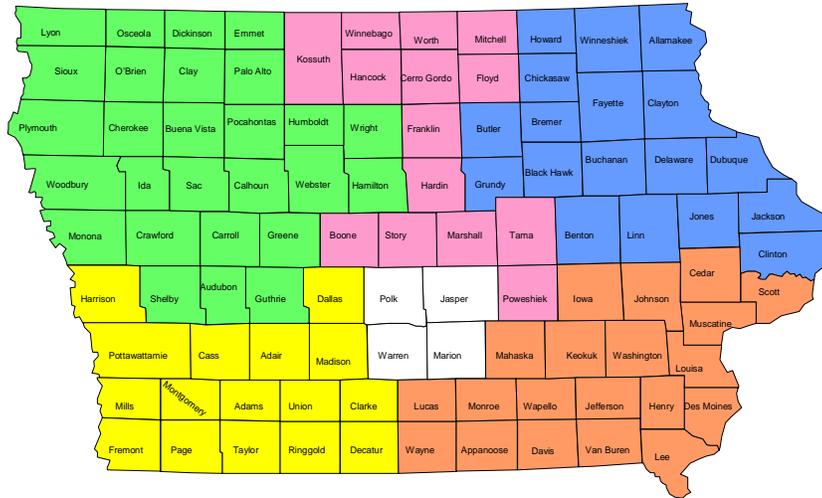
653 **Women and Children's Programs (W/C) -** Special programs for substance abuse treatment for  
654 pregnant women and women with dependent children. Services offered by these programs  
655 expand beyond the typical substance abuse treatment milieu to include other supportive  
656 assistance that enhances recovery opportunities in accordance with SAPT Block Grant  
657 requirements.  
658  
659

1  
2  
3  
4  
5

**ATTACHMENTS: SECTIONS 1**

1.3 Map of IDPH Regions

## MANAGED CARE PLAN REGIONS



5  
6

1

2

## **ATTACHMENTS: SECTION 2**

3

4

5

### **2.5.1 List of Documents Available in the Resource Room (Resource Room Documents)**

6



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48

**Attachment to Section 2.5.1**  
**List of Information and Documents Available in the Resource Room**

1. County Mental Health Services Overview
2. Iowa Plan Enrollment and Expenditure Data by Payment Cell, including historical count of Medicaid Members and Iowa Plan Enrollees by County
3. Iowa Plan Authorizations, Utilization, Claims and Customer Services  
    Selected Months
4. Quality Reports  
    CMS Approved QA Plan  
    Quality Improvement Reports  
    Quality Assurance Reports Available at:  
    <http://www.ime.state.ia.us/ManagedCare/IowaPlanReprocurement.html>
5. Provider Information  
    Magellan Provider Manual  
    Iowa Plan Medicaid Provider Directory  
    Mental Health Utilization Management Guidelines
6. Iowa Plan 2008 Performance Indicators  
    See current contract at:  
    <http://www.ime.state.ia.us/ManagedCare/ManagedCareDocs.html>
7. Consumer Information  
    Basic Medicaid Eligibility in Iowa  
    Iowa Plan booklet for consumers at:  
    [https://www.magellanassist.com/mem/benefits/pspdf/ia\\_clienthandbkrevaug03.pdf](https://www.magellanassist.com/mem/benefits/pspdf/ia_clienthandbkrevaug03.pdf)
8. Current Iowa Plan for Behavioral Health Contract with Magellan  
    See current contract at:  
    <http://www.ime.state.ia.us/ManagedCare/ManagedCareDocs.html>  
    Milliman Capitation Report
9. 1915 (b) Waiver Application Renewals
10. I-SMART

49	I-SMART Overview and Manual
50	I-SMART forms
51	11. IDPH Sliding Scale Fee
52	12. Miscellaneous Reports
53	

1  
2  
3  
4  
5  
6  
7  
8

**ATTACHMENTS: SECTION 4A**

4A.2 Covered Diagnoses

8                   **Attachment to Section 4A.2 - From Section 41.0 of Current Iowa Plan Contract**

9  
10                                   **COVERED DIAGNOSES**

11  
12   The Contractor is responsible for authorizing appropriate short- and long-term services for  
13   Medicaid Enrollees who have the following diagnosis series as defined in the ICD-9-CM. The  
14   Contractor will be responsible for any additional diagnoses added to the ICD-9-CM and any  
15   future versions. Substance abuse diagnoses are indicated in italics:

- 16  
17           290    Senile and presenile organic psychotic conditions  
18           291    Alcoholic psychoses  
19           292    Drug psychoses  
20           293    Transient organic psychotic conditions  
21           294    Other organic psychotic conditions (chronic)  
22           295    Schizophrenic disorders  
23           296    Affective psychoses  
24           297    Paranoid states  
25           298    Other non-organic psychoses  
26           299    Psychoses with origin specific to childhood  
27           300    Neurotic disorders  
28           301    Personality disorders  
29           302    Sexual deviations and disorders  
30           303    *Alcohol dependence syndrome*  
31           304    *Drug dependence*  
32           305    *Non-dependent use of drugs*  
33           306    Physiological malfunction arising from mental factors  
34           307    Special symptoms or syndromes, not elsewhere classified  
35           308    Acute reaction to stress  
36           309    Adjustment reaction  
37           311    Depressive disorder not elsewhere classified  
38           312    Disturbance of conduct, not elsewhere classified  
39           313    Disturbance of emotions specific to childhood and adolescence  
40           314    Hyperkinetic syndrome of childhood

41  
42   Services for a covered diagnosis cannot be denied solely on the basis of an individual also having  
43   a non-covered diagnosis. Mental health services, including inpatient care, cannot be denied  
44   solely on the basis of an individual having no Axis I diagnosis. The Contractor will be  
45   responsible for providing services necessary in the behavioral care and treatment of the covered  
46   diagnoses for Iowa Plan Enrollees who are dually diagnosed with a covered diagnosis and a non-  
47   covered diagnosis.

48  
49   The following ICD-9 diagnosis codes are excluded from Iowa Plan coverage, unless the Enrollee  
50   also has a diagnosis which is covered under the Iowa Plan:

- 51  
52           315           Specific delays in development  
53           316           Psychic factors associated with diseases classified elsewhere  
54           317           Mild mental retardation  
55           318           Other specific mental retardation  
56           319           Unspecific mental retardation  
57

58  
59  
60  
61  
62  
63  
64  
65  
66  
67  
68  
69  
70  
71

**41.1 COVERED SUBSTANCE ABUSE DISORDERS FOR IDPH PARTICIPANTS**

The Contractor will be responsible for providing necessary covered and required services for the substance abuse treatment needs of IDPH Participants who have the following substance abuse disorders:

- Non-Dependent Abuse of Alcohol
- Alcohol Dependency
- Drug Dependency
- Non-Dependent Abuse of Drugs
- Intervention for Significant Others when there is no identified diagnosed substance abuse client

**ATTACHMENTS: SECTION 7**

7.6 RFP Addenda

## **RFP ADDENDA**

This Section contains RFP Addenda. Where applicable, these Addenda shall be completed and returned with the Bid Proposal.

The Addenda included in this Section are:

- Certifications & Mandatory Guarantee
- Release of Information
- Mandatory Requirements and Reasons for Disqualification

## **RFP CERTIFICATIONS & MANDATORY GUARANTEE**

### **CERTIFICATION OF INDEPENDENCE AND NO CONFLICT OF INTEREST.**

The Bidder certifies that the Bid Proposal was developed independently. The Bidder also certifies that no relationship exists or will exist during the contract period between the Bidder and the Agency that interferes with fair competition or is a conflict of interest. The Agency reserves the right to reject a Bid Proposal or cancel the Notice of Intent, if in its sole discretion, any relationship exists that could interfere with fair competition or conflict with the interests of the Agency.

### **CERTIFICATION REGARDING REGISTRATION, COLLECTION AND REMISSION OF STATE SALES AND USE TAX.**

The Bidder shall certify it is either a) registered or will become registered with the Iowa Department of Revenue to collect and remit Iowa sales and use taxes as required by Iowa Code chapter 423; or b) not a "retailer" of a "retailer maintaining a place of business in this state" as those terms are defined in Iowa Code subsections 423.1(42) & (43). The Bidder also acknowledges that the Agency may declare the bid void if the above certification is false. Bidders may register with the Department of Revenue online at: <http://www.state.ia.us/tax/business/business.html>.

### **FIRM BID PROPOSAL TERMS.**

The Bidder guarantees the availability of the services offered and that all Bid Proposal terms, including price, shall remain firm, for the minimum number of days as stipulated in the RFP Special Terms, following the deadline for submitting proposals. By submitting a Bid Proposal, the Bidder agrees to provide services which meet or exceed the requirements of the Agency's RFP unless noted in the Bid Proposal and at the prices quoted by the Bidder.

### **BID PROPOSAL SECURITY.**

The Bidder guarantees the submission of a bid bond, a certified or cashier's check, or an irrevocable letter of credit in favor of or made payable to the Agency in the amount stipulated in the Special RFP Terms, which shall guarantee the availability of the services as provided in the preceding subsection. The Bidder understands that if the Bidder elects to use a bond, a surety licensed to do business in Iowa must issue the bond on a form acceptable to the Agency. The Bidder understands that the proposal security shall be forfeited if the Bidder chosen to receive the contract withdraws its Bid Proposal after the Agency issues a Notice of Intent to Award, does not honor the terms offered in its Bid Proposal, or does not negotiate contract terms in good faith. The Bidder further understands that the security submitted by Bidders will be returned, if not forfeited for reasons state above, when the Bid Proposals expire, are rejected, or the Agency enters into a contract with the successful Bidder, whichever is earliest.

### **CERTIFICATION REGARDING LOBBYING.**

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

1. No federal appropriated funds have been paid or will be paid on behalf of the Sub-Grantee to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of the Congress, an officer or employee of the Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan or cooperative agreement.
2. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of the Congress, or an employee of a Member of Congress in connection with this Contract, grant, loan, or cooperative agreement, the applicant shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3. The Bidder shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by 31 U.S.C. § 1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

**CERTIFICATIONS & MANDATORY GUARANTEE CERTIFICATION OF COMPLIANCE  
WITH PRO-CHILDREN ACT OF 1994**

Bidder shall comply with Public Law 103-227, Part C Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act). This Act requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the Deliverables are funded by federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees, and contracts. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities (other than clinics) where WIC coupons are redeemed. The Bidder further agrees that the above language shall be included in any subawards that contain provisions for children's services and that all subgrantees shall certify compliance accordingly. Failure to comply with the provisions of this law may result in the imposition of a civil monetary penalty of up to \$1000 per day.

**CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND  
VOLUNTARY EXCLUSION – LOWER TIER COVERED TRANSACTIONS.**

By signing and submitting this document, the Bidder is providing the certification set out below:

1. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the Bidder knowingly rendered an erroneous certification, in addition to other remedies available to the federal government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

2. The Bidder shall provide immediate written notice to the person to whom this document 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 document is submitted for assistance in obtaining a copy of those regulations.

4. The Bidder agrees by submitting this document 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 Agency or agency with which this transaction originated.

5. The Bidder further agrees by submitting this document that it shall include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

6. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that

the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. A participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Nonprocurement Programs.

7. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

8. Except for transactions authorized under paragraph 4 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the federal government, the Agency or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

a. The Bidder certifies, by submission of this document, 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.

b. Where the Bidder is unable to certify to any of the statements in this certification, such Bidder shall attach an explanation to this document.

#### **CERTIFICATION REGARDING DRUG FREE WORKPLACE**

1. Requirements for Contractors Who are Not Individuals. If the Bidder is not an individual, by signing below Bidder agrees to provide a drug-free workplace by:

a. publishing a statement notifying employees that the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited in the person's workplace and specifying the actions that will be taken against employees for violations of such prohibition;

b. establishing a drug-free awareness program to inform employees about:

(1) the dangers of drug abuse in the workplace;

(2) the person's policy of maintaining a drug-free workplace;

(3) any available drug counseling, rehabilitation, and employee assistance programs; and

(4) the penalties that may be imposed upon employees for drug abuse violations;

c. making it a requirement that each employee to be engaged in the performance of such contract be given a copy of the statement required by subparagraph (a);

d. notifying the employee in the statement required by subparagraph (a), that as a condition of employment on such contract, the employee will:

(1) abide by the terms of the statement; and

(2) notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than 5 days after such conviction;

e. notifying the contracting agency within 10 days after receiving notice under subparagraph (d)(2) from an employee or otherwise receiving actual notice of such conviction;

f. imposing a sanction on, or requiring the satisfactory participation in a drug abuse assistance or rehabilitation program by, any employee who is so convicted, as required by 41 U.S.C. § 703; and

g. making a good faith effort to continue to maintain a drug-free workplace through implementation of subparagraphs (a), (b), (c), (d), (e), and (f).

2. Requirement for individuals. If the Bidder is an individual, by signing below the Bidder agrees to not engage in the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance in the performance of the contract.

3. Notification Requirement. The Bidder shall, within 30 days after receiving notice from an employee of a conviction pursuant to 41 U.S.C. § 701(a)(1)(D)(ii) or 41 U.S.C. § 702(a)(1)(D)(ii):

a. take appropriate personnel action against such employee up to and including termination; or

b. require such employee to satisfactorily participate in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency.

IN WITNESS WHEREOF, the Bidder hereby certifies that the above is true and accurate, that the Bidder will fully comply with all obligations included herein, and that the Bidder has caused a duly authorized representative to execute this document.

<b>Organization:</b>	
Signature:	
Printed Name:	
Title:	Date:

## RELEASE OF INFORMATION

\_\_\_\_\_ (*name of Bidder*) hereby authorizes any person or entity, public or private, having any information concerning the Bidder's background, including but not limited to its performance history regarding its prior rendering of services similar to those detailed in this RFP, to release such information to the Agency.

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 Agency 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 Agency, and the State of Iowa from any liability whatsoever that may be incurred in releasing this information or using this information.

\_\_\_\_\_  
Printed Name of Bidder Organization

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

## MANDATORY REQUIREMENTS AND REASONS FOR DISQUALIFICATION

*The Departments will only evaluate proposals that meet the mandatory requirements defined in Part 1 of this addendum and are not subject to disqualification for the reasons listed in Part 2.*

### PART 1: MANDATORY REQUIREMENTS CHECKLIST

**Bidders are expected to confirm review of their proposal against the Mandatory Requirements for this RFP by initialing in the space provided. The Departments will make the final determination as to whether Mandatory Requirements have been met.**

<u>Bidder</u>	<u>Departments</u>	<b>Mandatory Requirements</b>
		1. Bid Proposal security as specified in the Special RFP Terms.
		2. Bid Proposal received by the due date and time as specified in Special RFP Terms. (RFP Section 3.2.(9))
		3. Bid Proposal acknowledges receipt of the Departments' amendments to the RFP. (RFP Section 3.2(10))
		4. Bid Proposal format meets RFP preparation requirements. (RFP Section 3.3(1))
		5. Transmittal Letter with all required content/information. (RFP Section 3.3(2)(a))
		6. Acceptance of terms and conditions stipulation. (RFP Section 3.3(2)(a)(3))
		7. Table of Contents. (RFP Section 3.3(2)(b))
		8. Executive Summary. (RFP Section 3.3(2)(c))
		9. Background information with all required content/information. (RFP Section 3.3(2)(d))
		10. Bid Proposal is fully responsive and able to meet the service requirements. (RFP Section 3.3(2)(e))
		11. Experience information with all required content/information. (RFP Section 3.3(2)(f))
		12. Personnel information with all required content/information. (RFP Section 3.3(2)(g))
		13. Financial information with all required content/information. (RFP Section 3.3(2)(h))
		14. Termination, litigation and investigation information. (RFP Section 3.3(2)(i))
		15. Submission of RFP Attachments. (RFP Section 3.3(2)(j))
		16. Cost proposal with all required content/information. (RFP Section 3.3(3))
		17. Bid Proposal contains all signatures, certifications, authorizations, stipulations, disclosures or guarantees required in the RFP.

\_\_\_\_\_  
Signature of Authorized Representative for Bidder      Initials      Printed Name

\_\_\_\_\_  
Signature of Agency Representative      Initials      Printed Name

## *PART 2: REASONS FOR DISQUALIFICATION*

Bidders should review their proposals against the following reasons for disqualification. Bid proposals meeting any of these reasons for disqualification will be rejected and will not be evaluated. Bidders do not need to return this page to the Agency.

1. The Bidder states that a service requirement cannot be met.
2. The Bidder's response materially changes a contract deliverable.
3. The Bidder fails to include information necessary to substantiate that it will be able to meet a contract deliverable. A response of "will comply" or merely repeating the requirement is not sufficient.
4. The Bidder's response limits the rights of the Agency.
5. The Bidder fails to respond to the Agency's request for information, documents, or references.
6. The Bidder indicates that the entire Bid Proposal is confidential.
7. The Bidder indicates the Cost Proposal is confidential in whole or in part.
8. The Bidder initiates unauthorized contact regarding this RFP with employees of the Agency or employees of any agency partnering in the issuance of this RFP.
9. The Bidder provides misleading or inaccurate response(s).
10. The Bidder includes assumptions in its bid proposal.
11. The Bidder is excluded by the federal government from participating in procurements involving federal funds.

## **Section 9 - Attachments**

- 1. FY09 Capitation Rates**
- 2. Performance Indicators**

**FY09 Capitation Rates**

The table below includes the actual capitation rate played by DHS to the current Iowa Plan Contractor.

<b>CATEGORY/AGE RANGE</b>	<b>FEMALE</b>	<b>MALE</b>
<b>FMAP 0 – 17</b>	\$8.65	\$10.50
<b>FMAP 18 – 64</b>	32.32	22.42
<b>SSI 0 – 17</b>	31.27	43.87
<b>SSI 18 – 64</b>	105.65	96.90
<b>Dual Eligibles 0 – 64</b>	58.29	64.07
<b>Foster Care 0 – 9</b>	33.86	53.73
<b>Foster Care 10 – 22</b>	145.45	150.57

Based on services in the current Iowa Plan Contract, the Departments' actuary, Milliman, has developed an estimated rate for the Dual Eligibles 65 and older.

<b>Estimated RY09 Capitation Rates: Dual Eligibles 65 and Older</b>	
<b>Female</b>	<b>Male</b>
26.42	27.32

The Departments' actuary, Milliman, has develop an estimated impact to the PMPM rates based on the changes in this RFP that would make community-based services more accessible to Iowa Plan members, as shown in the table below.

<b>Expansion of Services</b>	
<b>Reduction in Iowa Plan PMPM Costs</b>	
<b>Year One</b>	<b>0-1%</b>
<b>Year Two</b>	<b>Additional 1-2%</b>

# **Iowa Plan for Behavioral Health Performance Indicators**

**PERFORMANCE INDICATORS  
CARRYING MEDICAID FINANCIAL INCENTIVES  
for the  
IOWA PLAN FOR BEHAVIORAL HEALTH  
for  
CONTRACT PERIOD #1  
July 1, 2009 – June 30, 2010**

The Contractor shall provide to the Departments a monthly written report on all performance indicators to which financial incentives have been attached. These indicators will be reassessed annually by the Departments and the Iowa Plan Advisory Committee and may be modified annually at the Departments' discretion. Each indicator should be reported with either monthly or quarterly measurements (as specified) and with a contract year-to-date measurement. For performance indicators that utilize HEDIS specifications, the Contractor shall also report national Medicaid HEDIS 75<sup>th</sup> and 90<sup>th</sup> percentile rates for the indicator, using the most recently reported NCQA data, for comparison purposes.

The measurement specifications for each performance indicator shall be defined in detail in a methodology appendix attached to each report. The measurement specifications shall be reviewed and approved in writing by the Depts no later than 60 days after the Contract Operational Start Date.

For the attainment of each designated financial incentive performance indicator for the time period of July 1, 2009, through June 30, 2010, the Contractor shall be paid the amount the Department of Human Services has associated with each indicator. The Department of Human Services shall be solely responsible for determining whether or not the Contractor has met the required level of performance. The Department shall take whatever steps it deems appropriate to validate all information provided by the Contractor, including auditing Contractor measurement processes and data, prior to issuing incentive payments.

1. <u>Quality of Care: Mental Health Readmission</u>			
Rate of mental health inpatient readmission by children and adults at 7, 30, and 90 days will be no higher than the following:			
7-day readmission	30-day readmission	90-day readmission	
children: 3.5%	children: 9%	children: 17%	
adults: 5%	adults: 13%	adults: 24%	
Numerator: The number of inpatient readmissions within 7/30/90 days of discharge.*			
Denominator: The number of inpatient discharges that occur within the reporting periods, less 30 days.*			
*Discharges/readmits at the MHIs where the Enrollee is moving between inpatient and residential are not counted.			
Data Source: Claims.			
<b>Standard</b>	<b>7-day readmission 5% or less</b>	<b>30-day readmission 12% or less</b>	<b>90-day readmission 22% or less</b>

2. Quality of Care: Community Tenure

The average time between mental health hospitalizations per contract period shall not fall below 93 days for “High Need” children and adults.

For Enrollees defined as “High Need” who were admitted to a mental health inpatient hospital setting which is funded by the Contractor and subsequently readmitted to a mental health inpatient hospital setting funded by the Contractor within the contract period and the preceding 12 months of the contract period, the average number of days between discharge and readmission(s). The numbers must reflect all Enrollees who were re-admitted despite Contractor denial as well as those Enrollees whose admission was authorized.

Data Source: Authorizations.

<b>Standard</b>	<b>93 days or more (children) before readmission – (monitor only)</b> <b>93 days or more (adults) before readmission – (monitor only)</b> <b>93 days or more (children and adults) before readmission – (incentive)</b>
-----------------	---

3. Service Array: Integrated Services and Supports

At least 18.0% of mental health service expenditures, combined for children and adults, will be used in the provision of integrated services and supports, including natural supports, consumer-run programs, and services delivered in the home of the Enrollee.

Numerator: The Contractor’s combined mental health expenditures for integrated services and supports, consumer-run programs, and services delivered in the Enrollee’s home, but also reported separately for adults and children

Denominator: The Contractor’s total claims expenditures for mental health services, but also reported separately for adults and children.

Data Source: Claims.

<b>Standard</b>	<b>% of child MH service expenditures – (monitor only)</b> <b>% of adult MH service expenditures – (monitor only)</b> <b>18.0% or more of MH service expenditures – (incentive)</b>
-----------------	---

4. Quality of Care: ER Utilization

The number of ER presentations shall not exceed 8.5 visits/1000 Enrollee member months (annualized).

Numerator: The number of mental health or substance abuse emergency room presentations for treatment by Enrollees\*.

Denominator: Number of Enrollee\* member months divided by 1000 and multiplied by 12.

\* Excluding dually eligible Enrollees

Data Source: Claims and Enrollment.

<b>Standard</b>	<b>≤ 8.5 visits to ER per 1,000 Member months</b>
-----------------	---

<p>5. <u>Quality of Care: Follow-up After Hospitalization for Mental Illness (I)</u>  58% of Enrollees 6 years of age and older discharged from mental health inpatient care for selected disorders will receive outpatient, intensive outpatient program or partial hospitalization treatment services with a mental health practitioner within 7 days of discharge.</p> <p>76% of Enrollees 6 years of age and older discharged from mental health inpatient care for selected disorders will receive outpatient, intensive outpatient program or partial hospitalization treatment services with a mental health practitioner within 30 days of discharge.</p> <p>Numerator and Denominator: Utilize HEDIS 2009 specifications for the measure “Follow-Up After Hospitalization for Mental Illness”</p> <p>Data Source: Claims and Enrollment.</p>	
<b>Standard</b>	<b>58% of Enrollees receive follow-up treatment within 7 days of discharge</b> <b>76% of Enrollees receive follow-up treatment within 30 days of discharge</b>

<p>6. <u>Quality of Care: Follow-up After Hospitalization for Substance Abuse Treatment</u>  60% of Enrollees discharged from ASAM Levels III.5 and III.3 will receive a follow-up substance abuse service within 7 days of discharge</p> <p>Numerator: The number of Enrollees discharged from ASAM Levels III.5 and III.3 who received a follow-up substance abuse service reimbursed by the Contractor within 7 days (as documented in the Contractor’s claim system) of discharge.</p> <p>Denominator: The number of Enrollees discharged from ASAM Levels III.5 and III.3.</p> <p>Data Source: Authorizations and Claims.</p>	
<b>Standard</b>	<b>70% of Enrollees receive follow-up treatment within 7 days of discharge</b>

<p>7. <u>Quality of Care: Treatment of the Dually Diagnosed</u>  The Contractor shall increase the percentage of dually diagnosed Enrollees discharged from inpatient substance abuse and mental health treatment settings such that at least 25% of discharged Enrollees receive both substance abuse and mental health services within 7 days of discharge, and at least 50% of discharged Enrollees receive both substance abuse and mental health services within 30 working days of discharge</p> <p>Numerator: Dually diagnosed Enrollees discharged from either an inpatient substance abuse or a mental health treatment setting who received both substance abuse and mental health services within 7 and 30 days of discharge. Enrollees with both Medicaid and Medicare are excluded.</p> <p>Denominator: Dually diagnosed Enrollees discharged from either an inpatient substance abuse or a mental health treatment setting. Enrollees with both Medicaid and Medicare are excluded.</p> <p>Data Source: Authorizations, ICM Database, Claims Data.</p>	
<b>Standard</b>	<b>25% receive MH and SA treatment follow-up within 7 days</b> <b>50% receive MH and SA treatment follow-up within 30 days</b>

8. Network Management

The Contractor shall fully implement, to the Departments' satisfaction, the provider profile reporting and related provider network management requirements prescribed in Section 5C.2-5 of the RFP no later than May 31, 2010.

Data Source: Contractor Documentation of Profile Reports Design and Production and of High-Volume Provider Meetings and Goal Setting.

**Standard**

**Full implementation of the provider profile reporting and related provider network management requirements prescribed in Section 5C.5 of the RFP**

**MEDICAID PERFORMANCE INDICATORS  
WITH FINANCIAL DISINCENTIVES  
for the  
IOWA PLAN FOR BEHAVIORAL HEALTH  
for  
CONTRACT PERIOD #1  
July 1, 2009 – June 30, 2010**

The Contractor shall provide to the Departments a monthly written report on all performance indicators to which financial disincentives have been attached. These indicators will be reassessed annually by the Departments and the Iowa Plan Advisory Committee and may be modified annually at the Departments’ discretion. Each indicator should be reported with either monthly or quarterly measurement (as specified) and with a contract year-to-date measurement. For performance indicators that utilize HEDIS specifications, the Contractor shall also report national Medicaid HEDIS 75<sup>th</sup> and 90<sup>th</sup> percentile rates for the indicator, using the most recently reported NCQA data, for comparison purposes.

The measurement specifications for each performance indicator shall be defined in detail in a methodology appendix attached to each report. The measurement specifications shall be reviewed and approved in writing by the Departments no later than 60 days after the Contract Operational Start Date.

The initial review period shall begin July 1, 2009, and end June 30, 2010. Disincentives shall be assessed solely at the discretion of the Department of Human Services. The Departments shall take whatever steps they deem appropriate to validate all information provided by the Contractor, including auditing Contactor measurement processes and data.

1. <u>Consumer Involvement</u> New Enrollee information, including a list of network providers, will be mailed to each new Enrollee in the Iowa Plan within 5 working days after the first time his or her name is provided to the Contractor.	
When the name of a new Iowa Plan Enrollee is provided to the Contractor, the Contractor shall mail required new Enrollee information on Iowa Plan services within 5 working days. The standard shall be met for 95% of Enrollees, and in no case shall more than 10 working days elapse before all new Enrollees are mailed enrollment information.	
Data Source: Manual Tracking System.	
<b>Standard</b>	<b>95% within 5 working days 100% within 10 working days</b>

2. Quality of Care: Mental Health Discharge Plan

A discharge plan shall be documented on the day of discharge for 95% of Enrollees being discharged from the following mental health settings: inpatient, partial hospitalization, and day treatment. The discharge plan shall include, at a minimum: 1) the next appointment(s) and/or place of care, 2) medications (if applicable), 3) emergency contact numbers, and 4) if applicable, restrictions on activities and when the Enrollee can return to work or school, including the school setting.

Numerator: The number of Enrollees\* who have been discharged from mental health inpatient, mental health partial hospitalization, and mental health day treatment for whom a discharge plan was documented in the record on the day of discharge.

Denominator: The number of Enrollees\* discharged from mental health inpatient, mental health partial hospitalization, and mental health day treatment settings.

Note: This measure excludes Enrollees who left treatment against medical advice.

\*Numerator and Denominator numbers are based solely on the number of record reviews completed during the measurement period.

Data Source: Retrospective Chart Reviews.

**Standard**

**95% or more with documented discharge plan at discharge**

3. Quality of Care: Discharge to Homeless or Emergency Shelter

The percentage of Enrollees under the age of 18 discharged from a mental health inpatient setting to a homeless or emergency shelter shall not exceed 1.0% of all mental health inpatient discharges of children under the age of 18.

Numerator: The number of Enrollees under the age of 18 who were transferred to a homeless or emergency shelter upon discharge from mental health inpatient care.

Denominator: The number of Enrollees under the age of 18 who were discharged from mental health inpatient care.

Note: Enrollees may be excluded if discharged upon the signed recommendation of a DHS or JCS worker.

Data Source: Authorizations.

**Standard**

**≤ 1.0% of all MH discharges of children < 18**

<p>4. <u>Quality of Care: Follow-up Following Non-Authorization of Inpatient Admission</u>  95% of Enrollees who received services in an emergency room and for whom inpatient care was requested but not authorized shall have a follow-up contact within 3 business days of the date the Contractor is notified of the ER service.</p> <p>Numerator: The number of Enrollees who were served in an emergency room, for whom inpatient care was requested and denied, and who received a documented follow-up contact within 3 business days of the date the Contractor was notified of the emergency room service.</p> <p>Denominator: The number of Enrollees who were served in an emergency room, for whom inpatient care was requested and denied.</p> <p>Note: Documented follow-up may include treatment at a 24-hour setting to which the Member returned or was admitted following the ER presentation. In addition, documented follow-up includes Contractor’s attempt to reach the Enrollee telephonically for each 24-hour period up to 3 business days and a subsequent letter to the Member within 3 business days if the Enrollee could not be reached telephonically.</p> <p>Data Source: ER Tracking System.</p>	
<b>Standard</b>	<b>Follow-up contact with 95% or more within 3 business days</b>

<p>5. <u>Quality of Care: Participation in Joint Treatment Planning Conferences</u>  The Contractor shall arrange or participate in at least 20 Joint Treatment Planning conferences per month, and 450 per year.</p> <p>The number of times during the contract period in which staff representing the Contractor participated in prescheduled conference calls or face-to-face meetings in which persons authorized to commit funds from at least one other funding stream worked w/or on behalf of an Enrollee to design or revise a treatment plan.</p> <p>Data Source: JTP Tracking System.</p>	
<b>Standard</b>	<b>Arrangement or Participation in at least 20 JTTC per month, and 450 or more per year</b>

<p>6. <u>Quality of Care: Follow-up After Hospitalization for Substance Abuse Treatment</u>  At least 63% of Enrollees discharged from 24-hour substance abuse services (excluding Level III.1 – Halfway House) receive a follow-up substance abuse service within 30 days of discharge.</p> <p>Numerator: The number of Enrollees discharged from 24-hour substance abuse services (excluding Level III.1 – Halfway House) who received a follow-up substance abuse service reimbursed by the Contractor within 30 days of discharge (as documented in the Contractor’s claim system).</p> <p>Denominator: The number of Enrollees discharged from 24-hour substance abuse services (excluding Level III.1 – Halfway House).</p> <p>Data Source: Authorizations and Claims.</p>	
<b>Standard</b>	<b>63% receive follow-up SA service within 30 days of discharge</b>

<p>7. <u>Quality of Care: Substance Abuse Treatment Discharge Plan</u>  A discharge plan shall be documented on the day of discharge for 95% of Enrollees being discharged from a substance abuse ASAM level III.7, III.5, and III.3 setting.</p> <p>Numerator: The number of Enrollees* who have been discharged from a substance abuse ASAM level III.7, III.5, and III.3 setting for whom a discharge plan was documented in the record on the day of discharge.</p> <p>Denominator: The number of Enrollees* discharged from a substance abuse ASAM level III.7, III.5, and III.3 setting.</p> <p>Note: This measurement excludes Enrollees who left treatment against medical advice. This measure may be done based on a random sample of record audits.</p> <p>*Numerator and Denominator numbers are based solely on the number of record reviews completed during the measurement period.</p> <p>Data Source: Retrospective Chart Reviews.</p>	
<b>Standard</b>	<b>95% or more with discharge plan at discharge</b>

<p>8. <u>Administrative Accountability: Timely Care Reviews</u>  95% of care reviews will be resolved within 14 days.</p> <p>Numerator: The number of care reviews that are resolved and a letter sent to the provider or Enrollee within 14 days of receipt of the care review request and all associated paperwork.</p> <p>Denominator: The number of care reviews resolved.</p> <p>Note: A care review is defined as a request for a review of a Contractor clinical decision. Only Level I and Level II care reviews are included for the measurement of this indicator.</p> <p>Data Source: Care Review Tracking System.</p>	
<b>Standard</b>	<b>95% or more resolved within 14 days</b>

<p>9. <u>Claims Payment</u>          Medicaid claims shall be paid or denied within the following time periods:</p> <ul style="list-style-type: none"> <li>• 85% within 12 calendar days</li> <li>• 90% within 30 calendar days</li> <li>• 100% within 90 calendar days</li> </ul> <p>Times shall be calculated from the date the claim is received by the Contractor until the date the check or denial letter is mailed to the provider.</p> <p>Data Source: Claims.</p>	
<b>Standard</b>	<b>85% within 12 calendar days</b> <b>90% within 30 calendar days</b> <b>100% within 90 calendar days</b>

<p>10. <u>Appeal Reviews</u>          95% of appeals will be resolved as expeditiously as the Enrollee’s health condition requires and within 14 calendar days from the date the Contractor received the appeal, other than in instances in which the Enrollee has requested, or DHS has approved, an extension. 100% must be resolved within 45 calendar days from the date the Contractor received the appeal, even in the event of an extension.</p> <p>In the event of an extension, 95% of the time the Contractor shall resolve the appeal within the additional 14-calendar-day period, and, in the case of a DHS-approved extension, give the Enrollee written notice of the reason for the decision to extend the timeframe.</p> <p>Data Source: Appeal Tracking System.</p>	
<b>Standard</b>	<b>95% appeals resolved within 14 calendar days</b> <b>100% appeals resolved within 45 calendar days</b> <b>95% of extended reviews resolved within 14 calendar days from the end of the initial 14-day period</b>

<p>11. <u>Expedited Appeal Reviews</u>          95% of expedited appeals will be resolved as expeditiously as the Enrollee’s health condition requires and within 24 hours from the date the Contractor received the appeal, other than in instances in which the Enrollee has requested, or DHS has approved, an extension.</p> <p>In the event of an extension, 95% of the time the Contractor shall resolve the appeal within 14 calendar days from the end of the 24-hour period, and, in the case of a DHS-approved extension, give the Enrollee written notice of the reason for the decision to extend the timeframe.</p> <p>Data Source: Appeal Tracking System.</p>	
<b>Standard</b>	<b>95% appeals resolved within 24 hours of receipt</b> <b>100% appeals resolved within 48 hours of receipt</b> <b>95% of extended reviews resolved within 14 calendar days from the end of the 24-hour period</b>

12. Grievance Reviews

95% of grievances will be resolved as expeditiously as the Enrollee's health condition requires and within 14 days from the date the Contractor received all information necessary to resolve the grievance, and 100% must be resolved within 30 calendar days of the receipt of all required documentation.

Data Source: Grievance Tracking System.

**Standard**

**95% grievances resolved within 14 days, 100% resolved within 30 days**

13. Network Management

Credentialing of all Iowa Plan providers applying for network provider status shall be completed as follows: 85% within 30 days; 100% within 60 days.

Completion time shall be tracked from the time all required paperwork is provided to the Contractor until the time a written communication is mailed or faxed to the provider notifying them of the Contractor's determination.

Data Source: Credentialing Tracking System.

**Standard**

**85% credentialed within 30 days, 100% within 60 days**

14. Network Management

Revisions to the Provider Manual shall be distributed to all network providers at least 30 calendar days prior to the effective date of the revisions.

Mailing dates of provider manual material shall be sent at least 30 calendar days prior to the effective date of material contained in the mailing. This measure applies to all information sent for all network providers.

Note: With approval from the Departments, the time period preceding the effective date of a change may be less than 30 days if the change confers a benefit on providers or those served through the Iowa Plan.

Data Source: Manual.

**Standard**

**Distributed 30 days or more prior to effective date**

**IDPH PERFORMANCE INDICATORS  
CARRYING LIQUIDATED DAMAGES  
for the**

**IOWA PLAN FOR BEHAVIORAL HEALTH  
for**

**CONTRACT PERIOD #1  
July 1, 2009 – June 30, 2010**

**The Contractor shall provide to the Departments a monthly written report on all performance indicators to which disincentives have been attached. These indicators will be reassessed annually by IDPH and the Iowa Plan Advisory Committee and may be modified annually at IDPH’s discretion. Each indicator should be reported with either monthly or quarterly measures (as specified) and with a contract year-to-date measure.**

**The measurement specifications for each performance indicator shall be defined in detail in a methodology appendix attached to each report. The measurement specifications shall be reviewed and approved in writing by the Depts no later than 60 days after the Contract Operational Start Date.**

**For the attainment of each designated financial incentive performance indicator for the time period of July 1, 2009, through June 30, 2010, the Contractor shall be paid the amount the Department of Public Health has associated with each indicator. The Department of Public Health shall be solely responsible for determining whether or not the Contractor has met the required level of performance. IDPH shall validate all information provided by the Contractor prior to issuing incentive payments.**

1. <u>Minimum Number Served:</u>	
The Contractor shall at least serve the minimum number of unduplicated IDPH Participants.	
Methodology: Number of unduplicated IDPH Participants in accordance with contract condition with IDPH source of payment.	
Data Source: Iowa Service Management and Report Tool (ISMART).	
<b>Standard</b>	<b>Minimum unduplicated number of IDPH Participants for 7/1/09 – 6/30/10: 19,154</b>

2. <u>Use of Service Necessity Criteria:</u>	
90% of all retrospectively reviewed records for IDPH Participants will document the appropriate use of ASAM PPC2-R or the PMIC Admission and Continued Stay criteria, whichever is applicable, by network providers.	
Date Source: Provider Records.	
<b>Standard</b>	<b>90% appropriate use of service necessity criteria</b>

3. <u>Network Development:</u>	
IDPH-specific performance measures for the IDPH Participant provider network will be incorporated into all IDPH provider contracts by July 1, 2009.	
Date Source: Contractor Provider Contracts.	
<b>Standard</b>	<b>100% of all contracts</b>

4. <u>Timely Receipt of Care</u>	
90% of IDPH Participants who request and are in need of treatment for IV drug abuse are admitted to the IV drug treatment program not later than 14 days after making the request for admission, or 120 days after the date of the request if no program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual not later than 48 hours after such request.	
Numerator: The number of IDPH Participants who request and are in need of IV drug abuse treatment and who receive treatment within 14 days of making the request <i>when program capacity exists at the time of the request.</i>	
Denominator: The number of IDPH Participants who request and are in need of IV drug abuse treatment <i>when program capacity exists at the time of the request.</i>	
Numerator: The number of IDPH Participants who request and are in need of IV drug abuse treatment and who receive treatment within 120 days of making the request <i>when program capacity does <u>not</u> exist at the time of the request.</i>	
Denominator: The number of IDPH Participants who request and are in need of IV drug abuse treatment <i>when program capacity does <u>not</u> exist at the time of the request</i>	
Data Source: Provider Records.	
<b>Standard</b>	<b>90% or more in treatment within 14 days of request (capacity exists) 90% or more in treatment within 120 days of request (capacity doesn't exist)</b>

5. <u>Client Mix</u> The Contractor shall maintain the appropriate percentages of IDPH Participant client mix.  Methodology: Percent of IDPH Participants in accordance with contract conditions with IDPH source of payment.	
	<b>Standard</b>
<b>Women:</b>	<b>27.8%</b>
<b>Pregnant:</b>	<b>4.3%</b>
<b>Criminal justice referral source:</b>	<b>63.9%</b>
<b>Unemployed:</b>	<b>30.7%</b>
<b>Race other than white:</b>	<b>12.5%</b>
<b>Prior substance abuse treatment:</b>	<b>41.3%</b>
<b>Monthly taxable income under \$1000:</b>	<b>65%</b>

6. <u>Wait Time</u> The Contractor shall ensure that 75% of IDPH Participants recommended for and admitted to an Iowa Plan level of care are admitted within 5 calendar days of the assessment date.  Data Source: I-SMART	
<b>Standard</b>	<b>75% of IDPH Participants recommended for and admitted to an Iowa Plan level of care, are admitted within 5 calendar days of the assessment date.</b>

**PERFORMANCE INDICATORS MONITORING ONLY**

for the

**IOWA PLAN FOR BEHAVIORAL HEALTH**

for

**CONTRACT PERIOD #1**

**July 1, 2009 – June 30, 2010**

The Contractor shall provide to the Departments a monthly written report on all monitoring-only performance indicators. These indicators will be reassessed annually by the Departments and the Iowa Plan Advisory Committee and may be modified annually at the Departments’ discretion. Each indicator should be reported with either monthly or quarterly measurements (as specified) and with a contract year-to-date measurement. For performance indicators that utilize HEDIS specifications, the Contractor shall also report national Medicaid HEDIS 75<sup>th</sup> and 90<sup>th</sup> percentile rates for the indicator, using the most recently reported NCQA data, for comparison purposes.

The measurement specifications for each performance indicator shall be defined in detail in a methodology appendix attached to each report. The measurement specifications shall be reviewed and approved in writing by the Departments no later than 60 days after the Contract Operational Start Date.

**Consumer Involvement and Quality of Life**

1. The Contractor shall conduct an annual Iowa Plan Eligible Person experience of care survey that assesses experience of care with mental health and substance abuse services for both child and adult populations.	
<ul style="list-style-type: none"> <li>• The survey instruments shall be standardized, validated tools approved by the Departments and shall address areas recommended by the Recovery Advisory Committee.</li> <li>• The number of surveys distributed shall represent at least the minimum number required to comprise a statistically valid sample of those Iowa Plan Eligible Persons who have accessed services in the past six months.</li> <li>• The acceptable response rate shall be determined by DHS and IDPH, in consultation with the Contractor.</li> <li>• Results shall be reported to Iowa Plan Eligible Persons as well as corrective actions implemented in response to findings of the surveys.</li> </ul>	
<b>Standard</b>	<b>Consumer Surveys conducted twice per contract year and results reported</b>

2. Based on the annual Eligible Person experience of care survey, 85% of respondents indicate satisfaction with services provided by the Iowa Plan.	
<b>Standard</b>	<b>85% or more respondents express satisfaction</b>

**Access and Array**

3. The number of Iowa Plan Enrollees, reported overall and separately for children and adults, for whom wraparound and rehabilitation and support services were provided during the month, shall be 1% or more for the aggregate Enrollee population.	
Data Source: Paid Claims Data.	
<b>Standard</b>	<b>1% or more received wraparound, rehab, and support services</b>

4. The Contractor shall demonstrate compliance with the following access standards: Enrollees with emergency needs within 15 minutes of presentation or telephone contact with Contractor or provider; Enrollees with urgent, non-emergency needs seen within 1 hour of presentation at a service delivery site or within 24 hours of telephone contact with Contractor or provider; Enrollees with persistent symptoms within 48 hours of reporting symptoms; Enrollees with the need for routine services within 4 weeks of the request for an appointment. (Reported quarterly as YTD)	
<b>Standard</b>	<p><b><u>Emergency:</u> within 15 minutes of presentation or telephone contact</b></p> <p><b><u>Urgent:</u> within 1 hour of presentation or within 24 hours of telephone contact</b></p> <p><b><u>Persistent Symptoms:</u> within 48 hours of reporting symptoms</b></p> <p><b><u>Routine Services:</u> within 4 weeks of request for appointment</b></p>

5. The Contractor shall demonstrate compliance with geographical standards of access (Urban--inpatient 30 minutes; outpatient 30 minutes. Rural--inpatient 45 minutes; outpatient 30 minutes) <u>by county</u> , and separately for the following mental health and substance abuse services: Inpatient mental health facility: adult services Inpatient mental health facility: child and adolescent services Inpatient substance abuse facility: adult services Inpatient substance abuse facility: child and adolescent services Intensive mental health outpatient program and partial hospitalization program: adult services Intensive mental health outpatient program and partial hospitalization program: child and adolescent services Outpatient mental health provider (by psychiatrist, psychologist and master of social work & other master level): adult services Outpatient mental health provider (by psychiatrist, psychologist and master of social work & other master level): child and adolescent services Outpatient substance abuse provider: adult services Outpatient substance abuse provider: child and adolescent services	
<b>Standard</b>	<p><b><u>Urban:</u> Inpatient 30 minutes; Intensive mental health outpatient program and partial hospitalization program 30 minutes; Outpatient 30 minutes</b></p> <p><b><u>Rural:</u> Inpatient 45 minutes; Intensive mental health outpatient program and partial hospitalization program 45 minutes; Outpatient 30 miles</b></p>

**Access and Array (continued)**

6. The Contractor shall provide services to at least 16.0% of Iowa Plan Enrollees, reporting the unduplicated number and the percentage of Enrollees in the Iowa Plan receiving services, broken out by MH-only, SA-only, and both MH and SA.

Numerator: The unduplicated number of Enrollees receiving at least once service reimbursed by the Contractor.

Denominator: Unduplicated number of Enrollees.

Also report using the following stratifications consistent with the definitions of the following modified HEDIS 2009 measures: “Identification of Alcohol and Other Drug Dependence Treatment” and “Mental Health Utilization”

- Mental health, substance abuse, and combined
- Mental health and substance abuse (Enrollees receiving both)
- Mental health services: inpatient, intensive outpatient or partial hospitalization, outpatient or emergency department, other [Iowa Plan-specific services to be defined with the Departments]
  - Ages 0-12, 13-17, 18-64 and 65 and older
- Substance abuse services: inpatient, residential (III.7 and III.5/III.3), outpatient or emergency department, other [Iowa Plan-specific services to be defined with the Departments]
  - Ages 0-12, 13-17, 18-64 and 65 and older

Data Source: Claims and Enrollment.

<b>Standard</b>	<b>16.0% or more receive services Other Measures – Monitor Only</b>
-----------------	---

**Utilization**

<p>7. The Contractor shall report on monthly, year-to-date and prior years’ Enrollee admissions and days per thousand for the following services:</p> <ul style="list-style-type: none"> <li>• Mental health services: inpatient, sub-acute, intensive outpatient or partial hospitalization (visits per thousand rather than days), other [Iowa Plan-specific services to be defined with the Departments] <ul style="list-style-type: none"> <li>• Ages 0-12, 13-17, 18-64 and 65 and older</li> </ul> </li> <li>• Substance abuse services: inpatient (IV and IVD), residential (III.7 and III.5/III.3), PMIC, other [Iowa Plan-specific services to be defined with the Departments] <ul style="list-style-type: none"> <li>• Ages 0-12, 13-17, 18-64 and 65 and older</li> </ul> </li> </ul> <p>The Contractor shall report on monthly, year-to-date and prior years’ Enrollees visits per thousand for the following services:</p> <ul style="list-style-type: none"> <li>• Mental health services: outpatient, emergency department, other [Iowa Plan-specific services to be defined with the Departments] <ul style="list-style-type: none"> <li>• Ages 0-12, 13-17, 18-64 and 65 and older</li> </ul> </li> <li>• Substance abuse services: outpatient, emergency department, other [Iowa Plan-specific services to be defined with the Departments] <ul style="list-style-type: none"> <li>• Ages 0-12, 13-17, 18-64 and 65 and older</li> </ul> </li> </ul>	
<b>Standard</b>	<b>Monitor Only</b>

<p>8. The Contractor shall report the number and percentage of “High Need” Enrollees receiving services, stratifying by child and adult.</p>	
<b>Standard</b>	<b>Monitor Only</b>

**Appropriateness**

<p>9. The average length of stay for Enrollee mental health inpatient services for any given month shall not exceed the ALOS previously under FFS (12.0 days) and shall not fall below 5.0 days for acute services unless explicitly agreed upon by the Departments with the Contractor.</p>	
<b>Standard</b>	<b>ALOS less than 12 days, but not less than 5 days</b>

**Integration and Interface**

<p>10. The Contractor shall identify and provide Intensive Clinical Management services to Enrollees meeting the Contractor’s criteria, reporting on the number and percentage of Enrollees actively served, and shall ensure that such Enrollees receive Joint Treatment Planning services following their identification.</p>	
<b>Standard</b>	<b>100% of ICM-eligible Enrollees receive JTTPS upon identification</b>

**Provider Satisfaction**

<p>11. The Contractor shall conduct an annual provider survey in which at least 80% of responding network providers indicate satisfaction, and shall report key findings to the Departments, including identified opportunities for improvement.</p>	
<b>Standard</b>	<b>80% or more providers satisfied</b>

**Quality of Care**

**12. Quality of Care: Follow-up Care Post-inpatient Stay for Enrollees with Co-Occurring Mental Health and Substance Abuse Conditions**

The Contractor shall identify Enrollees with active symptoms of both mental health and substance abuse admitted to an inpatient level of care or to a SA residential level of care (excluding Halfway House) and track the follow-up services received within 7 and 30 days that were paid by the Iowa Plan. Eligibles with both Medicaid and Medicare will be excluded. A sample report format is as follows:

# of Co-Occurring Discharges	Jul 09	Aug 09	Sept 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10	Apr 10	May 10	June 10
MH Inpatient												
MH Sub-acute												
# rec'd follow-up services												
MH services only												
SA services only												
MH & SA services												
No services												
% rec'd follow-up services												
MH services only												
SA services only												
MH & SA services												
No services												

# of Co-Occurring Discharges	Jul 09	Aug 09	Sept 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10	Apr 10	May 10	June 10
SA IP												
SA III.7												
SA III.5/III.3												
# rec'd follow-up services												
MH services only												
SA services only												
MH & SA services												
No services												
% rec'd follow-up services												
MH services only												
SA services only												
MH & SA services												
No services												

13. Quality of Care: Involuntary Hospitalization

The percent of involuntary admissions for mental health treatment to 24-hour inpatient settings shall not exceed 10% of all child admissions and 5% of all adult admissions.

Numerator: The number of Enrollees involuntarily admitted for mental health treatment to all inpatient settings regardless of whether the Contractor authorized or is funding the hospitalization. Calculate the measure two ways: once excluding Enrollees involuntarily admitted to the State Mental Health Institutes, and once including Enrollees involuntarily admitted to the State Mental Health Institutes.

Denominator: The number of Enrollees admitted for mental health treatment to all inpatient settings regardless of whether the Contractor is authorizing or is funding the hospitalization. Calculate the measure two ways: once excluding Enrollees involuntarily admitted to the State Mental Health Institutes, and once including Enrollees involuntarily admitted to the State Mental Health Institutes.

Data Source: Authorizations.

<b>Standard</b>	<p>≤ 1.5% child admissions are involuntary (excluding court-ordered SMHI admissions)                  ≤ 1.5% adult admissions are involuntary (excluding court-ordered SMHI admissions)                  ≤ TBD<sup>5</sup>% child admissions are involuntary (including court-ordered SMHI admissions)                  ≤ TBD% adult admissions are involuntary (including court-ordered SMHI admissions)</p>
-----------------	---

14. Quality of Care: Inpatient Substance Abuse Treatment Readmission

Rate of substance inpatient readmission by Enrollee children and adults at 7, 30, and 90 days will be no higher than the following:

7-day readmission	30-day readmission	90-day readmission
children: 3.5%	children: 9%	children: 17%
adults: 5%	adults: 13%	adults: 24%

Numerator: The number of Iowa Plan Enrollee inpatient readmissions within 7/30/90 days of discharge.

Denominator: The number of Iowa Plan Enrollee inpatient discharges that occur within the reporting periods, less 30 days.

Data Source: Claims.

<b>Standard</b>	<b>7-day readmission 12% or less</b>	<b>30-day readmission 30% or less</b>	<b>90-day readmission 45% or less</b>
-----------------	--	---	---

<sup>5</sup> The standard will be established by the Departments after reviewing and considering measurement data.

15. Quality of Care: Readmission for Non-Inpatient Services

Rate of readmission by Iowa Plan eligible children and adults at 7, 30, and 90 days for all other residential and intensive community-based programs for which there are at least 30 discharges per month.

Numerator: The number of readmissions within 7/30/90 days of discharge.

Denominator: The number of discharges that occur within the reporting periods, less 30 days.

Data Source: Claims.

<b>Standard</b>	<b>7-day readmission Monitor Only</b>	<b>30-day readmission Monitor Only</b>	<b>90-day readmission Monitor Only</b>
-----------------	---	--	--

16. Quality of Care: Implementation of Mental Health Inpatient Discharge Plans

94% of all discharge plans written for Enrollees being released from a mental health inpatient hospitalization shall be implemented. (Minimum of 185 charts).

Numerator: Number of Enrollees\* who have been discharged from a mental health inpatient setting during the contract period (whether or not the inpatient hospitalization was authorized by the Contractor at the time of discharge) for whom claims data or provider records reflect implementation of the follow-up plan written with the Enrollee at the time of discharge.

Denominator: Number of Enrollees\* who have been discharged from a mental health inpatient setting during the contract period (whether or not the inpatient hospitalization was authorized by the Contractor at the time of discharge).

\*Numerator and Denominator numbers are based solely on the number of record reviews completed during the measurement period.

DHS has the right to approve the sampling methodology and review criteria should the Contractor utilize provider records for this measurement.

Data Source: Chart Review.

<b>Standard</b>	<b>94% or more of all discharge plans are implemented Minimum of 185 charts</b>
-----------------	---

17. Quality of Care: Follow-up After Hospitalization for Mental Illness (II)

90% of Enrollees discharged from mental health inpatient care will receive other treatment services within 7 days of discharge.

Numerator and Denominator: Utilize HEDIS 2009 specifications for the measure “Follow-Up After Hospitalization for Mental Illness”, but supplement numerator counts with recorded direct personal contact follow-up with a Contractor Intensive Care Manager

Note: Individuals not enrolled in the Iowa Plan at the time of discharge, including those individuals who later gain Iowa Plan enrollment for the month of service, are excluded. Enrollees determined to have been admitted for a non-Iowa Plan diagnosis are also excluded.

Data Source: Claims and Contractor Care Management System.

<b>Standard</b>	<b>90% of Enrollees receive follow-up treatment or Intensive Care Manager contact within 7 days of discharge</b>
-----------------	--

18. Quality of Care: Follow-up After 24-Hour Substance Abuse Treatment

Eligible Persons discharged from ASAM Levels III.5/III.3, III.7, IV (Enrollees only) and PMIC (Enrollees only) will receive a follow-up substance abuse service within 7 and 30 days of discharge

Numerator: The number of Eligible Persons discharged from the specified SA program who received a follow-up substance abuse service reimbursed by the Contractor within 7 days (as documented in the Contractor’s claim system) of discharge.

Denominator: The number of Eligible Persons discharged from the specified SA program.

Data Source: Authorizations and Claims.

<b>Standard</b>	<p><b>42% of participants receive follow-up SA treatment within 7 days of Level IV discharge</b>  <b>72% of participants receive follow-up SA treatment within 7 days of Level III.7 discharge</b>  <b>70% of participants receive follow-up SA treatment within 7 days of Level III.5/III.3 discharge</b>  <b>59% of participants receive follow-up SA treatment within 7 days of PMIC discharge</b></p> <p><b>52% of participants receive follow-up SA treatment within 30 days of Level IV discharge</b>  <b>77% of participants receive follow-up SA treatment within 30 days of Level III.7 discharge</b>  <b>76% of participants receive follow-up SA treatment within 30 days of Level III.5/III.3 discharge</b>  <b>70% of participants receive follow-up SA treatment within 30 days of PMIC discharge</b></p>
-----------------	---

19. Quality of Care: Antidepressant Medication Management

48% of Enrollees 18 years of age and older who were newly diagnosed with and treated for a new episode of major depression remained on antidepressant medication for at least 84 days (12 weeks)

32% of Enrollees 18 years of age and older who were newly diagnosed with and treated for a new episode of major depression remained on an antidepressant medication for at least 180 days (six months)

Numerator and Denominator: Utilize HEDIS 2009 specifications for the measure “Antidepressant Medication Management”

Data Source: Claims and Enrollment.

\* The Contractor shall be responsible for generating these measures only after DHS has provided the Contractor with the pharmacy claims data necessary to calculate these measures.

<b>Standard</b>	<b>48% of adult Enrollees remained on antidepressant medication for at least 84 days 32% of adult Enrollees remained on antidepressant medication for at least 180 days</b>
-----------------	---

20. Quality of Care: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

50% of Enrollees with a new episode of alcohol or other drug dependence (AOD) initiate treatment through an AOD inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis

15% of Enrollees with a new episode of alcohol or other drug dependence (AOD) who initiated treatment had two or more additional services with an AOD diagnosis within 30 days of the initiation visit

Numerators and Denominators: Utilize HEDIS 2009 specifications for the measure “Initiation and Engagement of Alcohol and Other Drug Dependence Treatment”

Data Source: Claims.

<b>Standard</b>	<b>50% of Enrollees initiate recommended treatment within 14 days of the diagnosis 50% of Enrollees participate in at least two sessions of recommended services within 30 days of the assessment.</b>
-----------------	--

21. Quality of Care: Outcome Measurement – Adult Mental Health

The Contractor shall support High Need adult Enrollees such that at least 50% of adults receiving Targeted Case Management (TCM) services report improvement in functioning in terms of Multnomah Community Ability Scale (MCAS) or other DHS-approved standardized adult mental health assessment tool score when compared to the prior year.

Numerator: High Need adult Enrollees receiving TCM services, enrolled continuously across two successive, annual measurement periods, who reported an improvement in functioning based on functional assessment tool score.

Denominator: High Need adult Enrollees receiving TCM services who were enrolled continuously across two successive, annual measurement periods,

Data Source: Eligibility Data and MCAS (or other Department-approved assessment tool) Data.

**Standard**

**50% report improved functioning**

22. Quality of Care: Outcome Measurement – Child and Adolescent Mental Health

The Contractor shall support High Need child and adolescent Enrollees such that at least 60% of High Need children and adolescents experience improvement in functioning in terms of Child and Adolescent Functional Assessment Scale (CAFAS) or other DHS-approved standardized child and adolescent mental health assessment tool score when compared to the prior year.

Numerator: High Need child and adolescent Enrollees, enrolled continuously across two successive annual measurement periods, who experienced an improvement in functioning based on functional assessment tool score.

Denominator: High Need child and adolescent Enrollees who were enrolled continuously across two successive annual measurement periods.

Data Source: Eligibility Data and CFAS (or other Department-approved assessment tool) Data.

**Standard**

**60% experience improved functioning**

23. Quality of Care: Outcome Measurement – Adult Substance Abuse

The Contractor shall support High Need adult Enrollees such that at least 60% of High Need adults who qualify as High Need based on substance abuse service utilization experience improvement in functioning in terms of Departments-approved assessment tool score when compared to the prior year.

Numerator: High Need adult Enrollees who qualify as High Need based on substance abuse service utilization, enrolled continuously across two successive annual measurement periods, who experienced an improvement in functioning based on functional assessment tool score.

Denominator: High Need adult Enrollees who qualify as High Need based on substance abuse service utilization who were enrolled continuously across two successive annual measurement periods.

Data Source: Eligibility Data and Departments-Approved Assessment Tool Data.

<b>Standard</b>	<b>60% experience improved functioning</b>
-----------------	--

24. Quality of Care: Psychotropic Medication Screening

The Contractor shall screen all Enrollees admitted to MH and SA inpatient level of care for psychotropic medication use at admission. If the medication is not considered to be appropriate to the diagnosis/symptoms, interventions will be made with the prescribing doctor.

Methodology: a) count of the number of Enrollees admitted and screened, stratified by MH and SA

b) % of Enrollees admitted who have been screened for psychotropic medication use at admission, stratified by MH and SA

<b>Standard</b>	<b>Monitor Only</b>
-----------------	---------------------

25. Quality of Care: PCP Coordination

The Contractor shall measure the frequency with which network providers communicate with PCPs regarding Enrollees whom they are both treating.

Numerator: The number of randomly sampled network treatment records reviewed during the reporting period where communication between the network provider and PCP is documented to have occurred.

Denominator: The number of treatment records that were reviewed during the reporting period.

Data Source: Sampled Network Treatment Records.

<b>Standard</b>	<b>More than 70% of Treatment Record Document Communication to the PCP</b>
-----------------	--

26. Quality of Care: Return to the Community for Children in PMICS

The Contractor shall measure its performance in helping children return to the community by tracking average Iowa Plan Enrollee length of stay in PMICs for mental health services.

Numerator: The number of days of mental health inpatient stay in PMICs by Iowa Plan child and adolescent Enrollees

Denominator: The number of Iowa Plan child and adolescent Enrollees with a PMIC mental health inpatient stay

Data Source: Tracking Records.

**Standard**

**Monitor Only**