

Iowa Department of Human Services

REQUEST FOR PROPOSAL (RFP)

Takeover of Core Medicaid Management Information System Services

MED-18-004

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# *RFP Purpose.*

The purpose of this RFP is to solicit proposals that will enable the Department of Human Services (Agency) to select the most qualified contractor to take over Fee for Service claims operations and systems maintenance as well as encounter data collection and supports, federal and state reporting, mailroom operations, and related activities for Iowa’s Medicaid Management Information System (MMIS).

# *Duration of Contract.*

The Agency anticipates executing a contract that will have an initial 4 year contract term with the ability to extend the contract for 5additional 1**-**year terms. The Agency will have the sole discretion to extend the contract.

Procurement Timetable

There are no exceptions to any deadlines for the bidder; however, the Agency reserves the right to change the dates. Times provided are in Central Time.

|  |  |
| --- | --- |
| **Event** | **Date** |
| Agency Issues RFP Notice to Targeted Small Business Website (48 hours): | November 17, 2017 |
| Agency Issues RFP to Bid Opportunities Website | November 21, 2017 |
| Bidder Letter of Intent to Bid Due By | December 13, 2017  4:00 p.m. |
| Bidder Written Questions Due By | Date and Time for First Round of Questions: December 13, 2017 4:00 p.m.  Date and Time for Second Round of Questions: January 10, 2018 4:00 p.m.  Date and Time for Third Round of Questions: January 29, 2018 4:00 p.m. |
| Agency Responses to Questions Issued By | Date for First Round of Responses:  December 29, 2017  Date for Second Round of Responses:  January 19, 2018  Date for Third Round of Responses:  February 7, 2018 |
| **Bidder Proposals and any Amendments to Proposals Due By** | **February 20, 2018**  **4:00 p.m.** |
| Agency Announces Apparent Successful Bidder/Notice of Intent to Award | March 14, 2018 |
| Contract Negotiations and Execution of the Contract Completed | April 16, 2018 |
| Anticipated Start Date for Transition Phase | April 16, 2018 |
| Anticipated Start Date for Operations Phase | July 1, 2018 |

Section 1 Background and Scope of Work

1.1 Background.

*Legal Authority*

The Medicaid Management Information System (MMIS) is an integrated group of procedures and computer processing operations (subsystems) developed at the general design level to meet principal objectives. For Title XIX purposes, "systems mechanization" and "mechanized claims processing and information retrieval systems" is identified in section 1903(a)(3) of the Social Security Act (the Act) and defined in regulation at 42 C.F.R. § 433.111. The objectives of this system and its enhancements include the Title XIX program control and administrative costs; service to recipients, providers and inquiries; operations of claims control and computer capabilities; and management reporting for planning and control.

Section 1903(a)(3) of the Act provides for federal financial participation (FFP) in State expenditures for the design, development, or installation of mechanized claims processing and information retrieval systems and for the operation of certain systems. Additional HHS regulations and CMS procedures for implementing these regulations are in 42 C.F.R. part 433; 45 C.F.R. part 75; 45 C.F.R. part 95, subpart F; part 11, State Medicaid Manual; CMS sub-regulatory guidance; and Section 1903(r) of the Act, which imposes certain standards and conditions on mechanized claims processing and information retrieval systems (including eligibility determination systems) in order for these systems to be eligible for Federal funding under section 1903(a) of the Act.

The successful bidder will continue to support a federally-certified MMIS and comply with relevant legal authority and mandates under Health Insurance Portability and Accountability Act (HIPAA) legislation.

*Overview*

The Iowa Department of Human Services (DHS) is the single State entity responsible for administering the Medicaid program in Iowa. The Iowa Medicaid Program reimburses providers for delivery of services to eligible Medicaid recipients under the authority of Title XIX of the Act through enrolled providers and health plans. The Agency operates this program through its business unit, the Iowa Medicaid Enterprise (IME). The Agency is also responsible for the Children’s Health Insurance Program (CHIP – the separate CHIP program is called Healthy and Well Kids in Iowa, or ***hawk-i***).

On April 1, 2016, the IME transitioned to a managed care system, known as IA Health Link.  As a result of this transition the model for service delivery and reimbursement changed from a primarily Fee-for-Service (FFS) model to a risk based Managed Care Organization (MCO) model.  The majority of services are included in this statewide managed care structure, including long-term services and supports (LTSS), behavioral health, and pharmacy. Approximately 92% of all Iowa Medicaid Members are enrolled in an MCO with 8% remaining in FFS. Iowa’s ***hawk-i*** population is served by the same Medicaid MCOs and included in the total MCO population. As directed by Iowa Admin. Code r. 441-86.13, a Third Party Administrator (TPA) manages the ***hawk-i*** program. Beginning July 1, 2019, the Agency intends to disperse the current TPA functions into corresponding contracts listed in *Table 2*, as part of its procurement strategy.

*Iowa Medicaid Coverage Groups and Corresponding Programs*

There are three Iowa Medicaid coverage groups and corresponding programs: IA Health Link, Medicaid Fee-for-Service (FFS), and ***hawk-i***. Information regarding these programs is found at this link: <http://dhs.iowa.gov/sites/default/files/Comm020.pdf>. Please note, the data presented in the link focuses on Medicaid FFS programs.

Most of the Agency’s FFS population either falls into a premium payment coverage group or into a historically exempt population. Furthermore, during the 2017 legislative session it was determined that the Agency will not recognize a three month retroactive eligibility period except for pregnant women (and during the 60-day period beginning on the last day of the pregnancy) and infants under one year of age, for applications filed on or after November 1, 2017. This includes initial applications and applications to add new household members.

**Table 1: Current Iowa Medicaid Population Structure**

|  |  |  |  |
| --- | --- | --- | --- |
| **Eligibility Group** | **August 2017 Enrollment** | **Average Monthly Claims Processed** \* | **Delivery System** |
| IA Health Link  (including ***hawk-i***) | Medicaid 558,980 | 2,230,551\*\* | MCOs |
| ***hawk-i*** 48,118 | 58,056\*\* |
| FFS Medicaid | 54,620 | 248,882 | Agency |
| FFS Dental | 295,097 | 47,899\*\*\* | Agency |
| Dental Wellness | 290,320 | 17,666\*\*\* | PAHPs |
| ***hawk-i*** Dental (including dental-only) | 49,054 | 5,280 (dental claims only) | PAHP |

\*Based on claims processed from September 2016 through August 2017.

\*\*claims processed by line, which can include multiple services.

\*\*\*Due to changes in Dental Wellness program effective July 1, 2017, these figures do not represent claims going forward.

Beginning July 1, 2017, the Agency combined dental benefits for all adult enrollees into one Dental Wellness program, delivered via prepaid ambulatory health plans (PAHPs). In addition, the Agency provides children dental coverage through various packages. Medicaid kids receive comprehensive dental coverage on a FFS basis and ***hawk-i*** children receive dental coverage through a PAHP. ***hawk-i*** also has a dental-only program for children with third-party liability (TPL).

RFP Attachment F contains information on the current Agency environment, systems and applications that provide automated access to and/or support for information within the MMIS, a description of the tools that are in place for the IME system services component contractors, and the common managerial tools all IME Units are expected to use.

*Agency Vision*

The Agency’s goal through this procurement is to add value for Medicaid Members, providers, and other stakeholders, while supporting administration of the Medicaid program.

Additionally, since the transition to managed care, the Agency has refocused its efforts on delivery system reform and oversight of managed care. In this effort, the Agency seeks vendors who will bring strategic solutions, processes, and business operations which can operate within the Agency's culture of continuous process improvement and proactive analysis. The goal of which is to support quality assurance activities that lead to effective oversight of the various delivery systems.

*Medicaid Enterprise Modernization*

On December 4, 2015, CMS published a final rule, “Mechanized Claims Processing and Information Retrieval Systems (90/10),” which became effective January 1, 2016. This final rule revised the conditions and standards state Medicaid IT systems must meet to qualify for enhanced federal funding to better support Medicaid eligibility, enrollment, and delivery systems. This final rule also supported existing requirements for modular systems development. State Medicaid Director (SMD) Letter #s 16-004, 16-009, and 16-010 provided further guidance on this final rule, APD enhanced funding requirements, and modularity. Iowa’s goal is to develop the best overall MMIS strategy to achieve the most cost effective and administratively efficient MMIS modular solutions consistent with the guidance provided above and in the CMS Medicaid IT Supplement (MITS-11-01-V1.0) Enhanced Funding Requirements: Seven Conditions and Standards.

The IME intends to focus on systems and services where improvements are needed and not pursue a full replacement of the existing MMIS. Modular carve-outs will improve the quality, efficiency, and effectiveness of health services delivery and public health programs. Overarching goals for procurement of modular solutions include:

* Procure solutions that support Iowa Medicaid programs and policies.
* Procure solutions from an enterprise perspective, seeking where possible to leverage investments to avoid silos and redundant expenditures and instead maximize the return on investments and seek broader, integrated solutions.
* Procure solutions that employ the “Build Once, Reuse Often” strategy, where application and data strategies and designs will, when feasible, follow a component-based, service-oriented architecture, resulting in solutions being built once, reused often and maintained easily over time.
* Procure solutions that align with the framework of the Medicaid Information Technology Architecture (MITA), in order to promote coordination and enhance prospects for maximizing federal funding and standardize processes.
* Procure solutions that allow the Agency to manage information as a strategic enterprise-wide resource, using best practices in data management, application design, security and integration.

Iowa Approach

After analyzing initial research and factoring in projected state budget constraints, Iowa believes the most cost effective strategy is to incrementally modernize the MMIS and supporting systems.

Short term solution: In order to jumpstart the long-term solution, the first step is to begin modernizing the existing mainframe MMIS and supporting systems in the short term. This would allow the IME the ability to leverage existing investment into mainframe technologies, while incrementally working towards replacement of modules based off a modularity roadmap (to be developed in FFY18/19). The IME will begin integrating ***hawk-i*** (CHIP) system components into the MMIS and supporting Medical Systems in November 2017.

Long term vision: The Iowa OCIO recently released their roadmap for Cloud services. The Agency has begun migrating some services to the cloud, the last phase may be to move PHI. IME is exploring the possibility of utilizing Cloud-based Modular MMIS solutions. This also aligns with guidance received from CMS.

The IME is currently developing a framework based on the following:

1. A takeover of the current MMIS system operations (this RFP);
2. Enhancements to the legacy Medicaid Management Information System (MMIS);
3. Strategic modules carved out of the legacy MMIS over a five to eight year modernization and enhancement period; and
4. Focus on systems and services where improvements are needed and not pursue a full replacement of the existing MMIS.

*Scope of this RFP for Modernizing Existing Mainframe and Supporting Medical Systems*

Decisions on enhancements needed to support modernization of the existing legacy mainframe and supporting medical systems will be finalized over the next several months. Known enhancements are listed below and detailed in RFP Attachment F. Enhancements 1 and 2 below will potentially begin in November 2017 under the current contract. Enhancement 3 and 4 are included in the scope of this MMIS Takeover RFP. Enhancements 5 and 6 will be added to the Contract through the CSR process, and will potentially begin in July 2018.

1. Integration of ***hawk-i*** (CHIP) enrollment functions into MMIS.
2. Transition Managed Health Care functions (exclusion logic and enrollment confirmation based on eligibility) from TXIX systems to MMIS.
3. National Correct Coding Initiative (NCCI) claims editing solution.
4. Electronic Data Interchange (EDI) solution.
5. Integration of remaining ***hawk-i*** (CHIP) functions into MMIS and supporting Medical Systems.
6. MCO passive enrollment.

Major Milestones

* The MMIS takeover involves successful continuation of all systems and services currently provided by the incumbent MMIS vendor, as well as the enhancements included within the Scope of the RFP.
* The successful bidder will be required to maintain the systems and supporting infrastructure (applications, hardware where appropriate, databases, licenses) components currently supporting the existing MMIS.
* Current State of Iowa owned infrastructure for the MMIS will continue to be operated and managed by the State during the transition and any changes will evolve aligned with the Medicaid Enterprise Modernization and Modularity Roadmap.
* Any systems and services replaced by a modular component will be carved out from the MMIS vendor’s oversight and management of such.

Future solicitations under consideration by the Agency as part of the overall efforts to modernize and modularize the Medicaid Enterprise include:

* Enterprise Architecture Roadmap and Strategy Services (EARS) – The EARS vendor will provide the enterprise vision and roadmap for the future modular MMIS. The selected vendor will provide the project Medicaid Enterprise architecture and system knowledge, expertise, leadership, consulting, and support as the MMIS is transitioned into the future modular state.
* Independent Verification and Validation Services (IV&V) – The Agency will utilize IV&V services to perform a rigorous independent evaluation of the correctness and quality of services procured for the Iowa MMIS and modules to ensure they meet Iowa’s RFP and federal Medicaid certification requirements. The IV&V vendor will review, analyze, evaluate, inspect, and test products and processes. The analysis will include the operational environment, hardware, software, interfacing applications, and documentation.
* System Integration Services (SI) – The Agency will pursue systems integration services to ensure comprehensive, end-to-end solutions that work together to provide complete business functionality. The selected vendor for systems integration services will be a point of accountability as the systems are implemented, configured, and maintained.
* Technical Project Management Office (PMO) – The Agency will procure a vendor to establish a PMO and deliver comprehensive project management services, risk analysis and mitigation, requirements management, change management, testing support, and other functions.
* Modular Solutions (Functionality and Services) – The Agency will issue multiple RFPs to procure modular solutions that offer functionality and services to replace existing MMIS operations. The term module means a packaged, functional business process or set of processes implemented through software, data, and interoperable interfaces that are enabled through design principles in which functions of a complex system are partitioned into discrete, scalable, reusable components. Modules may reside in any physical location (within the continental United States) and will be carved out from the current MMIS. This may allow them to be easily replaced at lower risk, reduced cost, and shorter duration in the future.

1.2 RFP General Definitions.

Definitions in this section correspond with capitalized terms in the RFP.

***“Agency”*** means the Iowa Department of Human Services.

***“Bid Proposal”*** or ***“Proposal”*** means the bidder’s proposal submitted in response to the RFP.

***“Centers for Medicare and Medicaid Services”*** or ***“CMS”*** is part of the U.S. Department of Health and Human Services. CMS oversees Medicare and Medicaid, as well as many other federal healthcare programs, including those that involve Health Information Technology such as the meaningful use incentive program for electronic health records (EHR). In addition to Medicare and Medicaid, CMS administers the Children's Health Insurance Program (CHIP), the Health Insurance Portability and Accountability Act (HIPAA) and key portions of the 2015 Medicare Access and CHIP Reauthorization Act (MACRA) law.

***“Cloud Computing”***

For security and privacy requirements, the Agency follows the National Institute of Standards and Technology (NIST) definition of cloud computing as “a model for enabling convenient, on-demand network access to a shared pool of configurable computing resources (e.g., networks, servers, storage, applications, and services) that can be rapidly provisioned and released with minimal management effort or service provider interaction.” NIST has identified five essential characteristics of cloud computing: on-demand service, broad network access, resource pooling, rapid elasticity, and measured service.

Types of service models:

1. *Software as a Service (SaaS)*:  The capability provided to the Department is to use the provider’s applications running on a cloud infrastructure. The applications are accessible from various client devices through a thin-client interface such as a web browser (e.g., web-based email). The Department does not manage or control the underlying cloud infrastructure including network, servers, operating systems, storage, or even individual application capabilities, with the possible exception of limited user-specific application configuration settings;
2. *Platform as a Service (PaaS):*  The capability provided to the Department is the ability to deploy onto the cloud infrastructure consumer-created or acquired applications created using programming languages and tools supported by the provider. The Department does not manage or control the underlying cloud infrastructure including network, servers, operating systems, or storage, but has control over the deployed applications and possibly application hosting environment configurations; and
3. *Infrastructure as a Service (IaaS):*  The capability provided to the Department is to provision processing, storage, networks, and other fundamental computing resources where the Department is able to deploy and run arbitrary software, which can include operating systems and applications. The Department does not manage or control the underlying cloud infrastructure but has control over operating systems, storage, deployed applications, and possibly limited control of select networking components (e.g., host firewalls).

Cloud computing is defined to have several deployment models, each of which provides distinct trade-offs for agencies which are migrating applications to a cloud environment. NIST defines the cloud deployment models as follows:

1. *Private cloud.* The cloud infrastructure is operated solely for an organization. It may be managed by the organization or a third party and may exist on premise or off premise.
2. *Community cloud.* The cloud infrastructure is shared by several organizations and supports a specific community that has shared concerns (e.g., mission, security requirements, policy, and compliance considerations). It may be managed by the organizations or a third party and may exist on premise or off premise.
3. *Public cloud.* The cloud infrastructure is made available to the general public or a large industry group and is owned by an organization selling cloud services.
4. *Hybrid cloud*. The cloud infrastructure is a composition of two or more clouds (private, com­munity, or public) that remain unique entities but are bound together by standardized or proprietary technology that enables data and application portability (e.g., cloud bursting for load-balancing between clouds).

***“Consumer Choices Option”*** or ***“CCO”*** is an option available under the Home and Community Based Services waivers that gives Members control over a targeted amount of Medicaid dollars so that they may develop a plan to meet their needs by directly hiring employees and/or purchasing other goods and services.

***“Contractor”*** means the bidder who enters into a Contract as a result of this Solicitation.

***“Coordination of Benefits Agreement”*** or ***“COBA”*** is a file that standardizes the way that eligibility and Medicare claims payment information within a claims crossover context is exchanged with CMS.

***“Deliverables”*** means all of the services, goods, products, work, work product, data (including data collected on behalf of the Agency), items, materials and property to be created, developed, produced, delivered, performed, or provided by or on behalf of, or made available through, the Contractor (or any agent, contractor or subcontractor of the Contractor) in connection with any contract resulting from this RFP.

***“Health Home”*** is a team of professionals working together to provide whole-person, patient-centered, coordinated care for certain Medicaid populations. Programs that currently fall under Health Home are:

***“Chronic Condition Health Home”*** is for individuals who have two chronic conditions or one chronic condition and are at risk for a second chronic condition from the following list:

|  |  |
| --- | --- |
| * + High Blood Pressure   + Obesity   + Heart Disease   + Diabetes | * + Substance Abuse   + Asthma   + Mental Health Needs |

***“Integrated Health Home”*** or ***“IHH”*** is for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED). The Integrated Health Home is administered by the Medicaid Managed Care Organizations and provided by community-based Integrated Health Homes.

***“Home and Community-based Services (HCBS) Programs*** are for people with disabilities and older Iowans who need services to allow them to stay in their home and community instead of going to an institution. LTSS are delivered through seven 1915(c) waiver programs and five non-waiver programs. More information can be found at this link: <http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs>.

**HCBS Waiver Programs.** Under HCBS waiver programs, Iowa can waive certain Medicaid program requirements, allowing the State to provide care for people who might not otherwise be eligible under Medicaid. Through the following 1915(c) waivers, Iowa targets services to people who need LTSS:

|  |  |
| --- | --- |
| * + AIDS/HIV   + Brain Injury   + Children’s Mental Health   + Elderly | * + Health and Disability   + Intellectual Disability   + Physical Disability |

**HCBS Non-waiver Programs** include:

* Habilitation Services – State Plan 1915(i) program
* Home Health program (including EPSDT private duty nursing/personal cares)
* Hospice program
* Money Follows the Person (MFP) program
* Program of All-inclusive Care for the Elderly (PACE) program

***“HIPP”*** is the Health Insurance Premium Payment Program.

***“Invoice”*** means a Contractor’s claim for payment. At the Agency’s discretion, claims may be submitted on an original invoice from the Contractor or may be submitted on a claim form accepted by the Agency, such as a General Accounting Expenditure (GAX) form.

***“Online Bidders Library”*** means an on-line library established for bidders available at http://www.sp.dhs.state.ia.us/MED-18-004. The Agency is making online resources available only to registered bidders. Instructions for bidder access are provided in Section 2.4.

***1.3 Scope of Work.***

**1.3.1 Deliverables.**

The Scope of Work for this RFP is set forth in Attachment H, Sample Contract, which details:

* Section 1. SPECIAL TERMS
* Section 2. GENERAL TERMS FOR SERVICES CONTRACTS
* Section 3. SPECIAL CONTRACT ATTACHMENTS

Section 2 Basic Information About the RFP Process

2.1 Issuing Officer.

The Issuing Officer is the sole point of contact regarding the RFP from the date of issuance until selection of the successful bidder. The Issuing Officer for this RFP is:

Stephanie Clark

Hoover State Office Building

1305 E Walnut Street

Des Moines, IA 50309-1833

1st Floor

Phone: (515) 256-4646

RFPMED-18-004@dhs.state.ia.us

2.2 Restriction on Bidder Communication.

From the issue date of this RFP until announcement of the successful bidder, the Issuing Officer is the point of contact regarding the RFP. There may be no communication regarding this RFP with any State employee other than the Issuing Officer, except at the direction of the Issuing Officer or as otherwise noted in the RFP. The Issuing Officer will respond only to questions regarding the procurement process.

2.3 Downloading the RFP from the Internet.

The RFP and any related documents such as amendments or attachments (collectively the “RFP”), and responses to questions will be posted at the State of Iowa’s website for bid opportunities: <http://bidopportunities.iowa.gov/>. Check this website periodically for any amendments to this RFP. The posted version of the RFP is the official version. The Agency will only be bound by the official version of the RFP document(s). Bidders should ensure that any downloaded documents are in fact the most up to date and are unchanged from the official version.

2.4 Online Resources.

The Agency is making online resources available to registered bidders in the Online Bidders Library. Only those bidders that provide their intent to bid (see Section 2.5) will be granted access. The Online Bidders Library contains the current Core MMIS Policies and Procedures, historical claims information, recent CMRs, and the current Core MMIS Services contract and amendments. Other links are provided to general information regarding the currently covered services, rates, payments, legislative reports, current initiatives, and state plan documents.

The optimal browser for accessing the sharepoint is Internet Explorer 11. If users experience difficulties opening documents from the SharePoint library, they may download this fix from Microsoft if running within a Windows environment: <https://support.microsoft.com/en-us/kb/3140245>. Also, when users sign in, they have to check the “Sign me in automatically” box.

***2.5 Intent to Bid.***

The Agency requests that bidders provide their intent to bid to the Issuing Officer by the date and time in the Procurement Timetable. Electronic mail is the preferred delivery method. The intent to bid should include the bidder's name, contact person, mailing address, electronic mail address, fax number, telephone number, and a statement of intent to submit a bid in response to this RFP. Though it is not mandatory that the Agency receive an intent to bid, the Agency will only respond to questions about the RFP that have been submitted by bidders who have expressed their intent to bid. The Agency may cancel an RFP for lack of interest based on the number of letters of intent to bid received.

***2.6 Reserved.***

2.7 Questions, Requests for Clarification, and Suggested Changes.

Bidders who have provided their intent to bid on the RFP are invited to submit written questions, requests for clarifications, and/or suggestions for changes to the specifications of this RFP (hereafter “Questions”) by the due date and time provided in the Procurement Timetable. Bidders are not permitted to include assumptions in their Bid Proposals. Instead, bidders shall address any perceived ambiguity regarding this RFP through the question and answer process. If the Questions pertain to a specific section of the RFP, the page and section number(s) must be referenced. The Agency prefers to receive Questions by electronic mail. The bidder may wish to request confirmation of receipt from the Issuing Officer to ensure delivery.

The Agency will post responses to questions received on the State’s website at: <http://bidopportunities.iowa.gov/> by the dates provided in the Procurement Timetable. Follow-up questions to initial responses are permissible as long as all questions are received by the final due date and time for bidder Questions as provided in the Procurement Timetable.

The Agency assumes no responsibility for verbal representations made by its officers or employees unless such representations are confirmed in writing and incorporated into the RFP. In addition, the Agency’s written responses to Questions will not be considered part of the RFP. If the Agency decides to change the RFP, the Agency will issue an amendment.

2.8 Submission of Bid Proposal.

The Bid Proposal shall be received by the Issuing Officer by the time and date specified in the Procurement Timetable. The Agency will not waive this mandatory requirement. Any Bid Proposal received after this deadline will be rejected and will not be evaluated.

Bid Proposals are to be submitted in accordance with the Bid Proposal Formatting section of this RFP. Bidders mailing Bid Proposals shall allow ample mail delivery time to ensure timely receipt of their Bid Proposals. It is the bidder’s responsibility to ensure that the Bid Proposal is received prior to the deadline. Postmarking or submission to a courier by the due date shall not substitute for actual receipt of the Bid Proposal by the Agency.

2.9 Amendment to the RFP and Bid Proposal.

The Agency reserves the right to amend or provide clarifications to the RFP at any time. Amendments will be posted to the State’s website at <http://bidopportunities.iowa.gov/>. If the amendment occurs after the closing date for receipt of Bid Proposals, the Agency may, in its sole discretion, allow bidders to amend their Bid Proposals.

If the bidder amends their Bid Proposal, the amendment shall be in writing and signed by the bidder. The bidder shall provide the same number of copies of the amendment as is required for the original Bid Proposal, for both hardcopy and CD-ROM(s) or USB flash drives, in accordance with the Bid Proposal Formatting Section. The amendment must be also be submitted on a CD-ROM or USB flash drives. It is a mandatory requirement that the Issuing Officer shall receive any amendments by the deadline for submitting Bid Proposals. However, if the RFP is amended after receipt of proposals, any bid amendment must be received by the deadline set by the Agency.

2.10 Withdrawal of Bid Proposal.

The bidder may withdraw its Bid Proposal prior to the closing date for receipt of Bid Proposals by submitting a written request to withdraw to the Issuing Officer. Electronic mail and faxed requests to withdraw will not be accepted.

2.11 Costs of Preparing the Bid Proposal.

The costs of preparation and delivery of the Bid Proposal are solely the responsibility of the bidder.

2.12 Rejection of Bid Proposals.

The Agency reserves the right to reject any or all Bid Proposals, in whole and in part, and to cancel this RFP at any time prior to the execution of a written contract. Issuance of this RFP in no way constitutes a commitment by the Agency to enter into a contract.

2.13 Review of Bid Proposals.

Only bidders that have met the mandatory requirements and are not subject to disqualification will be considered for award of a contract.

2.13.1 Mandatory Requirements.

Bidders must meet these mandatory requirements or will be disqualified and not considered for award of a contract:

* The Issuing Officer must receive the Bid Proposal, and any amendments thereof, prior to or on the due date and time (See RFP Sections 2.8 and 2.9).
* The bidder is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from receiving federal funding by any federal department or agency (See RFP Additional Certifications Attachment).
* The bidder is eligible to submit a bid in accordance with the Bidder Eligibility Requirements of this RFP (See RFP Bidder Eligibility Requirements Section).

2.13.2 Reasons Proposals May be Disqualified.

Bidders are expected to follow the specifications set forth in this RFP. However, it is not the Agency’s intent to disqualify Bid Proposals that suffer from correctible flaws. At the same time, it is important to maintain fairness to all bidders in the procurement process. Therefore, the Agency reserves the discretion to permit cure of variances, waive variances, or disqualify Bid Proposals for reasons that include, but may not be limited to, the following:

* Bidder initiates unauthorized contact regarding this RFP with employees other than the Issuing Officer (See RFP Section 2.2);
* Bidder fails to comply with the RFP’s formatting specifications so that the Bid Proposal cannot be fairly compared to other bids (See RFP Section 3.1);
* Bidder fails, in the Agency’s opinion, to include the content required for the RFP;
* Bidder fails to be fully responsive in the Bidder’s Approach to Meeting Deliverables Section, states an element of the Scope of Work cannot or will not be met, or does not include information necessary to substantiate that it will be able to meet the Scope of Work specifications (See RFP Section 3.2.4);
* Bidder’s response materially changes Scope of Work specifications;
* Bidder fails to submit the RFP attachments containing all signatures (See RFP Section 3.2.3);
* Bidder marks entire Bid Proposal confidential, makes excessive claims for confidential treatment, or identifies pricing information in the Cost Proposal as confidential (See RFP Section 3.1);
* Bidder includes assumptions in its Bid Proposal (See RFP Section 2.7); or
* Bidder fails to respond to the Agency’s request for clarifications, information, documents, or references that the Agency may make at any point in the RFP process.

The determination of whether or not to disqualify a proposal and not consider it for award of a contract for any of these reasons, or to waive or permit cure of variances in Bid Proposals, is at the sole discretion of the Agency. No bidder shall obtain any right by virtue of the Agency’s election to not exercise that discretion. In the event the Agency waives or permits cure of variances, such waiver or cure will not modify the RFP specifications or excuse the bidder from full compliance with RFP specifications or other contract requirements if the bidder enters into a contract.

2.14 Bid Proposal Clarification Process.

The Agency may request clarifications from bidders for the purpose of resolving ambiguities or questioning information presented in the Bid Proposals. Clarifications may occur throughout the Bid Proposal evaluation process. Clarification responses shall be in writing and shall address only the information requested. Responses shall be submitted to the Agency within the time stipulated at the occasion of the request.

2.15 Verification of Bid Proposal Contents.

The contents of a Bid Proposal submitted by a bidder are subject to verification.

2.16 Reference Checks.

The Agency reserves the right to contact any reference to assist in the evaluation of the Bid Proposal, to verify information contained in the Bid Proposal, to discuss the bidder’s qualifications, and/or to discuss the qualifications of any subcontractor identified in the Bid Proposal.

2.17 Information from Other Sources.

The Agency reserves the right to obtain and consider information from other sources concerning a bidder, such as the bidder’s capability and performance under other contracts, and the bidder’s authority and ability to conduct business in the State of Iowa. Such other sources may include subject matter experts.

2.18 Criminal History and Background Investigation.

The Agency reserves the right to conduct criminal history and other background investigations of the bidder, its officers, directors, shareholders, or partners and managerial and supervisory personnel retained by the bidder for the performance of the resulting contract. The Agency reserves the right to conduct criminal history and other background investigations of the bidder’s staff and subcontractors providing services under the resulting contract.

2.19 Disposition of Bid Proposals.

Opened Bid Proposals become the property of the Agency and will not be returned to the bidder. Upon issuance of the Notice of Intent to Award, the contents of all Bid Proposals will be in the public domain and be open to inspection by interested parties subject to exceptions provided in Iowa Code chapter 22 or other applicable law.

2.20 Public Records and Request for Confidential Treatment.

Original information submitted by a bidder may be treated as public information by the Agency following the conclusion of the selection process unless the bidder properly requests that information be treated as confidential at the time of submitting the Bid Proposal. See the Bid Proposal Formatting Section for the proper method for making such requests. The Agency’s release of information is governed by Iowa Code chapter 22. Bidders are encouraged to familiarize themselves with Chapter 22 before submitting a Bid Proposal. The Agency will copy public records as required to comply with public records laws.

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

In the event the Agency receives a request for information marked confidential, written notice shall be given to the bidder seventy-two (72) hours prior to the release of the information to allow the bidder to seek injunctive relief pursuant to Iowa Code § 22.8.

The bidder’s failure to request confidential treatment of material pursuant to this section and the relevant law will be deemed, by the Agency, as a waiver of any right to confidentiality that the bidder may have had.

2.21 Copyrights.

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

2.22 Release of Claims.

By submitting a Bid Proposal, the bidder agrees that it shall not bring any claim or cause of action against the Agency based on any misunderstanding concerning the information provided herein or concerning the Agency's failure, negligent or otherwise, to provide the bidder with pertinent information as intended by this RFP.

2.23 Reserved. (Presentations)

2.24 Notice of Intent to Award.

Notice of Intent to Award will be sent to all bidders that submitted a Bid Proposal by the due date and time. The Notice of Intent to Award does not constitute the formation of a contract between the Agency and the apparent successful bidder.

2.25 Acceptance Period.

The Agency shall make a good faith effort to negotiate and execute the contract. If the apparent successful bidder fails to negotiate and execute a contract, the Agency may, in its sole discretion, revoke the Notice of Intent to Award and negotiate a contract with another bidder or withdraw the RFP. The Agency further reserves the right to cancel the Notice of Intent to Award at any time prior to the execution of a written contract.

2.26 Review of Notice of Disqualification or Notice of Intent to Award Decision.

Bidders may request reconsideration of either a notice of disqualification or notice of intent to award decision by submitting a written request to the Agency:

Bureau Chief

c/o Bureau of Service Contract Support

Department of Human Services

Hoover State Office Building, 1st Floor

1305 E. Walnut Street

Des Moines, Iowa 50319-0114

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

The Agency must receive the written request for reconsideration within five days from the date of the notice of disqualification or notice of intent to award decision, whichever is earlier. The written request may be mailed, emailed, or delivered. It is the bidder’s responsibility to assure timely delivery of the request for reconsideration. The request for reconsideration shall clearly and fully identify all issues being contested by reference to the page and section number of the RFP. If a bidder submitted multiple Bid Proposals and requests that the Agency reconsider a notice of disqualification or notice of intent to award decision for more than one Bid Proposal, a separate written request shall be submitted for each. At the Agency’s discretion, requests for reconsideration from the same bidder may be reviewed separately or combined into one response. The Agency will expeditiously address the request for reconsideration and issue a decision. The bidder may choose to file an appeal with the Agency within five days of the date of the decision on reconsideration in accordance with 441 IAC 7.41 et seq.

2.27 Definition of Contract.

The full execution of a written contract shall constitute the making of a contract for services and no bidder shall acquire any legal or equitable rights relative to the contract services until the contract has been fully executed by the apparent successful bidder and the Agency.

2.28 Choice of Law and Forum.

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

2.29 Restrictions on Gifts and Activities.

Iowa Code chapter 68B restricts gifts that may be given or received by state employees and requires certain individuals to disclose information concerning their activities with state government. Bidders must determine the applicability of this Chapter to their activities and comply with the requirements. In addition, pursuant to Iowa Code § 722.1, it is a felony offense to bribe or attempt to bribe a public official.

2.30 Exclusivity.

Any contract resulting from this RFP shall not be an exclusive contract.

2.31 No Minimum Guaranteed.

The Agency anticipates that the selected bidder will provide services as requested by the Agency. The Agency does not guarantee that any minimum compensation will be paid to the bidder or any minimum usage of the bidder’s services.

2.32 Use of Subcontractors.

The Agency acknowledges that the selected bidder may contract with third parties for the performance of any of the Contractor’s obligations. The Agency reserves the right to provide prior approval for any subcontractor used to perform services under any contract that may result from this RFP.

2.33 Bidder Continuing Disclosure Requirement.

To the extent that bidders are required to report incidents when responding to this RFP related to damages, penalties, disincentives, administrative or regulatory proceedings, founded child or dependent adult abuse, or felony convictions, these matters are subject to continuing disclosure to the Agency. Incidents occurring after submission of a Bid Proposal, and with respect to the successful bidder after the execution of a contract, shall be disclosed in a timely manner in a written statement to the Agency. For purposes of this subsection, timely means within thirty (30) days from the date of conviction, regardless of appeal rights.

Section 3 How to Submit A Bid Proposal: Format and Content Specifications

These instructions provide the format and technical specifications of the Bid Proposal and are designed to facilitate the submission of a Bid Proposal that is easy to understand and evaluate.

3.1 Bid Proposal Formatting.

| **Subject** | **Specifications** | |
| --- | --- | --- |
| **Paper Size** | 8.5" x 11" paper (one side only). Charts or graphs may be provided on legal-sized paper. | |
| **Font** | Bid Proposals must be typewritten. The font must be 11 point or larger (excluding charts, graphs, or diagrams). Acceptable fonts include Times New Roman, Calibri and Arial. | |
| **Page Limit** | The Bid Proposal is limited to 200 pages. Resumes, Section 3.2.4.1 Special Submissions, and RFP Forms will not count toward the page limit. | |
| **Pagination** | | | All pages are to be sequentially numbered from beginning to end (do not number Proposal sections independently of each other). |
| **Bid Proposal General Composition** | | | * Bid Proposals shall be divided into two parts: Technical Proposal and Cost Proposal. * Technical Proposals submitted in multiple volumes shall be numbered in the following fashion: 1 of 4, 2 of 4, etc. * Bid Proposals must be bound and use tabs to label sections. |
| **Envelope Contents and Labeling** | | | * Envelopes shall be addressed to the Issuing Officer. * The envelope containing the original Bid Proposal shall be labeled “original” and each envelope containing a copy of the Bid Proposal shall be labeled “copy.” Each envelope must be numbered to correspond with the number of copies of Proposals. * The Technical and Cost Proposals must be packaged separately with each copy in its own envelope. |
| **Number of Hard Copies** | | | Submit one (1) original hard copy of the Proposal and 4 identical copies of the original. The original hard copy must contain original signatures. |
| **CD-ROM/USB Flash Drive** | | | * The Technical Proposal and Cost Proposal must be provided on separate CD(s). The CD-ROM must be placed in the envelope with the original Bid Proposal. * The Technical Proposal must be saved in less than five files. The CD(s) must be compatible with Microsoft Office 2007 (or later) software. Proposals shall be provided in Microsoft Word format. An additional Proposal copy may be submitted in PDF format. Files shall not be password protected or saved with restrictions that prevent copying, saving, highlighting, or reprinting of the contents. |
| **Request for Confidential Treatment** | | | Requests for confidential treatment of any information in a Bid Proposal must meet these specifications:   * The bidder will complete the appropriate section of the Primary Bidder Detail Form & Certificationwhich requires the specific statutory basis supporting the request for confidential treatment and an explanation of why disclosure of the information is not in the best interest of the public. * The bidder shall submit one (1) complete paper copy of the Bid Proposal from which confidential information has been redacted. This copy shall be clearly labeled on the cover as a “public copy”, and each page upon which confidential information appears shall be conspicuously marked as containing confidential information. The confidential material shall be redacted in such a way as to allow the public to determine the general nature of the material removed. To the extent possible, pages should be redacted sentence by sentence unless all material on a page is clearly confidential under the law. The bidder shall not identify the entire Bid Proposal as confidential. * The Cost Proposal will be part of the ultimate contract entered into with the successful bidder. Pricing information may not be designated as confidential material. However, Cost Proposal supporting materials may be marked confidential if consistent with applicable law. * The bidder shall submit a CD-ROM containing an electronic copy of the Bid Proposal from which confidential information has been redacted. This CD-ROM shall be clearly marked as a “public copy”. |
| **Exceptions to RFP/Contract Language** | | | If the bidder objects to any term or condition of the RFP or attached Sample Contract, specific reference to the RFP page and section number shall be made in the Primary Bidder Detail & Certification Form. In addition, the bidder shall set forth in its Bid Proposal the specific language it proposes to include in place of the RFP or contract provision and cost savings to the Agency should the Agency accept the proposed language.  The Agency reserves the right to either execute a contract without further negotiation with the successful bidder or to negotiate contract terms with the selected bidder if the best interests of the Agency would be served. |

3.2 Contents and Organization of Technical Proposal.

This section describes the information that must be in the Technical Proposal. Bid Proposals should be organized into sections **in the same order provided here** using tabs to separate each section.

3.2.1 Information to Include Behind Tab 1:

**Transmittal Letter.**

The transmittal letter serves as a cover letter for the Technical Proposal. It must consist of an executive summary that briefly reviews the strengths of the bidder and key features of its proposed approach to meet the specifications of this RFP.

**3.2.2 Information to Include Behind Tab 2: Proposal Table of Contents.**

The Bid Proposal must contain a table of contents.

3.2.3 Information to Include Behind Tab 3: RFP Forms.

The forms listed below are attachments to this RFP. Fully complete and return these forms behind Tab 3:

* Release of Information Form
* Primary Bidder Detail & Certification Form
* Subcontractor Disclosure Form (one for each proposed subcontractor)
* Certification and Disclosure Regarding Lobbying

3.2.4 Information to Include Behind Tab 4: Bidder’s Approach to Meeting Deliverables.

The bidder shall address each Deliverable that the successful contractor will perform as listed in *Attachment H: Sample Contract, Section 1.3.1* (Deliverables) by first restating the Deliverable from the RFP and then detailing the bidder’s planned approach to meeting each contractor Deliverable immediately after the restated text. Bid responses should provide sufficient detail so that the Agency can understand and evaluate the bidder’s approach, and should not merely repeat the Deliverable.

Bidders are given wide latitude in the degree of detail they offer or the extent to which they reveal plans, designs, examples, processes, and procedures. Bidders do not need to address any responsibilities that are specifically designated as Agency responsibilities.

**Note:**

* Responses to Deliverables shall be in the same sequence as presented in the RFP.
* Bid Proposals shall identify any deviations from the specifications the bidder cannot satisfy.
* Bid Proposals shall not contain promotional or display materials unless specifically required.
* If a bidder proposes more than one method of meeting the RFP requirements, each method must be drafted and submitted as separate Bid Proposals. Each will be evaluated separately.

**3.2.4.1 Special Submissions.**

The bidder shall provide draft transition, systems implementation, and operations plans detailing activities and timelines in this section.

3.2.5 Information to Include Behind Tab 5: Bidder’s Background.

The bidder shall provide the information set forth in this section regarding its experience and background.

**3.2.5.1 Experience.**

The bidder shall provide the following information regarding the organization’s experience:

3.2.5.1.1 Level of technical experience in providing the types of services sought by the RFP.

3.2.5.1.2 Description of all services similar to those sought by this RFP that the bidder has provided to other businesses or governmental entities within the last twenty-four (24) months.

For each similar service, provide a matrix detailing:

1. Project title;
2. Project role (primary contractor or subcontractor);
3. Name of client agency or business;
4. General description of the scope of work;
5. Start and end dates of contract as originally entered into between the parties;
6. If there were any alteration(s) to the contract timeframe(s) or the contract was terminated for any other reason before completion of all obligations under the contract provisions, fully explain the reason(s) for the alteration or termination;
7. Total value of the contract at the time it was executed and any alteration(s) to that amount. Provide reason(s) for the alteration(s) to the contract value;
8. Whether the services were provided timely and within budget;
9. Any damages, penalties, disincentives assessed, or payments withheld, or anything of value traded or given up by the bidder that are valued at or above $500,000. Include the estimated cost assessed against the bidder for the incident with the details of the occurrence;
10. List administrative or regulatory proceedings or adjudicated matters related to this service to which the bidder has been a party; and
11. Contact information for the client’s project manager including address, telephone number, and electronic mail address.

**3.2.5.1.3** List any details of whether the bidder or any owners, officers, primary partners, staff providing services or any owners, officers, primary partners, or staff providing services of any subcontractor who may be involved with providing the services sought in this RFP, have ever had a founded child or dependent adult abuse report, or been convicted of a felony.

**3.2.5.1.4** Letters of reference from three (3) of the bidder’s previous clients knowledgeable of the bidder’s performance in providing services similar to those sought in this RFP, including a contact person, telephone number, and electronic mail address for each reference. It is preferred that letters of reference are provided for services that were procured in a competitive environment. Persons who are currently employed by the Agency are not eligible to be references.

**3.2.5.1.5** Description of experience managing subcontractors, if the bidder proposes to use subcontractors.

**3.2.5.2 Personnel.**

The bidder shall provide the following information regarding personnel:

**3.2.5.2.1 Tables of Organization.**

Illustrate the lines of authority in two tables:

* One showing overall operations
* Oneshowing staff who will provide services under the RFP

**3.2.5.2.2 Reserved.**

**3.2.5.2.3 Information About Project Manager and Key Project Personnel.**

* Include names and credentials for the project manager and any additional key project personnel who will be involved in providing services sought by this RFP. Include resumes for these personnel. The resumes shall include: name, education, and years of experience and employment history, particularly as it relates to the scope of services specified herein. Resumes shall also include the percentage of time the person would be specifically dedicated to this project, if the bidder is selected as the successful bidder. Resumes should not include social security numbers.
* Include the project manager’s experience managing subcontractor staff if the bidder proposes to use subcontractors.
* Include the percentage of time the project manager and key project personnel will devote to this project on a monthly basis.

**3.2.5.3 Reserved.**

3.3 Cost Proposal.

**Content and Format.**

The Cost Proposal shall be submitted using the pricing worksheet set forth in Attachment G of this RFP. Bidders should submit an Excel version of Attachment G.

The Bidder’s Cost Proposal shall include all charges of any kind associated with the goods and services offered by the bidder in order to meet all RFP requirements. CSR rates are to be inclusive of all administrative costs. Bidders are instructed that the Agency will not accept costs exceeding $450,000 for transition costs (exclusive of the NCCI, EDI, and Imaging/scanning Solution Implementation costs) that may be incurred in the Transition Period. The Agency will not be liable for any fees or charges for the goods and services offered by the bidder that are not set forth in the Cost Proposal, to include any licensing fees for Contractor solutions.

Section 4 Evaluation Of Bid Proposals

4.1 Introduction.

This section describes the evaluation process that will be used to determine which Bid Proposal provides the greatest benefit to the Agency. When making this determination, the Agency will not necessarily award a contract to the bidder offering the lowest cost to the Agency or to the bidder with the highest point total. Rather, a contract will be awarded to the bidder that offers the greatest benefit to the Agency.

4.2 Evaluation Committee.

The Agency intends to conduct a comprehensive, fair and impartial evaluation of Bid Proposals received in response to this RFP. In making this determination, the Agency will be represented by an evaluation committee.

4.3 Proposal Scoring and Evaluation Criteria.

The evaluation committee will use the method described in this section to assist with initially determining the relative merits of each Bid Proposal.

**Scoring Guide.**

Points will be assigned to each evaluation component as follows, unless otherwise designated:

|  |  |
| --- | --- |
| 4 | Bidder has agreed to comply with the requirements and provided a clear and compelling description of how each requirement would be met, with relevant supporting materials. Bidder’s proposed approach frequently goes above and beyond the minimum requirements and indicates superior ability to serve the needs of the Agency. |
| 3 | Bidder has agreed to comply with the requirements and provided a good and complete description of how the requirements would be met. Response clearly demonstrates a high degree of ability to serve the needs of the Agency. |
| 2 | Bidder has agreed to comply with the requirements and provided an adequate description of how the requirements would be met. Response indicates adequate ability to serve the needs of the Agency. |
| 1 | Bidder has agreed to comply with the requirements and provided some details on how the requirements would be met. Response does not clearly indicate if all the needs of the Agency will be met. |
| 0 | Bidder has not addressed any of the requirements or has provided a response that is limited in scope, vague, or incomplete. Response did not provide a description of how the Agency’s needs would be met. |

**Technical Proposal Components.**

When Bid Proposals are evaluated, the total points for each component are comprised of the component’s assigned weight multiplied by the score the Bid Proposal earns. Points for all components will be added together. The evaluation components, including maximum points that may be awarded, are as follows:

|  |  |  |  |
| --- | --- | --- | --- |
| **Technical Proposal Components** | **Weight** | **Score (0-4)** | **Potential Maximum Points** |
| **Bidder’s Approach to Meeting Deliverables (Section 3.2.4) and Special Submissions (Section 3.2.4.1)** |  |  |  |
| **Scope of Work – Attachment H: Sample Contract** |  |  |  |
| * General Obligations (Section 1.3.1.1) | 50 |  | **200** |
| * Transition (Section 1.3.1.2) | 30 |  | **120** |
| * Operations (Section 1.3.1.3) | 200 |  | **800** |
| * Legacy Transition Services (Section 1.3.1.4) | 10 |  | **40** |
| * Turnover (Section 1.3.1.5) | 10 |  | **40** |
| **Bidder’s Background (Section 3.2.5)** |  |  |  |
| * Experience (Section 3.2.5.1) | 220 |  | **880** |
| * Personnel (Section 3.2.5.2) | 180 |  | **720** |
| **Total Potential Score** | 700 |  | **2,800** |

**Scoring of Cost Proposal Pricing.**

Cost Proposal pricing will be scored based on a ratio of the lowest Cost Proposal versus the cost of each higher priced Bid Proposal. Under this formula, the lowest Cost Proposal receives all of the points assigned to pricing. A Cost Proposal twice as expensive as the lowest Cost Proposal would earn half of the available points. The formula is:

**Weighted Cost Score = (price of lowest Cost Proposal/price of each higher priced Cost Proposal) X (points assigned to pricing)**

**Total Points Assigned to Pricing: 1,200.**

**Total Points Possible for Technical and Cost Proposals: 4,000**

4.4 Recommendation of the Evaluation Committee.

The evaluation committee shall present a final ranking and recommendation(s) to the Medicaid Director for consideration. In making this recommendation, the committee is not bound by any scores or scoring system used to assist with initially determining the relative merits of each Bid Proposal. This recommendation may include, but is not limited to, the name of one or more bidders recommended for selection or a recommendation that no bidder be selected. The Medicaid Director shall consider the committee’s recommendation when making the final decision, but is not bound by the recommendation.

# Attachment A: Release of Information

*(Return this completed form behind Tab 3 of the Bid Proposal.)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (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

# Attachment B: Primary Bidder Detail & Certification Form

*(Return this completed form behind Tab 3 of the Proposal. If a section does not apply, label it “not applicable”.)*

|  |  |  |
| --- | --- | --- |
| **Primary Contact Information (individual who can address issues re: this Bid Proposal)** | | |
| **Name:** |  | |
| **Address:** |  | |
| **Tel:** |  | |
| **Fax:** |  | |
| **E-mail:** |  | |
| **Primary Bidder Detail** | | |
| **Business Legal Name (“Bidder”):** | |  |
| **“Doing Business As” names, assumed names, or other operating names:** | |  |
| **Parent Corporation Name and Address of Headquarters, if any:** | |  |
| **Form of Business Entity (i.e., corp., partnership, LLC, etc.):** | |  |
| **State of Incorporation/organization:** | |  |
| **Primary Address:** | |  |
| **Tel:** | |  |
| **Local Address (if any):** | |  |
| **Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:** | |  |
| **Number of Employees:** | |  |
| **Number of Years in Business:** | |  |
| **Primary Focus of Business:** | |  |
| **Federal Tax ID:** | |  |
| **DUNS #:** | |  |
| **Bidder’s Accounting Firm:** | |  |
| **If Bidder is currently registered to do business in Iowa, provide the Date of Registration:** | |  |
| **Do you plan on using subcontractors if awarded this Contract? {If “YES,” submit a Subcontractor Disclosure Form for each proposed subcontractor.}** | |  |
|  | | (YES/NO) |

|  |  |  |
| --- | --- | --- |
| **Request for Confidential Treatment (See Section 3.1)** | | |
| **Location in Bid (Tab/Page)** | **Statutory Basis for Confidentiality** | **Description/Explanation** |
|  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Exceptions to RFP/Contract Language (See Section 3.1)** | | | |
| **RFP Section and Page** | **Language to Which Bidder Takes Exception** | **Explanation and Proposed Replacement Language:** | **Cost Savings to the Agency if the Proposed Replacement Language is Accepted** |
|  |  |  |  |

**PRIMARY BIDDER CERTIFICATIONS**

1. **BID PROPOSAL CERTIFICATIONS. By signing below, Bidder certifies that:** 
   1. Bidder specifically stipulates that the Bid Proposal is predicated upon the acceptance of all terms and conditions stated in the RFP and the Sample Contract without change except as otherwise expressly stated in the Primary Bidder Detail & Certification Form. Objections or responses shall not materially alter the RFP. All changes to proposed contract language, including deletions, additions, and substitutions of language, must be addressed in the Bid Proposal. The bidder accepts and shall comply with all Contract Terms and Conditions contained in the Sample Contract without change except as set forth in the Contract;
   2. Bidder has reviewed the Additional Certifications, which are incorporated herein by reference, and by signing below represents that Bidder agrees to be bound by the obligations included therein;
   3. Bidder has received any amendments to this RFP issued by the Agency;
   4. No cost or pricing information has been included in the Bidder’s Technical Proposal; and,
   5. The person signing this Bid Proposal certifies that he/she is the person in the Bidder’s organization responsible for, or authorized to make decisions regarding the prices quoted and, Bidder guarantees the availability of the services offered and that all Bid Proposal terms, including price, will remain firm until a contract has been executed for the services contemplated by this RFP or one year from the issuance of this RFP, whichever is earlier.
2. **SERVICE AND REGISTRATION CERTIFICATIONS. By signing below, Bidder certifies that:** 
   1. Bidder certifies that the Bidder organization has sufficient personnel resources available to provide all services proposed by the Bid Proposal, and such resources will be available on the date the RFP states services are to begin. Bidder guarantees personnel proposed to provide services will be the personnel providing the services unless prior approval is received from the Agency to substitute staff;
   2. Bidder certifies that if the Bidder is awarded the contract and plans to utilize subcontractors at any point to perform any obligations under the contract, the Bidder will (1) notify the Agency in writing prior to use of the subcontractor, and (2) apply all restrictions, obligations, and responsibilities of the resulting contract between the Agency and contractor to the subcontractors through a subcontract. The contractor will remain responsible for all Deliverables provided under this contract;
   3. Bidder either is currently registered to do business in Iowa or agrees to register if Bidder is awarded a Contract pursuant to this RFP; and,
   4. Bidder certifies 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>.
3. **EXECUTION.**

By signing below, I certify that I have the authority to bind the Bidder to the specific terms, conditions and technical specifications required in the Agency’s Request for Proposals (RFP) and offered in the Bidder’s Proposal. I understand that by submitting this Bid Proposal, the Bidder agrees to provide services described herein which meet or exceed the specifications of the Agency’s RFP unless noted in the Bid Proposal and at the prices quoted by the Bidder. The Bidder has not participated, and will not participate, in any action contrary to the anti-competitive obligations outlined in the Additional Certifications. I certify that the contents of the Bid Proposal are true and accurate and that the Bidder has not made any knowingly false statements in the Bid Proposal.

|  |  |
| --- | --- |
| **Signature:** |  |
| **Printed Name/Title:** |  |
| **Date:** |  |

# Attachment C: Subcontractor Disclosure Form

*(Return this completed form behind Tab 3 of the Bid Proposal. Fully complete a form for* ***each*** *proposed subcontractor. If a section does not apply, label it “not applicable.” If the bidder does not intend to use subcontractor(s), this form does not need to be returned.*)

|  |  |
| --- | --- |
| **Primary Bidder (“Primary Bidder”):** |  |
| **Subcontractor Contact Information (individual who can address issues re: this RFP)** | |
| **Name:** |  |
| **Address:** |  |
| **Tel:** |  |
| **Fax:** |  |
| **E-mail:** |  |

|  |  |
| --- | --- |
| **Subcontractor Detail** | |
| **Subcontractor Legal Name (“Subcontractor”):** |  |
| **“Doing Business As” names, assumed names, or other operating names:** |  |
| **Form of Business Entity (i.e., corp., partnership, LLC, etc.)** |  |
| **State of Incorporation/organization:** |  |
| **Primary Address:** |  |
| **Tel:** |  |
| **Fax:** |  |
| **Local Address (if any):** |  |
| **Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:** |  |
| **Number of Employees:** |  |
| **Number of Years in Business:** |  |
| **Primary Focus of Business:** |  |
| **Federal Tax ID:** |  |
| **Subcontractor’s Accounting Firm:** |  |
| **If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:** |  |
| **Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.** |  |
| **General Scope of Work to be performed by this Subcontractor** | |
|  | |
| **Detail the Subcontractor’s qualifications for performing this scope of work** | |
|  | |

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement;
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications;
3. Subcontractor recognizes and agrees that if the Primary Bidder enters into a contract with the Agency as a result of this RFP, all restrictions, obligations, and responsibilities of the contractor under the contract shall also apply to the subcontractor; and,
4. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor’s organization responsible for or authorized to make decisions regarding the prices quoted and the Subcontractor has not participated, and will not participate, in any action contrary to the anti-competitive obligations outlined in the Additional Certifications.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.

|  |  |
| --- | --- |
| **Signature for Subcontractor:** |  |
| **Printed Name/Title:** |  |
| **Date:** |  |

# Attachment D: Additional Certifications

*(Do not return this page with the Bid Proposal.)*

**CERTIFICATION OF INDEPENDENCE AND NO CONFLICT OF INTEREST**

By submission of a Bid Proposal, the bidder certifies (and in the case of a joint proposal, each party thereto certifies) that:

1. The Bid Proposal has been developed independently, without consultation, communication or agreement with any employee or consultant of the Agency who has worked on the development of this RFP, or with any person serving as a member of the evaluation committee;
2. The Bid Proposal has been developed independently, without consultation, communication or agreement with any other bidder or parties for the purpose of restricting competition;
3. Unless otherwise required by law, the information in the Bid Proposal has not been knowingly disclosed by the bidder and will not knowingly be disclosed prior to the award of the contract, directly or indirectly, to any other bidder;
4. No attempt has been made or will be made by the bidder to induce any other bidder to submit or not to submit a Bid Proposal for the purpose of restricting competition;
5. 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.
6. The bidder and any of the bidder’s proposed subcontractors have no other contractual relationships which would create an actual or perceived conflict of interest.

**CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION -- LOWER TIER COVERED TRANSACTIONS**

By signing and submitting this Bid Proposal, the bidder is providing the certification set out below:

1. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the bidder knowingly rendered an erroneous certification, in addition to other remedies available to the federal government the Agency 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 Bid Proposal is submitted if at any time the bidder learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.
3. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principle, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this Proposal is submitted for assistance in obtaining a copy of those regulations.
4. The bidder agrees by submitting this Proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the Agency or agency with which this transaction originated.
5. The bidder further agrees by submitting this Proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
6. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. A participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Nonprocurement Programs.
7. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
8. Except for transactions authorized under paragraph 4 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the federal government, the Agency or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

**CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND/OR VOLUNTARY EXCLUSION--LOWER TIER COVERED TRANSACTIONS**

1. The bidder certifies, by submission of this Proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency.
2. Where the bidder is unable to certify to any of the statements in this certification, such bidder shall attach an explanation to this Proposal.

**CERTIFICATION OF COMPLIANCE WITH PRO-CHILDREN ACT OF 1994**

The bidder must comply with Public Law 103-227, Part C Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act). This Act requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments. Federal programs include grants, cooperative agreements, loans or loan guarantees, and contracts. The law also applies to children’s services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children’s services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities (other than clinics) where WIC coupons are redeemed.

The bidder 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.

**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:
2. 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;
3. 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;

1. 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);
2. 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;

1. 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;
2. 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
3. making a good faith effort to continue to maintain a drug-free workplace through implementation of subparagraphs (a), (b), (c), (d), (e), and (f).
4. **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.
5. **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):
6. take appropriate personnel action against such employee up to and including termination; or
7. 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.

**NON-DISCRIMINATION**

The bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, national origin, or handicap.

# Attachment E: Certification and Disclosure Regarding Lobbying

*(Return this executed form behind Tab 3 of the Bid Proposal.)*

**Instructions:**

Title 45 of the Code of Federal Regulations, Part 93 requires the bidder to include a certification form, and a disclosure form, if required, as part of the bidder’s proposal. Award of the federally funded contract from this RFP is a Covered Federal action.

1. The bidder shall file with the Agency this certification form, as set forth in Appendix A of 45 CFR Part 93, certifying the bidder, including any subcontractor(s) at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) have not made, and will not make, any payment prohibited under 45 CFR § 93.100.
2. The bidder shall file with the Agency a disclosure form, set forth in Appendix B of 45 CFR Part 93, in the event the bidder or subcontractor(s) at any tier (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) has made or has agreed to make any payment using non-appropriated funds, including profits from any covered Federal action, which would be prohibited under 45 CFR § 93.100 if paid for with appropriated funds. All disclosure forms shall be forwarded from tier to tier until received by the bidder and shall be treated as a material representation of fact upon which all receiving tiers shall rely.

**Certification for Contracts, Grants, Loans, and Cooperative Agreements**

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, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of 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, and 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 agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, ‘‘Disclosure Form to Report Lobbying,’’ in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. 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.

***Statement for Loan Guarantees and Loan Insurance***

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

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, ‘‘Disclosure Form to Report Lobbying,’’ in accordance with its instructions.

Submission of this statement is a pre-requisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than $10,000 for each such failure.

I certify that the contents of this certification are true and accurate and that the bidder has not made any knowingly false statements in the Bid Proposal. I am checking the appropriate box below regarding disclosures required in Title 45 of the Code of Federal Regulations, Part 93.

🞏 The bidder is NOT including a disclosure form as referenced in this form’s instructions because the bidder is NOT required by law to do so.

🞏 The bidder IS filing a disclosure form with the Agency as referenced in this form’s instructions because the bidder IS required by law to do so. If the bidder is filing a disclosure form, place the form immediately behind this Attachment E in the Proposal.

|  |  |
| --- | --- |
| **Signature:** |  |
| **Printed Name/Title:** |  |
| **Date:** |  |

# Attachment F: Current Business Operating Environment

**Program Description**

The following sections provide an overview of the Iowa Medicaid Program:

F.1 Medicaid Program Administration

Multiple state and federal agencies administer the Iowa Medicaid Program. The following sections describe their roles.

F.1.1 Iowa Department of Human Services

The Iowa Department of Human Services (Agency) is the largest Agency in Iowa State government, with approximately 4,233 State full-time employees. In addition to its primary Central Office location, DHS has remote office operations in all 99 counties in Iowa. These sites house field, case management, and child-support staff. There are six institutional facilities under DHS, including mental health institutes at Cherokee and Independence; State Boys Training School at Eldora; Civil Commitment Unit for Sexual Offenders; and two resource centers at Glenwood and Woodward.

DHS has six divisions, five field services area offices, and six facilities that serve developmentally disabled, mentally ill, or juvenile clients. The six divisions of the Agency include:

* The Division of Fiscal Management
* The Division of Data Management
* The Division of Field Operations
* The Division of Adult, Children, and Family Services
* The Division of Mental Health and Disability Services
* The Division of Medical Services (also known as the Iowa Medicaid Enterprise)

The responsibilities for the Medicaid program have been dispersed throughout the divisions. The Iowa Medicaid Enterprise (IME), led by the State Medicaid Director, administers the Iowa Medicaid and CHIP programs and coordinates the activities of its bureaus: MCO Oversight and Supports, Medical and LTSS Policy, and the IME Support and Operations team. The IME directs, coordinates, and oversees Medicaid and CHIP operations, MCO oversight, quality assurance, and cost containment activities in order to ensure effective program administration and adherence to laws, rules, regulations, and established policies. IME operations have a significant impact on Medicaid and CHIP policy which is administered by the Division of Adult, Children and Family Services. An illustration of the Agency’s organization is available at: <http://dhs.iowa.gov/sites/default/files/DHS_Table_of_Org.pdf>.

***State of Iowa Hardware Infrastructure***

The State of Iowa, Office of the Chief Information Officer (OCIO), has a large infrastructure in place in order to support the MMIS. DHS technology supports include local area and wide area network supports to connect all DHS offices and other applications required by its users. Below are highlights of key infrastructures.

***State of Iowa Primary and Secondary Data Centers***

The primary and secondary data centers provide redundant power and cooling, networking services; fire suppression, power protected by UPS and generator; each server in every rack has capability of multiple electrical paths, authorized personnel access only and camera system monitoring, Each data center hosts storage area network connectivity and data backup solutions.

***Servers***

The State of Iowa Office of the Chief Information Officer (OCIO) and DHS server environments are based on a VMWare Virtual Machine environment, which hosts a variety of operating systems including Windows, Linus, Oracle and Solaris. Multiple virtual networks are available to support diverse host connection requirements. DHS and the OCIO have a two-way trust to support Active Directory for management of user authentication and access to server-based data. Access to enterprise storage area network devices and database solutions are part of the OCIO service offering for state agencies to utilize in meeting their IT needs.

***DHS Remote Offices***

The DHS model for server deployment has been placement of a single Microsoft Windows Domain Controller server for file-and-print services wherever there is a DHS office. This model has been modified to support the Agency reorganization to less than full time offices (LTFT). The Agency currently has 57 less than full time offices that do not have a server at their location. All data including remote Domain Controllers are backed up centrally and replicated to a secondary site.

Users in a typical remote office use Intel-based personal computers running Windows 7 desktop operating system software. Although IE11 is the default browser, current versions of Chrome are also supported. PCs, printers and the local Domain Servers are connected to an Ethernet switch, with the local server supplying network login authentication, file, and print services. In addition, users rely on WAN connectivity for access to the Internet as well as DHS Hoover-based services such as Gmail, SQL 2016 databases, IIS 8.5 .Net Applications, Imaging, and Central Office server-based file storage. Users in DHS' remote offices also utilize the WAN to communicate with the OCIO mainframe.

In all offices, users rely on the LAN and WAN for access to DHS' imaging solution, which centrally locates archived images on an EMC Center storage device in the OCIO Data Center. This data is also replicated to a second Center located at the IME facility.

The ICN router is attached to the Capitol Complex Ethernet network, and this link is used by the ICN to communicate with DHS and ITE's networks in Primary Data Center.

F.1.2 U.S. Department of Health and Human Services

Within the U.S. Department of Health and Human Services, three agencies administer the Medicaid program. The following paragraphs describe their roles.

The Centers for Medicare and Medicaid Services (CMS) is responsible for promulgating Title XIX (Medicaid) regulations and determining state compliance with regulations. CMS also is responsible for certifying and recertifying all state MMIS operations.

The Office of Inspector General (OIG) is responsible for identifying and investigating instances of fraud and abuse in all state Medicaid programs. The Inspector General’s office also performs audits of all state Medicaid programs.

The Social Security Administration (SSA) is responsible for supplemental security income (SSI) eligibility determination. The Social Security Administration transmits this information via a state data exchange (SDX) file to the Agency for updating the eligibility system. Information is also provided on Medicare eligibility through beneficiary data exchange and Medicare Parts A and B buy-in files. The Agency then provides Medicare eligibility information to the MMIS as part of the eligibility file update process.

F.1.3 Iowa Medicaid Enterprise Professional Services

The Iowa Medicaid Enterprise (IME) is a collaboration of third party professional and system services contractors and Agency staff.  The Agency’s IME staff is relatively small with 41 State employees. Agency staff provide program and policy guidance, oversight, and contract monitoring to ensure access, cost effectiveness, and quality. To support the IME structure, the Agency’s contractors execute the majority of the Medicaid program business functions under a performance-based structure.

The IME currently has Core MMIS, Pharmacy Point of Sale (POS) and Program Integrity (SURS) vendors who provide what CMS would consider a system or sub-system of the current Medicaid Enterprise. At the core of the IME is its MMIS, a mainframe application hosted within the State’s data center, used primarily for batch processing claims and processing various file updates. The IME’s MMIS is built around subsystems that organize and control the data files used to process claims and provide reports. The MMIS contains standard subsystems such as: Recipient, Provider, Claims, Reference, Management and Administrative Reporting (MAR), Managed Care and Third-Party Liability (TPL), as well as the supporting Medically Needy and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) subsystems. The Core MMIS contractor provides, per contractual requirements, an Electronic Data Interchange (EDI) system and support services, and imaging/scanning solutions. The Agency currently separately contracts with Verscend Technologies for a claims editing solution to meet National Correct Coding Initiative requirements. The Core MMIS contractor will be responsible for providing an NCCI-compliant claims editing solution beginning July 1, 2018.

The IME professional services contracts include responsibilities directly in support of the claims processing and data retrieval. In addition, their activities promote the State’s responsibilities for service assessment and quality indicators. A summary of professional services contracts and their primary business functions beginning July 1, 2018 is below:

**Table 2: Iowa Medicaid Primary Business Functions**

| **Contract** | **Business Functions** | |
| --- | --- | --- |
| **Member Management, Consumer Assistance, and Eligibility Help Desk Services**  (including Member Services and DHS Contact Center, ***hawk-i*** will be added in July 2019) | * Member Enrollment/ Enrollment Broker * Member, DHS Contact, and ***hawk-i*** Call Centers * Member Outreach * Managed Care Liaison | * Application and Renewal Assistance * Support ELIAS Level 1 Help Desk/Ticketing * Consumer Assistance for Program Eligibility Requirements |
| **Program Integrity** | * PI System and Database * Data Analytics and Program Analysis * Surveillance and Utilization Review * Encounter Data Quality * MCO Oversight * PERM Project | * Medical Necessity Reviews, Audits, and Payment Recovery * Referrals to Department of Inspections and Appeals (DIA) * CHIPRA and Adult Medicaid Quality Measure Reporting * Ad Hoc Reports |
| **Provider Cost Audit and Rate Setting Services** | * Provider Cost Audits * Provider, Nursing Facility, and LTC Rate Setting | * Provider Cost Settlements * Drug Pricing and Pharmacy Reimbursement Methodologies |
| **Provider Services** | * Provider Call Center * Provider Enrollment and Credentialing | * Provider Outreach, Education and Training * Provider Publications |
| **Quality Improvement Organization Services**  (including Medical Services and HCBS QA) | * Medical Support * Utilization Management * Claims Pre-Payment Review | * HCBS Quality Oversight |
| **Revenue Collections and Estate Recovery Services** | * Third Party Liability Recovery * Pay and Chase * Yield Management * Provider Overpayment and Credit Balance Recovery | * ***hawk-i*** data match * Estate Recovery Services * Provider Withholds and Tax Offsets * Stale Dated Checks * Bank Deposits |
| **Pharmacy Point-of-Sale System** (including Pharmacy Medical Services) | * Pharmacy Claims Adjudication * Drug-Drug Interaction Management * Retro drug Utilization Review * Pharmacy Prior Authorization | * Pharmacy Prior Authorization Management * Preferred Drug List and Supplemental Rebate Program |

F.2 Overview of Current MMIS Information Technology (IT) Operations

The Iowa MMIS is a mainframe application with primarily batch processing for fee for service claims and file updates. The Core MMIS contractor manages the system, as well as the workflow management process system known as OnBase**®**. Infrastructure services are hosted by the State’s Office of the Chief Information Officer. The Division of Data Management (DDM) manages the separate DW/DS system, Buy-in, TXIX, IMPA, Individualized Services Information System (ISIS) and the Premium Payment System. Separate vendors manage the Pharmacy Point of Sale (POS) system that provides real-time processing for pharmacy claims and the Surveillance and Utilization Review System (SURS) that provides Medicaid Program Integrity reporting and analytics.

The Iowa MMIS, as is the case with virtually all of the systems in operation today, is built around subsystems that organize and control the data files used to process claims and provide reports. The MMIS contains the eight standard subsystems: Claims Processing, Recipient, Provider, Reference, Management and Administrative Reporting (MAR), Managed Care and Third-Party Liability (TPL), as well as the supporting Medically Needy and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) subsystems.

The MMIS is Health Insurance Portability and Accountability Act (HIPAA) 5010, National Council for Prescription Drug Program (NCPDP), and International Classification of Diseases (ICD-10) complaint. In addition, the Agency strives to align with guidance in the Minimum Acceptable Risk Standards for Exchanges (MARS-E) 2.0, Medicaid Information Technology Architecture (MITA), and Medicaid Enterprise Certification Toolkit (MECT). Those efforts will continue and be a part of the MMIS takeover ongoing Contractor expectations.

**F.2.1 MMIS Enhancements Currently Underway**

Active projects related to the MMIS that may be assumed by the successful bidder include the following:

**F.2.1.1 Transformed-Medicaid Statistical Information System (T-MSIS)**

T-MSIS is a CMS initiative to improve Medicaid and CHIP data and data analytics, as well as reduce the number of reports and data requests required of states. T-MSIS will be a main source of Medicaid and CHIP operational data, and CMS intends to use the T-MSIS data to calculate and derive other reports states are currently required to submit, such as Early Periodic Screening, Diagnosis and Treatment Program (EPSDT) and Children’s Health Insurance Program Annual Reporting Template System (CARTS). The anticipated completion date for the project is February 28, 2018. More information about this project can be found in the Online Bidders Library.

**F.2.1.2 New Medicare card project**

CMS uses the Health Insurance Claim Number (HICN) with multiple parties, such as Social Security Administration (SSA), Railroad Retirement Board (RRB), States, Medicare providers, Medicare plans, etc. The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 mandates the removal of the SSN-based HICN from Medicare cards to address the current risk of beneficiary medical identity theft. Per federal regulations, CMS must mail out all Medicare cards with the new Medicare Beneficiary Identifier (MBI) by April 2019. Changes to Agency internal systems and the MMIS are currently underway, systems testing with external partners are schedule to be completed by December 29, 2017 and expected implementation date (ready to accept the new Medicare number) is April 2018. In addition, the MMIS will need to support the EO1 (COBA) file /ERF processes by the time the MBI will be used (no later than April 2019).

**F.2.1.3 *hawk-i* Enrollment and Reporting**

The Agency’s eligibility system (ELIAS) determines eligibility for ***hawk-i***. Enrollment currently occurs in a contracted third-party administrator (TPA) system. The Agency plans to integrate the TPA system ***hawk-i*** enrollment, capitation, and reporting functions into the current MMIS. This project will be completed in two phases. The first phase is to bring ***hawk-i*** enrollment data into the MMIS, this will allow MMIS to issue enrollment and capitation files directly to the MCOs. The target completion date for phase 1 is April 30, 2018. The second phase will bring ***hawk-i*** MCO assignment, enrollment, and reporting functions into the MMIS. This phase is projected to begin in July 2018, with a target completion date of April 30, 2019. More information about this project can be found in the Online Bidders Library.

F.2.1.4 MCO Passive Enrollment

Currently new Members are fee for service prior to the actual MCO assignment. The Agency is in the initial planning stages for implementation of an MCO passive enrollment process. Passive enrollment means the State assigns and enrolls Members into a managed care plan without offering an “up front” plan selection period. This is often referred to as an “auto-assignment process.” Once assigned, the Member will have opportunities to change plans. This will then remove the FFS period prior to the Members being enrolled in managed care. This phase is projected to begin in July 2018, with a target completion date for the project of January 1, 2019.

F.2.1.5 Electronic Visit Verification (EVV)

The Agency is in the initial planning stages for implementation of an EVV solution for personal care services and home health care services. Any MMIS enhancements needed to consume EVV files from an external system and tie to authorization of claims would not begin until July 1, 2018. To allow for sufficient provider testing, the target completion dates are:

* Phase 1 (personal care services) is November 1, 2018
* Phase 2 (home health care services) is November 1, 2022

F.2.2 Eligibility

Medicaid eligibility is determined within one of three different systems that are managed by the Division of Data Management (DDM): ELIAS, FFP system, or IABC. These systems are described in Sections F.2.5.20-22.

F.2.3 Providers

The Iowa Medicaid Program provides direct reimbursement to enrolled providers who have rendered services to eligible Members. Providers may be reimbursed for covered services following application, enrollment, and completion of a provider agreement. The Iowa Medicaid Program currently recognizes a multitude of provider types with their corresponding MMIS code values, which can be found within the Online Bidders Library.

F.2.4 Covered Services

The Iowa Medicaid Program covers all federally mandated services as well as a number of optional services. The services currently covered under the program are listed in the Medicaid Guide within the Online Bidders Library.

**F.2.5 MMIS Operating Environment**

The legacy MMIS system is written in COBOL and controlled using Job Control Language (JCL). A complete MMIS DSD documenting the components can be found within the Online Bidders Library.

Table F.1 below provides an overview of the Iowa MMIS and includes the topics and a description of all current MMIS subsystems.

This section highlights the information technology applications that are in use in the Iowa Medicaid Enterprise (IME) operating environment. All contractors operating within the IME will use existing common managerial tools where necessary to perform their operational functions. Detailed information about all of the tools is available within the Online Bidders Library.

All hardware is located within the State of Iowa facilities. The Agency is responsible for managing the network, operating systems, and network security. The CORE MMIS vendor is responsible for installation and administering the application(s), application security, application development, and coordination of COTS vendor support as appropriate, unless another IME Unit is the designated owner.

The following topics highlight the CORE MMIS-related subsystems and applications.

**Table F.1: Core MMIS-related Subsystems and Applications**

| **Information System** | **Current Responsible Unit** |
| --- | --- |
| **Iowa Medicaid Management Information System (MMIS)**  **F.2.5.1: Claims Processing (Fee for Service)**  **F.2.5.2: Recipient Subsystem (Member Management)**  **F.2.5.3: Provider Subsystem**  **F.2.5.4: Reference Subsystem**  **F.2.5.5: Medically Needy Subsystem**  **F.2.5.6: Management and Administrative Reporting System (MARS)**  **F.2.5.7: Surveillances and Utilization Review System (SURS)**  **F.2.5.8: Third Party Liability (TPL) System**  **F.2.5.9: Prior Authorization Function**  **F.2.5.10: EPSDT Subsystem**  **F.2.5.11: Managed Care – Assignment, Capitation and Enrollment**  **F.2.5.12: Managed Care – Encounter Data**  **F.2.5.13: Eligibility Verification Information System (ELVS)**  **F.2.5.14: Premium Invoicing Function**  **F.2.5.15: Dental Program**  **F.2.5.16: Workflow Process Management System (OnBase®)**  **F.2.5.17: EDI Support Services**  **F.2.5.18: NCCI Claims Editing** | CORE MMIS |
| **F.2.5.19: Right Fax** | Agency DDM, CORE manages interfaces to Workflow Process Management |

**F.2.5.1 Claims Processing (Fee for Service)**

The claims processing subsystem is one of the most critical modules of the Medicaid Management Information System (MMIS). It captures, controls and processes claims data from the time of initial receipt (on hardcopy or electronic media) through the final disposition, payment and archiving of claims history files. The claims processing subsystem edits, audits and processes claims to final disposition consistent with the policies, procedures and benefit limitations of the Iowa Medicaid Program. To accomplish this, the subsystem uses the data contained in the most current recipient eligibility file, provider master file, reference files, TPL resource file and prior authorization (PA) file.

The claims processing subsystem maintains claims history including both paid and denied claims. The MARS and SURS subsystems use claims history in producing management and utilization reports, as does the claims processing subsystem in applying history-related edits and audits. Online inquiry is available for 36 months of adjudicated claims history, lifetime procedures, and any claims still in process. Service limitations for vision, dental and hearing aid are displayed in the recipient eligibility subsystem key panel.

The claims processing subsystem processes, pays or disallows and reports Medicaid claims accurately, efficiently and in a timely manner. Paper claims are scanned and verified before entry into the MMIS adjudication process. Electronic claims are received through an EDI clearinghouse. Claims may also be entered manually through the online CICS screens. The claims processing subsystem includes the ability to process Medicare crossover claims.

The claims processing subsystem provides up-to-date claims status information through online inquiry and provides data to the MARS, SURS and EPSDT subsystems, and other accounting interfaces used to generate administrative reports. Claims are adjudicated during nightly batch cycles Monday-Friday. The claims engine ensures accurate and complete processing of all input to final disposition. The claims processing subsystem offers online features such as online, real-time claim credits and adjustments.

Outputs of the claims processing subsystem include detailed remittance advices for providers and member explanations of medical benefits (EOMBs). This subsystem also produces updates to the claims history files, prior authorization file, recipient eligibility file and provider file.

The MMIS processes all Iowa fee for service claim forms and a variety of electronic media claims (EMC) including transfers from claims clearinghouses and direct computer data transfer. All claims entered into the subsystem are processed similarly according to claim type, regardless of the initial format of the claim document. Pre-processing is performed to reformat the various inputs into the MMIS claim layout.

The system determines to either pay or deny a service according to criteria on the exception control file. This parameter table, which is maintained online, enables the Agency to control the disposition of edits and audits without any programming effort involved. Separate exception codes are posted for each edit and audit exception for each line item. Each exception code can be set to several dispositions depending on such factors as input media (paper or magnetic tape) and claim type. Claim type is assigned by a combination of claim invoice and other indicators within the claim.

If all exceptions on a claim have a disposition of pay, deny or pay and report, the claim is adjudicated and the payment amount is computed according to the rules and regulations of the State of Iowa. If any exception for the claim is set to suspend, then the claim is either printed on a detailed suspense correction report or listed for an online suspense correction as dictated by parameters on the exception control file. A super-suspend disposition is used for edits so severe that no resolution short of correcting the error is possible (such as invalid provider data). The pay-and-report disposition allows the Agency to test the impact of a new exception and decide how to treat the condition in the future such as pay, deny, or educate providers. Claims with special exception codes are routed according to Agency instructions. The specific unit responsible for correction of an exception is designated by the location code on the exception control file.

The MMIS allows the detail and summary resolution text to be entered on the text file of the reference subsystem. This information is then available to the resolution staff during exam entry, suspense correction, and inquiry processes, thus providing an online resolution manual.

A remittance advice is produced for every claim in the system and shows the amount paid and the reasons for claim denial or suspense. The message related to each exception code is controlled by parameters on the exception control file. A different message can be printed according to claim submission media, claim type, and whether the claim is denied or suspended. The actual text of the message is maintained online on the text file.

The MMIS maintains 36 months of adjudicated claims history online. The claims, as well as all claims in process, are available for online inquiry in a variety of ways. Claims can be viewed by member identification (ID), provider number, National Provider Identifier (NPI), claim transaction control number (TCN) or a combination of the above. The search criteria can be further limited by a range of service dates, payment dates, payment amounts, billed amounts, claim status, category of service, procedure codes or diagnosis codes within a claim type. Claims can be displayed either in detail, one claim per screen, in summary format, and several claims per screen. Additional inquiry capability allows the operator to browse the member, provider or reference files from the claim screen to obtain additional information related to the claim. A summary screen is also available for each provider containing month-to-date, year-to-date, and most recent payment information. The claims processing subsystem has the capability to suspend or deny claims based on TPL information carried in the MMIS files.

The MMIS supports cost containment and utilization review by editing claims against the prior authorization record to ensure that payment is made only for treatments or services, which are medically necessary, appropriate, and cost-effective. The Utilization Review (UR) criteria file provides a means of placing program limitations on service frequency and quantity as well as medical and contraindicated service limits. It provides a means for establishing prepayment criteria, including cross-referencing of procedure and diagnosis combinations.

The claims processing subsystem contains a claims processing assessment system (CPAS) module designed to provide claim sampling and reporting capability required to support the Agency in conducting CPAS reviews.

Each step in document receipt processing and disposition includes status reporting and quality control. The Iowa MMIS generates several reports useful in managing claim flow and resolution. Reports are used to track the progress of claims at each resolution location, identify potential backlogs, pinpoint specific claims that have suspended, monitor workload inventories, and ensure timely processing of all pended claims. Meanwhile, quality control staff monitors all operations for adherence to standards and processing accuracy in accordance with contractual time commitments and error rates.

The claims receipt, entry and control module function ensures that all claims and related input to the MMIS are captured at the earliest possible time in an accurate manner. This function monitors the movement and distribution of claims once they are entered into the system to ensure an accurate trail from receipt of claims through final disposition. The function includes both manual and automated processes for claim control.

**F.2.5.2 Recipient Subsystem (Member Management)**

The recipient subsystem is the source of all eligibility determination data for the MMIS, whether generated by the Agency or by the MMIS. The information contained in the MMIS eligibility file is used to support claims processing, management and administrative reporting, surveillance and utilization review reporting, managed care functionality and TPL. The recipient subsystem currently meets or exceeds all federal and state requirements for a Medicaid recipient subsystem.

The MMIS recipient subsystem is designed to provide the flexibility required to accommodate the Agency’s changing approach to the management of its public assistance programs.

The recipient subsystem accepts data only from the Title XIX system for eligibility and facility data. The recipient subsystem receives daily transmissions of eligibility updates from the Title XIX system, which are used for batch updates of the recipient eligibility file.

The MMIS batch file update methodology is supplemented with online, real-time updates to the recipient record. The guardian effective date and ID are added or updated through the online feature of the recipient subsystem. All online updates to the recipient eligibility file are thoroughly controlled to ensure the accuracy of the updates before they are applied to the file.

Audit trails are supported through the use of the online transaction log file. The transaction log files records a before and after image of each MMIS master file record updated online. The transaction log file is then used to support daily online update activity reporting and is retained for historical purposes.

The Agency and the Contractor share the responsibility for the operation of the recipient subsystem. The Agency determines which individuals are eligible to receive benefits under the Iowa Medical Assistance program and sets limitations and eligibility periods for those individuals. The Agency is responsible for transmitting, either electronically or by other approved media, eligibility data elements required to maintain the MMIS recipient eligibility file on both a daily and monthly basis.

The Contractor is responsible for operating the MMIS recipient subsystem. The recipient subsystem will process the Agency’s daily and monthly update transmissions and submit all balancing and maintenance reports to the Agency. Any discrepancies discovered during the update process are promptly reported to the Agency.

The Contractor provides reports from the recipient subsystem files in the format specified by the Agency. These reports include the detailed recipient eligibility updates, recipient update control and update error reports. Several reports are created from monthly recipient processing, such as the recipient list reports, the possible duplicate reports, and the recipient purge report.

The purpose of the Member Management module is to accept and maintain an accurate, current, and historical source of eligibility and demographic information on individuals eligible for medical assistance in Iowa and for supporting analysis of the data contained within the Member database. The maintenance of Member data is required to support Iowa eligibility verification, claims processing and reporting functions. The Member management function maintains an accurate and current identification of Members eligible for both Medicaid and Medicare. The Member management function must also contain historical Member information that supports claims adjudication and audit requirements according to Iowa records retention rules.

**F.2.5.3 Provider Subsystem**

The provider subsystem maintains comprehensive provider related information on all providers enrolled in the Iowa Medicaid Program to support claims processing, management reporting, surveillance and utilization review. The provider subsystem processes provider applications and information changes interactively using online screens. This capability for immediate entry, verification and updating of provider information, ensures that only qualified providers complying with program rules and regulations are reimbursed for services rendered to eligible Medicaid Members. The provider subsystem currently meets or exceeds all federal and state requirements for a Medicaid provider subsystem.

The provider subsystem retains provider related data on six files: provider master file, the provider group file, provider intermediary file, Medicare-to-Medicaid cross-reference file, provider HMO plan file, and the National Association of Boards of Pharmacy (NABP)-to-Medicaid cross-reference file. These files are used to interface with the claims processing, recipient, MARS, SURS, TPL, and EPSDT subsystems to supply provider data for claims processing and provider enrollment and participation reporting. Provider enrollment is also passed into ISIS to facilitate service plans for Long Term Care service plans.

**F.2.5.4 Reference Subsystem**

The reference subsystem's function is to provide critical information to the claims processing and MAR subsystems. The data to support claims pricing and to enforce state limits on services resides in the reference subsystem. The basic design of the MMIS reference subsystem offers the Agency flexibility in meeting changing program requirements.

Real-time file updating allows for the immediate editing and correcting of update transactions to all of the reference subsystem files. Once a transaction has been applied, it is effective immediately for claims adjudication. The subsystem provides many user-maintained parameters that allow the IME to fine-tune the edits and audits of the Iowa MMIS.

While the basic design of the system stresses online file updates and inquiries, the reference subsystem also incorporates batch updating of key files. The reference subsystem accepts batch procedure, diagnosis, DRG, and APC updating.

The system accommodates mass adjustments due to retroactive price changes. The adjusted claim is priced against the policy in effect on the date of service, even if the price is established after the date that the claim was originally processed.

**F.2.5.5 Medically Needy System**

The medically needy program provides medical assistance to individuals who meet the categorical but not the financial criteria for Medicaid eligibility. Medically needy eligible may be responsible for a portion of their medical expenses. This is referred to as "spend down.” The Agency determines the spend down obligation for these Members. Once individuals become eligible by meeting their spend down obligation, Medicaid pays the claims that were not used for spend down for the certification period.

The medically needy module serves as an “accumulator” of claims that apply toward the spend down amount. The module displays the medically needy spend down amount, the amount of claims that have accumulated towards the spend down amount, information for each certification period, the date spend down is met, and information about claims used to meet spend down. The Agency can access the medically needy screens online.

The medically needy function of the MMIS consists of processing claims for Members eligible for the medically needy program tracking medical expenses to be applied to the spend down and providing reports of spend down activity.

The Iowa medically needy subsystem’s function is to accumulate, track, and apply Medicaid claims to the spenddown for individuals who meet the categorical but not the financial criteria for Medicaid eligibility and who are described as medically needy.

Medically needy eligible individuals may be responsible for a portion of their medical expenses through the spenddown process. The Agency’s IM workers determine initial eligibility and the spenddown obligation for these Members. The Title XIX system sends a record to the MMIS unit identifying these potential medically needy eligible individuals, which allows the MMIS to accumulate claims toward their spenddown amount.

The medically needy subsystem serves as an accumulator of claims that apply toward the spenddown amount. The subsystem displays the medically needy spenddown amount, the amount of claims that have accumulated towards the spenddown amount, information for each certification period, the date that the spenddown obligation is met and information about claims used to meet the spenddown obligation. Agency staff can access these medically needy screens online.

Once individuals become eligible by meeting their spenddown obligation, Medicaid pays the claims that were not applied to the spenddown for that certification period. The medically needy function of the MMIS consists of processing claims for Members eligible for the medically needy program, tracking medical expenses to be applied to the spenddown and providing reports of the spenddown activity.

Cases that have a spenddown obligation in either the retroactive or the prospective certification period have information passed from the IABC system, to the MMIS medically needy subsystem. Medically needy cases that are approved and have zero spenddown in both the retroactive and prospective certification periods, are maintained by the IABC system and are not passed to the MMIS medically needy subsystem. Individuals with active fund codes are automatically eligible for Medicaid. The IABC system passes information to Title XIX, which then passes a Member record to the MMIS when the Member is eligible for Medicaid.

The Medicaid card is issued by a vendor under contract to the Agency.  The MMIS generates and sends a file to the contractor daily for new Members who have not previously been issued a card. Members enrolled in the medically needy program are not eligible to receive an ID card until they have met spenddown obligations and their fund codes in the MMIS system have changed to eligible fund codes. The card does not have an expiration date (e.g., there is no annual reissuance).  If a Member needs a new card, Agency staff use a system called Online Card Replacement Application (OCRA). The system generates a record that is passed daily to the MMIS and included in the daily file feed to the Medicaid card vendor. The MMIS tracks the card issuance date used to determine if a new Member has been issued a card or not.

**F.2.5.6 Management and Administrative Reporting System (MARS)**

The MARS subsystem provides the Agency management staff with a timely and meaningful reporting capability in the key areas of Medicaid program activity. MAR reports are designed to assist management and administrative personnel with the difficult task of effectively planning, directing, and controlling the Iowa Medicaid Program by providing information necessary to support the decision-making process.

The MARS subsystem presents precise information that accurately measures program activity and ensures control of program administration. The MARS subsystem also provides historical, trend and forecasting data that assists management in administering the Iowa Medicaid Program. In addition, the MAR subsystem provides necessary information to all levels of management to predict potential problems and plan solutions.

The MARS subsystem extracts key information from other subsystems for analysis and summarization. The MAR subsystem maintains this data in many different variations for use in producing its reports. This information can also be used as an extensive base of data for special or on-request reporting.

The Agency and the Contractor share responsibility for the ongoing operation of the MARS subsystem. The Agency's responsibilities are to determine the format, reporting categories, parameters, content, frequency, and medium of all routinely produced reports and special reports. The Agency is also responsible for submitting information to be incorporated with MMIS data files for reporting, including budget data, buy-in premium data and managed care encounter data. In addition, the Agency determines policy, makes administrative decisions, transmits information, and monitors contractor duties based on MAR reports.

The Contractor is responsible for operating the MARS subsystem and supporting all of the functions, files, and data elements necessary to meet the requirements of the RFP. All reports have uniform cutoff points so that consistent data is input to each MARS report covering the same time period. A complete audit trail is provided among the MAR reports and between reports generated by MARS and other subsystems for balancing within the cycle.

The Contractor produces and makes available the MARS reports and other outputs in formats, media, and time frames specified by the Agency. The Contractor produces reports at different summary levels according to the Agency specifications and verifies the accuracy of all reports.

The Contractor develops, provides and maintains both system and user documentation for the Agency personnel and its own staff. The Contractor provides knowledge transfer for the Agency personnel and contractors on an ongoing, as needed basis.

The MMIS MARS subsystem has been designed and refined to run within a batch-processing environment. The system is able to handle large amounts of input data, to manage system input and output (I and O) resources efficiently, to minimize program execution and central processing unit (CPU) time requirements and to provide reliable and effective restart and recovery capabilities.

**F.2.5.7 Surveillance and Utilization Review Subsystem (SURS)**

The SURS subsystem is designed to provide statistical information on recipients and providers enrolled in the Iowa Medicaid Program. The subsystem features effective algorithms for isolating potential mis-utilization. Also, it provides an integrated set of reports to support the investigation of that potential misuse.

**F.2.5.8 Third-Party Liability (TPL) System**

The TPL subsystem is a fully integrated part of the MMIS. A significant amount of TPL processing occurs within the recipient subsystem, claims processing subsystem and MARS subsystems.

TPL coverage is maintained by Member within the recipient subsystem. The TPL resource file within the recipient subsystem contains Member identification data, policy numbers, carrier codes, coverage types, and effective dates. An indicator on the recipient eligibility file is set for those Members having verified policy information on the TPL resource file.

The claims processing subsystem identifies claims with potential TPL coverage by examining the TPL resource file and indicators from the claim form. Claims for services with third-party coverage may be paid, paid and reported, suspended or denied based on the individual circumstances.

**F.2.5.9 Prior Authorization**

The Contractor is responsible for maintaining the prior authorization file, which contains procedures requiring prior authorization, information identifying approved authorization, certification periods, and incremental use of the authorized service. The Contractor receives file updates from the QIO contractor for selected authorization codes. These authorizations are loaded on the prior authorization file that is used by the MMIS for processing claims. The Contractor must ensure that all claims are denied for services requiring pre-procedure review by the QIO contractor if a validation number indicating approval is not present on the PA file. The Contractor is responsible for ensuring that in cases requiring preadmission review by the QIO contractor, payment is made only if an approval certification is present on the claim and that payment is made only for the approved number of days and at the specified level of care.

The Contractor will also receive file updates from the QIO contractor on authorized services. These files will cover the array of services under the QIO contractor’s responsibility.

The Contractor uses Individualized Service Information System (ISIS) as a prior authorization file to verify authorized services, Members and rates for payment of HCBS Waiver programs. ISIS is also used for prior authorization of facility, remedial services, habilitation services, and targeted case management services. Approved service authorizations are sent from ISIS to the prior authorization subsystem. Approved eligibility spans are sent from ISIS through the Title XIX system to the MMIS recipient eligibility file.

All ISIS Waiver Service Authorizations are passed daily to the TXIX System for additional processing by the Prior Authorization subsystem.  Only approved service authorizations are used in a match process with all ISIS Prior Authorization Service records.  This process creates add, change and delete files that are passed daily to MMIS for ISIS service payments.

**F.2.5.10** **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Subsystem**

The EPSDT subsystem is a proactive medical services program for recipients under the age of 21. Its goal is to prevent illness, complications and the need for long-term treatment by screening and detecting health problems in the early stages. The EPSDT subsystem supports the IME in the timely initiation and delivery of services. It also supports care management; federal reporting and follow-up treatment tracking by interfacing with MMIS paid claims history and recipient eligibility.

The MMIS EPSDT subsystem satisfies the Agency’s requirements for Member notification, services tracking and reporting. The subsystem maintains EPSDT eligibility and screening information, as well as required demographic data, on the recipient eligibility file and the EPSDT master file. It generates notifications, referral notifications, and a state-defined periodicity schedule based on the information collected from the recipient eligibility file and the EPSDT master file. The EPSDT subsystem reports all screenings and referrals and tracks the treatments, which result from screening referrals. Extensive detail and summary reports are produced as well as required federal reporting and case documentation.

**F.2.5.11 Managed Care – Assignment, Capitation and Enrollment**

The Managed Health Care system is responsible for assigning and tracking membership enrollment with a Managed Care Organization. When new Members are received from the eligibility system, Members eligible for managed health care are assigned to a default MCO. The Member receives a welcome packet and is given the option to change to or from the MCO or change their designated MCO during an open enrollment period. Members who continue in Medicaid past the first year are given open enrollment windows during which they may elect to change to a different MCO. The Managed Health Care subsystem is responsible for default MCO assignments, open enrollment period management, letter notifications to Members and providers, roster notifications, statistical reporting, Capitation Payments, and managed health care coverage rules.

Additional files are created by the MMIS for the care and coordination of a Member’s enrollment:

* Enrollment Data (834)
* LTSS and Waiver Plan
* COBA – E01 process MMIS the FFS dual eligible Members to CMS/COBC on file COBA ID 70020.
* EPSDT file to IDPH
* Prior Authorizations
* TPL
* Claims History (Institutional, Pharmacy and Professional)
* Medicaid Provider Information
* When a Member is assigned to a new MCO:
  + CCO Detail and Summary
  + Health Home/Integrated Health Home
  + Case Manager
  + Member NEMT TripsMember HCBS Waiver Service Plan
  + Member Healthy Behaviors
  + Exception to Policy (ETP) Documents
  + Pharmacy Prior Authorization
  + Provider Lien Data File

MMIS is also responsible for the determination of appropriate Capitation Payments based upon a Member’s eligibility and enrollment. Monthly Capitation Payments are generated for processing the first full week of the calendar month. The timing is intended for appropriate reporting period and also to allow additional time for latent eligibility updates. Off cycle Capitation Payments and adjusts can occur for latent eligibility, historical adjustments, maternity case payments, or recoupments,

Monthly Capitation Payments are generated in the form of ACH payments directly to the MCOs’, PAHPs’, and NEMT broker’s financial institutions. These payments will align directly with the 820 file that is created and sent to the plans and broker.

Additional files that are periodically sent to the MCOs are as follows:

* The following files are sent daily
  + Medicaid Provider File
  + Carrier Code File
  + Universal Provider Application
  + Provider Lien Data
* The following files are sent weekly
  + Pharmacy Prior Authorization
  + Pharmacy PDL
  + Member Waiver Slot Status
* The following files are sent monthly
  + Data Dictionary
  + Provider OCD
  + Encounter Claim Error File
  + Healthy Behaviors File

Additional files that are periodically sent from MCOs to MMIS are as follows:

* + The following files are sent when a Member is disenrolled from the MCO
  + TPL File
  + Prior Authorization
  + Case Manager File
  + Member NEMT Trips
  + Member HCBS Waiver Service Plan
  + Member PCP Assignment
* The following files are sent daily
  + HIPP Referral
  + Death Referral
  + Incarceration Referral
* The following files are sent weekly
  + Terminated Pregnancy
  + Member Healthy Behaviors
* The following files are sent monthly
  + Maternity Case Payment Request
  + Medicaid Provider File
  + HH/IHH Member Months
  + IHH/CHH File
  + Provider Lien Data File

**F.2.5.12 Managed Care – Encounter Data**

MMIS then processes those encounter transactions and applies another set of validation edits to ensure the encounter claim meets minimum requirements. An encounter claim error reporting file is transmitted to each MCO, PAHP and the NEMT broker. If an encounter is rejected by the edits of MMIS, all reasons for rejection are sent in the reporting file. All accepted and rejected encounters are retained in MMIS.

After the encounters are processed in the MMIS, they are sent to many downstream entities, including CMS, actuarial consultants, IME Pharmacy Point of Sale vendor, IDPH, DHS Data Warehouse and the University of Iowa. See Encounter Data Flow document in the Online Bidders Library.

**F.2.5.13 Eligibility Verification Information System (ELVS)**

The Eligibility Verification Information System (ELVS) provides date-specific information to providers regarding Member eligibility, provider payment amounts, TPL coverage, and managed health care participation. ELVS is provided at no charge to the providers. Authorized users may request verification for a specific date with the Member SSN or State ID, and DOB. Through EDI 270/271, providers may also search by Last Name, First Name, and DOB.

The IVR unit works against the Eligibility Verification System (ELVS) database. The IVR is a telephone voice and touch-tone response system maintained by the Contractor that provides access to limited data elements from the MMIS. The IVRS operates seven days a week 24 hours a day. The information reported by IVRS is in the form of digitally recorded phrases stored on the IVR computer.

Providers may query Member eligibility or recent provider payment information by responding to prompts on their touch-tone telephones. Based on information supplied by the caller ELVS systematically retrieves data, interprets the data, and then communicates the appropriate phrases back to the caller.

**F.2.5.14 Premium Invoicing Function**

On a monthly basis, MMIS creates and sends a file to the Premium Payment System (PPS) for all months that need to be invoiced for a premium. Currently, the Iowa Health and Wellness Plan is the only program that may bill a premium through PPS. However, all Dental Wellness Plan premiums will be billed through PPS starting in July 2018. ***hawk-i*** premiums will also be billed through PPS starting in July 2019.

A Member’s healthy behaviors are taken in to account to determine if premiums need to be billed. MMIS tracks a Member’s enrollment year to determine if and when healthy behaviors are met. Reporting is required on the healthy behaviors as well.

**F.2.5.15 Dental Program**

In June of 2017, Iowa Medicaid announced the new Dental Wellness Plan covering most adults eligible for a Medicaid dental benefit. The new plan was effective July 1, 2017, and superseded the original Dental Wellness Plan (which was limited only to those adults eligible through the Affordable Care Act’s Medicaid Expansion).

Dental Wellness Plan members have two dental carrier options to choose from, Delta Dental or MCNA Dental. All Dental Wellness Plan members will receive full dental benefits in their first year of eligibility. Members who complete their dental healthy behaviors each year will continue to receive full benefits. Members who do not complete their dental healthy behaviors may be charged a monthly premium.

Comprehensive information on the plan, including links to the dental carriers, healthy behaviors and other important information is on the Dental Wellness Plan website at: <https://dhs.iowa.gov/dental-wellness-plan>.

MMIS is responsible for maintaining dental eligibility records, claims, payments and reconciliations.

**F.2.5.16** **Workflow Process Management System (OnBase®)**

OnBase**®** from Hyland Software is an enterprise content management (ECM) software suite that combines document imaging, electronic document management, records management, and workflow. Emdeon Transform is the imagining/scanning solution currently used by the incumbent Core MMIS contractor for all documentation, such as paper claims and correspondence that flow into the IME via the mailroom. The successful bidder will provide an imaging/scanning solution for use with OnBase. Once documents are scanned into the system they follow the further path of classify, Optical Character Recognition (OCR), and verification before transferred to OnBase and placed in a workflow queue based on document type. For informational purposes only, the current Agency standard imagining/scanning solution is Kofax, which is utilized within other Agency divisions.

The IME utilizes the workflow module as the primary call log application for the call centers as well as a support application for the OnBase and MMIS help desk. The Agency owns the OnBase licenses, but the solution is managed by the Contractor. Other OnBase products in use include scanning computer output to laser disk (COLD), Document Import Processor (DIP) and Report Services. The scan modules are used to bring all correspondence received into the OnBase system. COLD and DIP are modules that are used to import documents from the other systems in the IME, including reports from the MMIS and claims from the imaging system. Report Services is a module used to give the users a customizable interface to standard and ad-hoc reports in the OnBase system.

**F.2.5.17 Electronic Data Interchange (EDI)**

The successful bidder will provide an EDI solution.

Iowa Medicaid currently accepts HIPAA levels 1 through 7 transactions through an Electronic Data Interchange (EDI). The current solution is operated by Electronic Data Interchange Support Services (EDISS), a subsidiary of the incumbent MMIS vendor. EDI tools provide a secure environment for the exchange of files and a test environment to onboard providers and external clearinghouses. Claims are validated prior to entry into the MMIS to ensure they meet acceptable quality standards. Claims that do not pass editing at the EDI gateway are rejected and reported back to the providers on either/or:

* 277CA – Claims Acknowledgment
* 999 – Functional Acknowledgement

The EDI portal has a help desk to provide electronic data interface technical support and to assist Iowa Medicaid providers with connection and issue resolution.

See the Online Bidders Library for more information on EDI edit types and the life of a claim in EDISS.

**F.2.5.18** **National Correct Coding Initiative (NCCI) Claims Editing**

The successful bidder will provide an NCCI claims editing solution, whether that be a third-party solution, or built into the existing MMIS.

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The CMS annually updates the National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual). The Coding Policy Manual should be utilized by carriers and FIs as a general reference tool that explains the rationale for NCCI edits.

Iowa Medicaid currently utilizes Verscend to provide NCCI and Iowa-specific CCI edits for Iowa Medicaid Claims. Claims are adjudicated in the claims engine and a batch file is sent to Verscend for CCI and additional cross claim edits that the existing MMIS claims engine does not perform. The cycle waits for the claims edit responses and updates the adjudication accordingly for denials and cutbacks. Verscend provides a portal for providers to obtain additional detail surrounding the CCI edit applied to the claim.

**F.2.5.19** **RightFax**

RightFax is a fax management software product that accepts and sends faxes which uses a connector tool that allows the IME to automatically flow faxes from RightFax to OnBase for imaging and workflows. The software also allows IME users to send faxes from their desktops.  RightFax is supported by the DDM. The Contractor is responsible for the interface to the document repository and workflow systems, and the administration on IME users and roles.

**Table F.2: Other Supporting Systems and Applications**

|  |  |
| --- | --- |
| **Information Systems** | Current Responsible Unit |
| **F.2.5.20: ELIAS** | Agency DDM |
| **F.2.5. 21: Family Planning Program (FPP) system** | Agency DDM |
| **F.2.5.22: Individual Automated Benefits Calculation (IABC) system** | Agency DDM |
| **F.2.5.23: Title XIX System** | Agency DDM |
| **F.2.5.24: Individualized Services Information System (ISIS) and Consumer Choices Option (CCO)** | Agency DDM |
| **F.2.5.25: Medicare Prescription Drug Part D Database** | Agency DDM |
| **F.2.5.26: Medicaid Medicare Information Database (MMCR)** | Agency DDM |
| **F.2.5.27: Medicaid for Employed People with Disabilities (MEPD)** | Agency DDM |
| **F.2.5.28: Buy-In** | Agency DDM |
| **F.2.5.29: Medicaid Quality Utilization and Improvement Data System (MQUIDS)** | Agency DDM |
| **F.2.5.30: Iowa Medicaid Electronic Records System (I-MERS)** | Agency DDM |
| **F.2.5.31: Iowa Medicaid Portal Application (IMPA)** | Agency DDM |
| **F.2.5.32: Data Warehouse and Decision Support (DW/DS) System** | Agency DDM |
| **F.2.5.33: Pharmacy Point-of-Sale System** | Pharmacy Point-of-Sale Unit |
| **F.2.5.34: DataProbe®** | Program Integrity Unit |
| **F.2.5.35: HCBS Quality Assurance Provider Oversight** | QIO Unit |
| **F.2.5.36: Iowa EHR Medicaid Incentive Payment Administration** | PSI / MAXIMUS |
| **F.2.5.37: Iowa Health Information Network (IHIN)** | Iowa Health Information Network Non-profit |
| **F.2.5.38: Health Insurance Premium Payment (HIPP)** | Agency DDM |
| **F.2.5.39: Premium Payment System (PPS)** | Agency DDM |
| **F.2.5.40: State Payment Program** | Agency DDM |
| **F.2.5.41: Iowa Medicaid Provider Search** | Agency DDM |
| **F.2.5.42: Call Center Management System and IVR** | Agency DDM/One Neck |

**F****.2.5.20 Eligibility Integrated Application Solution (ELIAS)**

ELIAS is the Agency’s eligibility determination system for the Medicaid and CHIP programs.

The ELIAS system utilizes SOA, ESB and data and workflow triggers to maintain real-time up to date recipient information within the MMIS. ELIAS utilizes the Modified Adjusted Gross Income (MAGI) methodology to determine eligibility for Children, Adults under age 65, Parents and Caretakers, Pregnant women and for MAGI- exempt populations, for whom income is not an eligibility factor, such as foster care children. MAGI is a methodology based on federal tax rules for how income is counted and family size is determined for Medicaid and CHIP eligibility.

In addition to MAGI eligibility groups, ELIAS will determine eligibility for Medicaid programs that are not subject to the MAGI methodology (non-MAGI populations). Aged, Blind and Disabled populations will be transitioned to ELIAS in early 2018.

**F.2.5.21** **Family Planning Program (FPP) system**

FPP is a web-based data processing system designed to allow family planning clinic workers and Agency IM workers to enter client information to determine eligibility for Iowa Family Planning Program benefits.

**F.2.5.22** **Individual Automated Benefits Calculation (IABC) System**

The IABC system data remains to support LTSS, SNAP and TANF programs.

**F.2.5.23** **Title XIX System**

The Title XIX system accepts Member medical eligibility from the current IABC, FPP, and ELIAS systems. In addition, other types of eligibility are passed from the following systems:

1. ISIS system passes eligibility indicators for Targeted Case Management, PACE, and Money Follows the Person programs, and County of Legal Settlement.
2. Verified Date of Death file is received from Iowa Department of Public Health (IDPH).
3. Medicare Part A, B, and D entitlement/enrollment information is received from CMS.

The Title XIX system processes each Member record, reviews eligibility, and determines the type of coverage group that provides the most benefit coverage for the Member using hierarchical business rules. After all eligibility has been set for each Member, the Title XIX system adds the Federal Funding and Reporting codes for MARS Federal reporting. Then, the primary active eligibility coverage is analyzed and multiple coverages could be applied to provide the Member with the eligibility they are entitled or assigned to. Those coverages could include Medicare Part A, B, and D Prescription Drug Coverage, enrollment, or disenrollment in Managed Health Care, and TPL (TXIX adds indicators for other insurance from the TPL system, to the eligibility information before sending to MMIS.

The Title XIX System interfaces with a premium billing system to manage enrollment the MEPD population. TXIX passes eligibility and premium information to the billing system. MEPD premiums must be paid, or TXIX blocks eligibility from passing to the MMIS system for the MEPD Member. Medicaid eligibility is stored in the Title XIX system on a full-month basis, with 24 months of historical data included on the file. The Title XIX system checks for premium payments before passing eligibility to MMIS. The Title XIX System passes daily and monthly files to the MMIS:

1. Title XIX Member eligibility which includes Medicaid, presumptive eligibility, facility, incarceration dates, and HCBS waiver eligibility.

**F.2.5.24 Individualized Services Information System (ISIS)**

The purpose of ISIS is to assist workers in the facility, HCBS waiver, and targeted case management programs in both processing and tracking applications and authorizations through approval or denial. The ISIS application is used by Income Maintenance Worker (IMWs), case managers, QIO contractor staff, child health specialty clinics, transition specialists, financial management service authorization staff, Member and provider customer service representatives, and Agency policy staff.

The information for the approved Member is sent from ISIS to the Title XIX system for additional processing. The Title XIX system passes the prior authorization service record to the MMIS to allow claims to pay at the assigned rates and units.

The process starts in ISIS upon receipt of a file created by the eligibility system that contains facility and waiver program eligibility. The ISIS system prompts each participant to perform key tasks and each participant must respond by entering the appropriate information for that task before the process can move to the next task. The final approval milestone must be completed (closed) before an approved service plan can be sent to the MMIS prior authorization subsystem.

Consumer Choices Option (CCO) is used in conjunction with ISIS as an add-on for Member s to create a “savings” account for medical insurance. Veridian currently manages the Member’s accounts and are the primary users.

**F.2.5.25 Medicare Prescription Drug Part D Database**

The Medicare Part D database is an eligibility component of the Title XIX System. The Part D file from CMS provides prescription drug eligibility for Dual eligible Members on Medicaid-Medicare. The Medicare Part D database processes daily and monthly, sending and receiving files to and from CMS. Using Title XIX Member data, records are created to indicate current, prospective, retroactive, or changed eligibility information in relation to dual eligibility. In an attempt to increase the match rate with CMS, the Title XIX System uses data in the Medicaid Medicare Information (MMCR) database to overlay the demographic data passed from IABC to both the Social Security Buy-in (SSBI) database and the Medicare Part D database. The Part D response records contain the Part D claw-back information and data for each Member.

NOTE: Medicare Part D database processing is not a part of the SSBI, Iowa’s part A and B Buy-in system.

**F.2.5.26 Medicaid Medicare Information Database (MMCR)**

The MMCR database was created by the Title XIX system and contains both Medicare and Medicaid data for each Member. In 2006, Medicare Part D Drug Coverage was enacted, and all Iowa dual eligibles were auto-assigned to Medicare Part D drug coverage, which replaced the Iowa Medicaid drug coverage for dual eligible Members. This made Medicare Part D an eligibility component of the Title XIX System.

The MMCR database provides the State with historical data passed originally from IABC and also CMS Medicare Parts A, B & D.

This database was created to store history information for Iowa Medicaid Members entitled to Part A and/or Part B Medicare. The MMCR database identifies the Medicare status of Members that appear to be eligible for Medicare Part D. This database is not only valuable as a research tool; it is also used to pass Medicare data to the MMIS and GHS, the Pharmacy POS contractor, for coordination of coverage for dual eligible Members. Also, Part D information is passed to the MMIS for the generation of the Part D informational letter.

Another purpose of the MMCR database is sending a file of dual eligible Members to the Coordination of Benefits Contractor (COBC), GHI, who is a CMS contractor. This file is used to identify Iowa’s dual eligible Members for Medicare crossover claims processing. This file is sent to the COBC bi-weekly. It contains new eligibility and updates for eligibility for all dual eligible Members.

The MMCR database provides the State with historical data passed originally from the IABC System and also CMS Medicare Parts A, B and D. The Title XIX (Medicaid) portion of the MMCR database is created by using the demographic data in the Title XIX eligibility record. Each time a TXIX record is updated by IABC, if there are demographic changes, this information is stored in the MMCR database.

The federal information (Medicare) portion of the MMCR database is created by using the data from the CMS Enrollment Database (EDB) and Part D eligibility files. This portion contains demographic data as well as Medicare A, B and D entitlement and enrollment data. When information is received from CMS, all data is checked within the MMCR database, and if changes have been made, this record is identified by source, and stored within the database.

**F.2.5.27 Medicaid for Employed People with Disabilities (MEPD)**

MEPD is a Medicaid coverage group implemented to allow persons with disabilities to work and continue to have access to medical assistance. The MEPD subsystem is integrated within the Title XIX system. The MEPD system applies business rules for Member Medicaid eligibility, which includes applying premium payments and creating billing statements. The process and rules for this premium program are dependent upon timely premium payment.

**F.2.5.****28 Buy-In (BI)**

This is a Medicaid program in which recipients qualify to have the State pay a portion of their medical insurance. It has an interface with IABC, TXIX and CMS. The Buy-In system is comprised of a Custom Information Control System (CICS) and VSAM mainframe component that supports Medicare Parts A and B entitlement, enrollment, and premium activity. The BI system creates the Iowa interface with CMS for Medicare Part A and B entitlement and enrollment for Medicaid eligible Members.

The Title XIX system provides Member eligibility to the BI system. The BI system processes Member eligibility along with previous Medicare buy-in eligibility, if any, and this information is then transmitted by Iowa to CMS once a month. CMS responds to the Iowa data in the second week of the following month. The CMS response file is processed by the BI system and provides Iowa the necessary Iowa Medicare premium totals and a record for each Iowa Member denoting the Medicare eligibility and premium status. The Iowa Member records are stored in the BI system.

**F****.2.5.29 Medicaid Quality Utilization and Improvement Data System (MQUIDS)**

The Medicaid Quality Utilization and Improvement Data System (MQUIDS) is a data entry and retrieval application designed to facilitate the QIO contractor’s job functions used by QIO. It provides common graphical user interfaces that mask the complexities of business rules associated with data entry and display of information for user analysis. The content is guided by the business and policy requirements of medical review. The QIO reviews frequently involve the documentation of health information on individual Members that must be protected. MQUIDS is hosted by DDM.

**F.2.5.30 Iowa Medicaid Electronic Records System (I-MERS)**

I-MERS is a web-based tool designed to help inform medical decisions by giving providers access to information about services Iowa Medicaid has paid for specific Members. I-MERS is available to the following types of providers and administrative staff enrolled in Iowa Medicaid: physician, advanced registered nurse practitioners (ARNP), hospital, federally qualified health center (FQHC), rural health clinic (RHC), community mental health center (CMHC), psychiatric medical institution for children (PMIC), home health agency, and pharmacy.

**F****.2.5.31 Iowa Medicaid Portal Application (IMPA)**

The Iowa Medicaid Portal Application was initially created to support provider critical incident reporting. It has been expanded to include the following features. Provider Incident Reporting – This is a real-time web application that enables IMPA users and or providers who are legally responsible to report incidents.  The application has rules-based workflow that integrates the provider reporting with DHS/IME policy and program staff.

Informational Letters (IL’s) – All IL’s are issued and made available through either secure login or anonymous access to the IME’s list server. Users sign up for IL’s under a variety of different categories (e.g., by Provider Type, by Claim Type, etc.) or a user can sign-up for e-mail notification for all IL’s issued.  The IL’s are maintained within the portal for easy access and searching.

Remittance Advice – All providers now use IMPA to access image of their remittance advice(s).

Uploading Documents – There are several reports required for various Medicaid services and programs. Within IMPA, a user can upload a document (e.g. services report) and it is then loaded within the IME’s document management system.

Provider Re-Enrollment– The entire process is accomplished via a web-based application within IMPA. This includes validation of existing provider information (e.g. Business Entity Management), current NPI’s enrolled within Medicaid (Rendering NPI Roster, Pay-To NPI Roster), and the ability to upload any and all documents required as part of the enrollment (e.g., copy of a required license). Shortly after the initiation of the re-enrollment process, all new provider enrollments will be accomplished using these modules in a web-based process.

Providers can complete their application and attestation to receive incentive payments for the adoption, implementation, or upgrade of a certified electronic health record system.

Providers who have completed training use this portal to submit applications for presumptive eligibility for children.

Managed Care Organizations use IMPA extensively for looking up a Member using the Member lookup tool. This tool retrieves different pieces of information on a Member from several systems with DHS. Data from MMIS, IABC, documents from the DHS imaging system, ISIS and the Data Warehouse are all retrieved in a single location that allows external users access the data in a secured location.

**F.2.5.32 D****ata Warehouse and Decision Support (DW/DS) System**

The Agency maintains and operates a Data Warehouse and Decision Support (DW/DS) system. This system provides access to data for data analysis and decision-making capabilities The DW/DS system maintains the most recent 10 years of claims data from the MMIS. The DW/DS system’s relational database includes the full claim record for adjudicated claims and other Member, provider, reference and prior authorization data from the MMIS. IME staff from the Agency and contractors use the DW/DS system. The Agency’s Division of Data Management (DDM) provides technical support for ETL, datamart creation, and assistance in developing queries and reports to fulfill the analytical needs for the IME.

**F.2.5.****33 Pharmacy Point-of-Sale (POS) System**

The Pharmacy Point-of-Sale (POS) system supports two primary functions: pharmacy claims processing and drug rebate. The Pharmacy POS contract also includes a prior authorization system that interfaces with the POS to receive pharmacy prior authorizations.

The Pharmacy POS system operates on a State-owned hardware platform, which is housed with the current POS contractor. The pharmacy POS contractor is responsible for developing and maintaining interfaces and achieving technical integration with all other modules that use pharmacy data.

The Pharmacy POS system provides for on-line, real time adjudication of pharmacy claims with edits, including application of prior authorization requirements and audits that support the Agency’s policies and objectives. The system includes the following functions:

1. Claims processing for pharmacy claims.
2. Reference (formulary file).
3. Prospective drug utilization review (ProDUR).
4. Drug rebates.
5. Verification of provider and client eligibility.
6. Cost avoidance edits for third-party liability including private insurance and Medicare.
7. Price determination utilizing all pricing sources required.
8. Copayment calculation and tracking in accordance with state regulations.
9. Dispensing fees requirements.
10. Standard ProDUR and customized ProDUR interventions.
11. Customized messaging.
12. Acceptance of prior authorization data from multiple sources.
13. Preferred drug list (PDL) and recommend drug list enforcement through claims processing.
14. Support for additional programs such as Medicare Part B and Medicare Transitional Assistance when they are initiated.
15. Customized override functionality.
16. Ability to implement smart PA edits using patient profiles and therapeutic classes.
17. Administration of all aspects of federal and supplemental rebates excluding supplemental rebate negotiation and contracting.
18. Patient restrictions or lock-ins.
19. Physician exemptions from certain edits.

**F.2.5.****34 DataProbe System®**

The DataProbe System® solution is a surveillance and utilization review system (SURS) developed and hosted by the current Program Integrity contractor. The solution includes an analytic data warehouse platform and toolset to identify fraud, waste and abuse in Iowa’s Medicaid Program, and produce SURS reporting. This solution is expected to be CMS-certified for Iowa by January 2019.

**F.2.5.****35 HCBS Quality Assurance Provider Oversight**

The HCBS QA system provides support for quality reviews, complaint and incident management, slot management, and quality reporting for the HCBS program. The system is hosted by DDM.

**F.2.5.****36 Iowa EHR Medicaid Incentive Payment Administration**

The Iowa EHR Medicaid Provider Incentive Payment Portal (PIPP) is hosted and supported by Policy Studies Incorporated, now owned by Maximus. The PIPP system accepts the attestation of eligible hospitals and eligible providers for the adoption, implementation, upgrade, or meaningful use of certified EHR technology. CORE MMIS interfaces with the PIPP system by sharing provider data, receiving payment requests, and returning payment results. All interfaces are currently operated in batch mode using Secure File Transfer Protocol.

**F.2.5.****37 Iowa Health Information Network (IHIN)**

The current IHIN solution provided by Informatics Corporation of America (ICA), uses a federated data model. The current platform is not technologically capable of supporting Medicaid needs and the decision has been made to replace the platform. The original legislation restricted the IHIN to a federated model based on concerns around data use, privacy and data sharing. As a result, the IHIN platform architecture was developed within these constraints. In order to best support Iowa’s healthcare goals and vision, the legislature recently adjusted these constraints and opened up the option for a non-federated centralized model. It was determined to best support Iowa Medicaid’s future healthcare needs and vision, it would be necessary to privatize the IHIN and replace the platform architecture. In 2015, the Iowa Legislature authorized the movement of the IHIN into a nonprofit status, outside of state government. Following a bidding process by IDPH, the Hielix/Koble Group (HKG) application was selected to take over stewardship of the non-profit IHIN. The IHIN operates under a new nonprofit organization structure, developed with guidance from HKG, and will continue to operate and begin to enhance functionality and offerings to modernize and improve services to support Medicaid providers’ abilities to reach MU measures.

It is the goal of Iowa Medicaid to incorporate the capabilities of the Health Information Network to simplify administration of the program for both Medicaid and the provider organizations. IME is also committed to ensuring the IHIN is a cornerstone in facilitating information exchange for care coordination, and encouraging patient engagement and healthy behaviors through access to personal health records.

**F.2.5.38 Health Insurance Premium Payment System (HIPS)**

The HIPS system is utilized by Agency HIPP staff to record applications; collect the minimum data needed to evaluate the application (insurer, covered individuals, type of insurance, cost); determine if the application would be cost effective; approve or deny the application and produce notices of the action to be sent to the applicant; create a case from an approved application; establish a payment schedule and provide warrants to request the actual payments from another program; maintain all of the information on cases such as payment schedules and premium changes; maintain information about the individuals covered, employers and insurance companies; track and record the activity internally with ticklers and narratives; and inform the applicant of the status of their application with Notice of Actions.

**F.2.5.39: Premium Payment System (PPS)**

This system manages Iowa Health and Wellness Plan Member’s premiums; amount due; dollars paid; and generates statements and statistical program reporting. MMIS creates a monthly invoice file that is consumed by PPS in order to create the Statements that are sent to Members. PPS will be updated to begin receiving an invoice file from MMIS for dental and ***hawk-i*** premiums in the near future.

F.2.5.40: State Payment Program

This system provides central office staff and county CPC offices with information about the assignment of State Payment Program cases. This system has a file transfer interface for counties to submit monthly expenditure data for State Payment Program cases that they manage. The submitted expenditures are used by central office staff to make payments to the counties.

F.2.5.41: Iowa Medicaid Provider Search

The Iowa Medicaid Provider Search provides users the ability to search for Medicaid providers in specific geographical locations based on specialty or Medicaid enrolled provider type.

**F.2.5.42 Call Center Management System**

The current call center system is with Cisco® Unified Contact Center Express 7.0. Cisco Unified Contact Center Express provides easy-to-deploy, easy-to-use, secure, virtual, highly available and sophisticated customer interaction management for up to 300 agents. Its fully integrated self-service applications improve customer response with sophisticated and distributed automatic call distributor (ACD), interactive voice response (IVR), computer telephony integration (CTI) and agent and desktop services in a single-server contact-center-in-a-box deployment, while offering the flexibility to scale to larger more demanding environments. It also supports business rules for inbound and outbound voice, email, web, and chat. Customer interaction management helps ensure that each contact is delivered to the right agent the first time. The following links provide information highlighting the Cisco system:

<http://www.cisco.com/en/US/docs/voice_ip_comm/cust_contact/contact_center/crs/express_7_0/configuration/guide/uccx70ag.pdf>

F.3 Provider Reimbursement

The Iowa Medicaid Program pays deductibles and coinsurance for services covered by Title XVIII (Medicare) of the Social Security Act. In certain situations, Iowa Medicaid also pays the monthly premium for supplemental medical insurance (Medicare Part B) for most Members age 65 or older and for certain blind or disabled people receiving medical assistance. Additionally, the Medicare Part A premium will be covered for Members who qualify under the Qualified Medicare Beneficiary (QMB) Program.

Iowa Admin. Code r. 441-79.1 governs Medicaid Provider reimbursement. These rules describe the types of reimbursement; basis of reimbursement of specific provider categories; and reimbursement rules and limitations or restrictions specifically for:

|  |  |
| --- | --- |
| * Ambulatory surgical centers * Community Mental Health Centers (CMHCs) and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3) * Community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services * Dentists * Drugs * Durable medical equipment * EPSDT private duty nursing and personal cares program | * HCBS habilitation services * HCBS home and vehicle modification and equipment Hospitals * Home health services * Hospice services * Independent laboratories * Medical supply dealers * Outpatient reimbursement for hospitals * Physicians * Pharmaceutical case management services * Prosthetic devices * Rehabilitation agencies * Remedial services * Translation and interpretation services |

These rules also govern:

|  |  |
| --- | --- |
| * Copayments by Members * HCBS consumer choices financial management * HCBS retrospectively limited prospective rates * Medicare crossover claims | * Prohibition against reassignment of claims * Prohibition against factoring * Reasonable charges for services, supplies, and equipment |

Medicaid provider fee schedules can be found at this link: <http://dhs.iowa.gov/ime/providers/csrp/fee-schedule>.

# Attachment G: Cost Proposal Form

Note: this Pricing Schedule is for example purposes only. Bidders must complete the Excel spreadsheet entitled Attachment G.



# Attachment H: Sample Contract

*(These contract terms contained in the Special Terms and General Terms for Services Contracts are not intended to be a complete listing of all contract terms but are provided only to enable bidders to better evaluate the costs associated with the RFP and the potential resulting contract. Bidders should plan on such terms being included in any contract entered into as a result of this RFP. All costs associated with complying with these terms should be included in the Cost Proposal or any pricing quoted by the bidder. See RFP Section 3.1 regarding bidder exceptions to contract language.)*

***This is a sample form. DO NOT complete and return this attachment.***

**CONTRACT DECLARATIONS AND EXECUTION**

|  |  |
| --- | --- |
| **RFP #** | **Contract #** |
| MED-18-004 | *{To be completed when contract is drafted.}* |
| **Title of Contract** | |
| *{To be completed when contract is drafted.}* | |

This Contract must be signed by all parties before the Contractor provides any Deliverables. The Agency is not obligated to make payment for any Deliverables provided by or on behalf of the Contractor before the Contract is signed by all parties. This Contract is entered into by the following parties:

|  |
| --- |
| **Agency of the State (hereafter “Agency”)** |
| Iowa Department of Human Services | | |
| **Contractor: (hereafter “Contractor”)** |
|  | | |
| **Contract Information** |
| Start Date: *{To be completed when contract is drafted.}* | | **End Date of Base Term of Contract:**  End Date of Contract:  *{To be completed when contract is drafted.}* | |
| **Possible Extension(s):** | | | |
| **Contractor a Business Associate?** Yes | | **Contractor subject to Iowa Code Chapter 8F?** No | |
| **Contract Include Sharing SSA Data?** No | | **Contractor a Qualified Service Organization?** Yes | |
| **Contract Warranty Period (hereafter “Warranty Period”):** The term of this Contract, including any extensions. | | **Contract Contingent on Approval of Another Agency:**  Yes  **Which Agency?** CMS | |
| **Security & Privacy Office Data Confirmation Number:**  \*\*\* | |
| **Contract Payments include Federal Funds?** Yes  **The contractor for federal reporting purposes under this contract is a:** Subrecipient or vendor **{***To be completed when contract is drafted.}*  **DUNS#:** *{To be completed when contract is drafted.}*  **Office of Child Support Enforcement (“OCSE”) Funded Percentage:** *{To be completed when contract is drafted if applicable.}*  **The Name of the Pass-Through Entity:** *{To be completed when contract is drafted.}*  **CFDA #:** *{To be completed when contract is drafted.}*  **Grant Name:** *{To be completed when contract is drafted.}*  **Federal Awarding Agency Name:** *{To be completed when contract is drafted.}* | | | |

This Contract consists of the above information, the attached General Terms for Services Contracts, Special Terms, and all Special Contract Attachments.

**SECTION 1: SPECIAL TERMS**

***1.1***Special Terms Definitions.

***“Business Hours”*** means 8:00 AM thru 5:00 PM Central Time (CT), excluding state holidays.

***“Capitation”*** or ***“Capitation Payment”*** means the HIPAA 820 Premium Payment paid to MCOs, PAHPs, PACE organizations, and the NEMT broker.

***“Centers for Medicare and Medicaid Services”*** or ***“CMS”*** is part of the U.S. Department of Health and Human Services. CMS oversees Medicare and Medicaid, as well as many other federal healthcare programs, including those that involve Health Information Technology such as the meaningful use incentive program for electronic health records (EHR). In addition to Medicare and Medicaid, CMS administers the Children's Health Insurance Program (CHIP), the Health Insurance Portability and Accountability Act (HIPAA) and key portions of the 2015 Medicare Access and CHIP Reauthorization Act (MACRA) law.

***“IME Units”*** are the professional and system services contractors within the IME that perform the majority of Iowa Medicaid program business functions under performance-based contracts.

***“Medicaid Enterprise Certification Toolkit”*** or ***“MECT”*** is a toolkit developed by CMS to assist states as they plan, develop, test, and implement their Medicaid Management Information Systems (MMIS). Since the initial release of MECT, CMS has updated the toolkit to accommodate modular and agile development, refined certification criteria, developed a new approach to CMS-state partnership, updated criteria to reflect the latest regulations and guidance, and provided templates and tools to assist states and their contractors in the certification process. More information can be found here: <https://www.medicaid.gov/medicaid/data-and-systems/mect/index.html>.

***“Member”*** means an individual enrolled in Iowa’s Medicaid, or CHIP (***hawk-i)*** Programs.

***“NEMT”*** means Non-emergency Medical Transportation, which in Iowa is managed by a broker.

***“National Correct Coding Initiative”*** or ***“NCCI”*** is a CMS program that consists of coding policies and edits. Providers report procedures/services performed on beneficiaries utilizing Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes. These codes are submitted on claim forms. NCCI policies and edits address procedures / services performed by the same provider for the same beneficiary on the same date of service. The coding policies of NCCI are based on coding conventions defined in the American Medical Association’s Current Procedural Terminology Manual, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice.

***“PAHP”*** means prepaid ambulatory health plan, such as the Iowa Dental Wellness plans or the ***hawk-i*** Dental plan.

***“Payment Error Rate Measurement”*** or ***“PERM”*** is a CMS program that measures improper payments in Medicaid and CHIP and produces error rates for each program.  The error rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the federal fiscal year (FFY) under review. CMS audits Iowa every three years, with the most recent audit for FFY 2017. The review period for the current audit started 10/1/2016 and goes through 9/30/2017. The Agency anticipates CMS will begin sending PERM errors in October 2017, and the Agency will be responding to those through at least March 2018, if not longer.

***“Service Organization Control 2”***or***“SOC 2”***means the internal controls in place at the third-party service organization. For a company to receive SOC 2 certification, it must have sufficient policies and strategies that satisfactorily protect the client’s data.

***1.2 Contract Purpose.***

*{To be completed when contract is drafted.}*

***1.3 Scope of Work.***

**1.3.1 Deliverables.**

The Contractor shall provide the following:

# 1.3.1.1 General Obligations

* 1. **Staffing.**

1. The Contractor shall designate individuals as “key personnel,” subject to Agency continued approval. The Agency reserves the right to interview any and all candidates for named key positions prior to approving the personnel. Special requirements for key personnel are as follows:
   1. Account Manager. Responsible for the overall service delivery of the team, complying with contractual requirements and meeting the Agency’s expectations. The Account Manager shall be responsible for Contract compliance and general project oversight. The Account Manager must adopt an exemplary behavior; also he or she must collaborate, and cultivate and promote the spirit of trust and professionalism with the Agency, other IME Units, and stakeholders. The Account Manager shall represent the Contractor and be the primary liaison with the Agency. Minimum qualifications include:
      1. Four years of experience in account management or major supervisory role for a government or private sector as a healthcare payer, including a minimum of three years of experience in a state of equivalent scope to Iowa.
      2. Bachelor’s Degree or at least 4 years relevant experience to the position.
      3. Previous management experience with Medicaid, specifically in MMIS operations, and knowledge of HIPAA rules and requirements is desired.
   2. Transition Manager. Responsible for facilitating all planning and operational readiness activities necessary to ensure a successful transition. This position will no longer be required once the Contractor has successfully transitioned to operations. The Transition Manager may also serve as the Account or Operations Manager. Minimum qualifications include:
      1. Four years of experience in account management or major supervisory role for government or in the private sector as a healthcare payer or provider.
      2. Bachelor’s Degree or equivalent relevant experience to the position.
   3. Claims Operations Manager. Responsible for day to day claims processing operations and personnel. Minimum qualifications include:
      1. Four years of experience managing claims processing operations and personnel for a Medicaid state entity, fiscal agent or private sector health care payor, including a minimum of two years MMIS experience.
      2. Bachelor’s Degree or equivalent relevant experience to the position.
   4. Systems Manager. Responsible for overseeing and managing all systems-related activities within the Contract. Minimum qualifications include:
      1. Four years of MMIS systems operations experience as manager in a state of equivalent scope to Iowa.
      2. Bachelor’s Degree in Information System Engineering, Computer Science, or a related field, or equivalent relevant experience to the position.
   5. Quality Assurance Manager. Responsible for overseeing and managing all quality assurance activities within the Contract. Minimum qualifications include:
      1. Three years progressive experience in the quality assurance function of a large scale claims processing organization or at least five years progressive experience in the quality assurance function of a large scale claims processing organization.
      2. Bachelor’s Degree with at least three courses in Statistics and or Quality Assurance or equivalent relevant experience to the position.
   6. Mailroom Manager. Responsible for overseeing and managing all mailroom and courier activities within the Contract. Minimum qualifications include:
      1. Four years of experience managing mailroom operations and personnel for a Medicaid state entity, fiscal agent or private sector health care payor.
      2. Bachelor’s Degree or equivalent relevant experience to the position.
   7. Encounter Data Specialist. Under the general direction of the Systems Manager, and in collaboration with the Agency’s Encounter Data Officer, the Encounter Data Specialist is an analyst/developer responsible for evaluating, identifying, and remediating encounter data errors created by operational gaps including those related to encounter claims processing, eligibility records and provider submission errors to improve the Agency’s overall encounter reconciliation process and ensure compliance with state and federal billing requirements. Minimum qualifications include:
      1. Four years of experience with claims processing operations for a Medicaid state entity, fiscal agent or private sector health care payor, including a minimum of two years MMIS experience.
      2. Bachelor’s Degree or equivalent relevant experience to the position.
2. Named key personnel shall:
3. Be committed to the project full time and co-located with Agency staff at the Iowa Medicaid Enterprise (IME) permanent facility in Des Moines, Iowa beginning April 16, 2018;
4. Be available during Business Hours to respond to questions and concerns related to the Contract, except for routine absences or participation in required off-site meetings. Account Manager and Operations Manager positions are required to communicate absences with the Agency contract manager and provide suitable coverage during extended absences;
5. Provide policy advice and support to the Agency and participate in meetings with the Agency as subject matter expert;
6. Prepare and present status updates periodically to the Agency and other stakeholders, as requested by the Agency;
7. Participate in program planning and evaluation activities to ensure the Agency is making informed decisions;
8. Develop and maintain dashboards and reports to ensure the Agency staff have the appropriate information at the time needed to effectively and efficiently operate the program;
9. Comply with all timelines in the Agency-approved transition plan; and
10. Develop and maintain a plan for job rotation and knowledge transfer to ensure that all functions can be adequately performed during the absence of key personnel for vacation and other reasons. Any planned absences of key personnel shall be immediately communicated to the Agency. The Contractor shall ensure staff are trained and able to perform the functions of sensitive positions when the primary staff member is absent.
11. The Agency reserves the right of prior approval for any replacement of the key personnel:
12. The Contractor must commit named key personnel to the project on or before the conclusion of the transition period of the Contract and for at least six months, and must not replace key personnel during this period except in cases of termination, death, or the key person’s resignation.
13. The Contractor shall provide the Agency with a minimum of 15 days’ notice prior to any proposed transfer or replacement of named key personnel. At the time of providing notice, the Contractor shall also provide the Agency with the resumes and references of the proposed replacement of named key personnel;
14. Replacement personnel must be in place performing their new functions before the departure of the personnel they are replacing;
15. Replacement personnel shall have knowledge transfer, experience, and ability comparable to the person originally in the position; and
16. The Agency may waive requirements (a) through (d) above upon presentation of good cause by the Contractor. In those instances when good cause is granted, the Contractor commits to replacing key personnel within thirty days (30) of the departure of a key person and to providing temporary personnel in the interim that are capable of maintaining operational performance at acceptable levels.
17. The Contractor shall provide the following non-managerial positions:
    1. Minimum of 10 programmers dedicated to maintenance and operations of the MMIS, one of which shall be dedicated to monitoring and supporting batch processing;
    2. Sufficient staff to perform business rules updates, benefit plan, workflow, interfaces reporting management and maintenance, and technical assistance for MMIS-related issues such as availability of the system, system access and user notifications as system changes are implemented, as necessary to support Medicaid program management and federal reporting requirements;
    3. Claims expert(s) who are qualified to research claim inquiries and provide expert witness testimony in judicial proceedings on the Agency’s behalf;
    4. Business Analysts who are responsible for meeting with IME policy and unit staff to capture and document modifications to the MMIS systems to support organization and mandated change. The analyst(s) must work across multiple levels of the organization and be able to identify and articulate the necessary workflow, configuration, rules, reporting requirements and interface modifications changes needed to support the business process change;
    5. Core help desk staff to support technical issues identified by external stakeholders such as Members or providers. These issues will be routed through the appropriate IME Units and escalated to the Contractor's help desk when necessary;
    6. EDI help desk for direct support to providers, billing agencies, or clearinghouses who are having difficulty with the submission of EDI transactions, and sufficient staff dedicated to Iowa Medicaid providers via phone calls and e-mail communications;
    7. Mailroom and courier staff; and
    8. Quality assurance/quality control staff with experience developing, executing and reporting formal quality assurance plans.
18. The Contractor shall primarily recruit Des Moines-based professionals and ensure that as many staff as possible directly associated with the provision of Contract services are collocated at the IME’s permanent facility to ensure collaboration with Agency staff. See Attachment 3.2.
    1. **System and Software Requirements**
19. The Contractor shall maintain systems and software, as necessary, to support Core MMIS functions, including the ability to interface with data sources as determined by the Agency.
20. The Contractor shall provide an NCCI claims editing solution to include but not limited to:
    * 1. Claims edits based on NCCI requirements and customized edits to support Agency differences with the NCCI edits;
      2. Perform timely NCCI edits pre-adjudication;
      3. Provide a means for explanation of a correction at a claim level to providers, IME Provider Services call center staff, and others as needed for research and examination;
      4. Produce reports determined by the Agency, to include at a minimum a quarterly report of edits applied to claims based on CMS NCCI guidance; and
      5. Perform necessary analysis to advise the Agency on the application of NCCI edits.
21. The Contractor shall provide an Electronic Data Interchange (EDI) solution for submission of claims to include but not limited to:
    * 1. Provide a secure environment for the exchange of files and a test environment to onboard providers and external clearinghouses; and
      2. Provide a help desk to provide EDI technical support and to assist Iowa Medicaid providers with connection and issue resolution.
22. The Contractor shall provide an imaging/scanning solution for all documentation, such as paper claims and correspondence that flow into the IME via the mailroom.
23. The Contractor shall provide an accurate, robust NDC crosswalk for reimbursement of physician administered drugs to include but not limited to:
    * 1. Appropriate correlation between NDC and Procedure Code; and
      2. Compliance with drug rebate program requirements.
24. The Contractor shall comply at all times with the CMS conditions and standards set forth in 45 C.F.R. § 95.615 and § 95.617.
25. The Contractor shall identify any licensing, software or hardware requirements the Agency must provide to implement Contractor solutions, subject to Agency approval.
26. The Contractor shall perform system quality assurance and testing in accordance with Agency-approved systems implementation plan.
27. The Contractor shall meet the Agency and the Office of the Chief Information Officer’s security standards for data collection, storage, and secured electronic transmissions. This includes, but is not limited to, a minimum 256-bit encryption for both authentication and data transmission. See Contract Section 2.9.6.
28. The Contractor shall ensure that the MMIS and Contractor solutions:
    * 1. Effectively apply all federal and State code, rules, and regulations to ensure claims are adjudicated accurately and efficiently;
      2. Accept and maintain accurate current and historical data;
      3. Create sufficient audit trails for all activity as per state and federal regulations regarding data retention; and
      4. Deliver all interfaces timely. Real-time exchange of data shall occur whenever possible to ensure data is consistent and accurate.
29. The Contractor shall manage application security for the MMIS systems to ensure access is available and appropriate to the role description.
30. The Contractor shall ensure security safeguards are in place to assure the integrity of system hardware, software, records, and files, including but not limited to:
31. Orienting new employees to security policies and procedures;
32. Conducting periodic review sessions on security procedures;
33. Developing lists of personnel to be contacted in the event of a potential or suspected security breach;
34. Maintaining entry logs for limited access areas;
35. Maintaining an inventory of Agency assets, not including any financial assets;
36. Limiting physical access to systems hardware, software, and libraries; and
37. Maintaining confidential and critical materials in limited access, secured areas.
38. If the Contractor’s systems or applications will host Agency data, the Contractor shall provide the following to the Agency:
    * 1. Completed Vendor Security Questionnaire using the template provided in Attachment 3.5;
      2. Documentation of SOC 2 compliance or the following documentation prior to system implementation and annually thereafter:
39. Attestation of passed information security risk assessment;
40. Attestation of passed network penetration scan; and
41. If the Contractor utilizes a web application in performance of services under this Contract, attestation of passed web application security scan.
    * 1. The Contractor shall develop and maintain, subject to Agency approval, a disaster recovery and business continuity plan to address recovery of business functions, business units, business processes, human resources, and the technology infrastructure. The Contractor shall comply with the Agency-approved plan at all times. The Contractor shall protect against hardware and software failures, human error, natural disasters, and other emergencies that could interrupt services and operations.
42. The Contractor shall coordinate with and track all systems and software used within the IME Operations, specifically any software packages utilized within the IME in conjunction with the MMIS to perform IME business functions.
43. The Contractor shall support system integration of all software products used for operations within Iowa Medicaid Enterprise.
44. The Contractor shall support system modifications (including workflow, business rules, data capture) needed as requested by Iowa Medicaid Enterprise. Professional services contract units will make system requests through their unit manager.
45. The Contractor shall develop, maintain, and comply at all times with an interface control document (ICD), subject to Agency approval. The ICD shall include, but is not limited to:
    1. Description of the data exchange and processing necessary to implement and operate NCCI, imaging/scanning, EDI functions, as well as operations of Core MMIS system functions;
    2. Interfaces necessary for electronic transmissions of data files, processing rules, and required sequence of data to manage the services;
    3. The Contractor shall develop this document with consultation from Agency data management staff and update as changes occur, but not less than annually; and
    4. As part of the Agency’s Medicaid Enterprise Modernization effort, the Contractor shall be required to identify and validate all MMIS interfaces and determine which interfaces will continue to be applicable, as well as identify new interfaces as new modules come online.
46. The Contractor shall take all steps necessary to maintain connectivity to Agency digital infrastructure, including updating interfaces as needed.
47. Any Contractor system enhancements or modifications are subject to CMS conditions and standards as identified in 42 C.F.R. § 433.112 and MECT, as appropriate. Upon Agency request, the Contractor shall engage with the Independent Verification and Validation (IV&V) vendor, and participate and cooperate with CMS certification.
    1. **Receipt of Checks**
48. The Contractor may receive checks or money orders related to the work that it performs. These checks and money orders may be for refunds, recoveries, cost settlements, premiums, or drug rebates. The Contractor shall meet the following requirements for checks or money orders:
49. Log and prepare all payments for deposit on the day of receipt and deliver them to the Revenue Collections contractor’s designated point of contact for daily deposits;
50. Assist in the maintenance and updating of the existing check classification code schematic, as necessary; and
51. Assist the Agency Division of Fiscal Management in the reconciliation of the monthly Title XIX Recovery bank account, if requested to do so.
    1. **Quality Assurance/Quality Improvement**
52. The Contractor shall perform quality assurance reviews on a statistically valid random sample basis of manually keyed and electronic claims, in accordance with the Agency-approved quality assurance plan.
53. The Contractor shall implement quality improvement procedures that are based on proactive improvements rather than retroactive responses. The Contractor must understand the nature of and participate in quality improvement procedures that may occur in response to critical situations and shall assist in the planning and implementation of quality improvement procedures based on proactive improvement. Duties include but are not limited to:
54. Monitor the quality and accuracy of the Contractor’s own work;
55. Perform continuous workflow analysis to improve performance of Contractor functions and submit quarterly reports of the quality assurance activities, findings and corrective actions (if any) to the Agency electronically. The quality assurance report shall at a minimum show the number of items sampled by category, the number of errors and the percent accurate;
56. Provide the Agency with a description of any changes to the workflow for approval prior to implementation; and
57. Survey the submitters of a random sample of the CSRs to verify that the user was satisfied with the timeliness, communication, accuracy and result of the CSR process. The sample size should be 10% of the CSR workload, with a minimum of five reviews per month. A report of results of the sample should be delivered to the Agency by the 15th of each month.
    1. **Performance Reporting and Corrective Actions** 
       1. The Contractor shall submit monthly performance reports using an Agency-approved format, similar to the sample in Attachment 3.4, detailing all deliverables and performance measures that have been met or unmet during the month. This report shall be submitted with the monthly invoice.
       2. The Contractor shall provide written notification to the Agency within two business days of discovery of any problems, concerns, or issues of non-compliance.
       3. The Contractor shall maintain records of such reports and other related communications issued in writing during the course of Contract performance.
       4. The Contract Owner has final authority to approve problem-resolution activities.
       5. The Agency’s acceptance of a problem report shall not relieve the Contractor of any obligation under this Contract or waive any other remedy. The Agency’s inability to identify the extent of a problem or the extent of damages incurred because of a problem shall not act as a waiver of performance or damages under this Contract.
       6. To the extent that Deficiencies are identified in the Contractor’s performance and notwithstanding other remedies available under this Contract, the Agency may require the Contractor to develop and comply with a corrective action plan to resolve the Deficiencies, subject to Agency approval.
    2. **Requests for Information**
58. The Contractor shall respond to Agency requests for information and other requests for assistance within the timeframe that the Agency specifies. The Contractor shall provide information in response to:
59. Freedom of Information Act (FOIA) requests;
60. Requests for Information (RFIs) from Iowa Legislators;
61. Open Records Act requests, as required in Iowa Code Chapter 22;
62. State or federal audits; and
63. Miscellaneous requests.
64. The Contractor shall comply with information protocols and response timeframes determined by the Agency Public Information Officer.
    1. **Centralized Email Mailboxes and Telephone Lines.**
       1. The Contractor shall manage assigned Agency centralized email mailboxes and telephone lines for communications necessary to support Core MMIS services functions.
       2. The Contractor shall track and log communications within IME systems.
       3. The Contractor shall monitor the quality and accuracy of the Contractor’s communications in accordance with the Agency-approved quality assurance plan.
       4. The Contractor shall submit a report to the Agency on management of communications, to include timeliness and accuracy of responses, on a quarterly and annual basis.
    2. **Branding**
       1. The Contractor shall not reference the Contractor's corporate name in any Deliverables associated with this Contract and shall not mark Deliverables as confidential or proprietary.
    3. **Subcontracts**
       1. All subcontracts shall be in writing and fulfill the requirements of 42 C.F.R. § 434.6 that are appropriate to the services or activity delegated under the subcontract.
       2. No subcontract terminates legal responsibility of the Contractor to the Agency to assure that all activities under the Contract are carried out.

**1.3.1.2** **Transition Phase**

1. **Planning.** The Contractor shall develop, maintain, and comply at all times with the following, subject to Agency approval:
2. Project work plans. Work plans include:
3. A transition plan detailing Contractor’s strategy to implement the staff, systems and services contemplated by this Contract;
4. A systems implementation plan detailing implementation, quality assurance, and testing activities related to Contractor’s system solutions;
5. An operations plan detailing the daily performance of all required activities by the Contractor, including required coordination and safeguards;
6. A quality assurance plan detailing requirements and timeframes for monitoring the quality and accuracy, as well as continuous workflow analysis, of the Contractor’s functions;
7. A reporting plan detailing requirements for submitting reports to the Agency. This plan shall be developed in consultation with the Agency. Reporting plan requirements include but are not limited to:
8. Use of standard naming conventions;
9. Templates for standardized reports that may be necessary to implement the project. The Contractor shall revise report content as needed and upon Agency request;
10. Use of the Agency-designated sharepoint site to upload reports, with links sent to relevant Agency staff via email;
11. Detail of whom the reports should be delivered to for review and approval, as necessary;
12. Any posting requirements for external stakeholders;
13. Frequency and due dates for reports;
14. An Agency report monitoring tool similar to the sample in Attachment 3.3; and
15. A monthly performance reporting tool similar to the sample in Attachment 3.4.
16. A training plan detailing, at minimum:
    * 1. Training of Contractor staff in all systems functions that they will use. This may include the Medicaid Management Information System (MMIS), Pharmacy Point of Sale (POS) system, Data Warehouse/Decision Support system (DW/DS) and other state systems;
      2. Training of Contractor staff in system and operational procedures required to perform the Contractor’s functions under the Contract;
      3. Continuous standard operating procedures training process for Contractor staff. At minimum, the Contractor shall train staff when:
         1. New staff or replacement staff are hired;
         2. New policies or procedures are implemented; and
         3. Changes are made to any existing policies or procedures prior to the change’s implementation if possible, and if not, concurrent with the change’s implementation.
      4. Ongoing training of Agency employees and other Agency contractors on the use of MMIS, workflow management tools, and Contractor systems or applications, as necessary. Such training shall be at no additional cost to the Agency.

Each plan shall generally adhere to the approximate timing and requirements set forth in Sections 1.3.1.3 and 1.3.2, to include, at minimum:

1. Definition of each project activity;
2. Sequence of activities;
3. Identification of who is responsible for each project activity;
4. Defined deliverables and outcomes;
5. Timeframe in which each activity will be completed;
6. A plan update schedule, which shall include updates no less frequently than quarterly; and
7. Identification of Agency responsibilities and expectations.
8. Standard operating procedures (SOPs).
9. SOPs shall be maintained in the Agency-prescribed format using standard naming conventions in the documentation.
10. SOPs shall document the processes and procedures used by the Contractor in the performance of its obligations under this Contract, including but not limited to:
    * + - 1. Notification and issue escalation procedures and timelines; and
          2. Policy manuals required for all Core MMIS functions.
11. SOPs shall be updated with any changes to the methods and procedures used by the Contractor in the performance of its duties under this Contract. The Contractor shall document all changes within 10 business days of the change. The Contractor shall use version control to identify the most current documentation and any previous versions, including their effective dates. The Contractor shall provide all documentation in electronic form and store all documentation within the Agency-designated repository.
12. SOPs shall be reviewed with the Agency no less than semi-annually.
13. **Operational Readiness**
14. The Contractor shall prepare for the onset of operations in the existing Agency environment. This includes but is not limited to the following:
15. Review the turnover plan from the current contractor;
16. Review the Agency’s comprehensive operational readiness checklist of its start-up activities;
17. Provide the Agency assurance that all checklist activities have been satisfactorily completed and signed-off by the Agency;
18. Develop and implement a corrective action plan for all outstanding activities for review and approval by the Agency;
19. Conduct training for its staff;
20. Gather and document all Agency technical and operational requirements pertaining to work performed under this Contract;
21. Produce and update all operations documentation and obtain Agency approval of each iteration;
22. Establish Agency-approved interfaces, as necessary; and
23. Obtain written approval from the Agency to start operations.
24. The Contractor shall work proactively with the Agency and the outgoing contractor to take over operations of the legacy MMIS.
25. The Contractor shall offer opportunities to existing Iowa Medicaid CORE operations staff to continue in similar positions at the IME where appropriate.
26. The Contractor shall ensure that projects "in process" are not delayed or placed at risk by the takeover of operations and technical support of the existing MMIS and CORE claims operations.
27. The system shall be operated uninterrupted from the same location where current operations are handled.

# 1.3.1.3 Operations

The Contractor shall:

1. **Mailroom and Courier Service**
   1. Operate the mailroom located at the IME facility, receive all incoming mail, log claims, screen all claim documents and attachments, and return to providers those claims that fail the screening criteria specified by the Agency. Sort and batch by type complete documents.
   2. Maintain the mail handling function for all paper forms and correspondence and be accountable for each claim from the time it is received.
   3. Provide courier service to pick up mail and deliver reports or other items to external entities as required.
   4. Scan, image, and stamp all hardcopy forms and correspondence with a sequential transaction control number (TCN) that uniquely identifies that document throughout the remainder of its processing. The documents are routed to the appropriate IME Unit for handling after imaging. A batch control activation record is entered for each new batch for hardcopy claim documents. The online batch control process is designed to establish control of claims receipts as soon as they enter the mailroom to ensure that claims are not lost or delayed in processing. The batch control file allows Contractor staff to monitor a batch of claims in the system as soon as the claims are batched.
   5. All outgoing mail shall be processed through the IME mailroom, including regular daily mail and small-volume mailings.
   6. Provide a print-ready copy of the documents to the printer the Agency selects (such as the state print shop or a commercial print shop).
   7. Provide audit acceptable operations for processing mail containing checks
2. **Member Management**
   1. Process updates to Member eligibility data transferred by the Agency for all medical assistance and process real time, daily or monthly or as directed by the Agency.
   2. Establish and adhere to a quality assurance process to reconcile the Agency's eligibility determination system and the MMIS systems. This process should be performed at a minimum frequency of monthly.
   3. Maintain and operate a process to access archived eligibility data.
   4. Manage dual eligibility coordination with CMS. Send a file to Medicare identifying individuals as dual eligible (Medicaid and Medicare) to indicate that a crossover claim should be generated. Receive Medicare enrollment information from Medicare and update eligibility for claims payment. Transfer dual information to the Agency's eligibility system for re-determination of eligibility.
   5. Maintain a minimum of 60 months of eligibility history including benefit plans, lock-in, managed care enrollment and waiver and long term care.
3. **Medically Needy**
   1. Receive case and Member eligibility-related data from IABC system.
   2. Create certification periods with spenddown amounts according files transferred from IABC.
   3. Prioritize medical expenses that have been submitted according to the Iowa Administrative Code and Code of Federal Regulations.
   4. Notify the IABC system when spenddown has been met.
   5. Track expenses that have been used for meeting spenddown.
   6. Generate notification documents.
   7. Update certification when requested by IM Workers.
4. **Provider Management**
   1. Maintain all provider master data necessary to ensure efficient operations and accurate adjudication of claims.
   2. Implement process improvements in the MMIS software and Provider portal to simplify administrative processes for providers.
   3. Update all necessary information to track, consolidate and report 1099 information prior to issuance of the 1099. Accurate 1099 statements must be sent timely as per federal regulations.
   4. Manage the exchange of provider information with the IME Pharmacy Point of Sale in the most effective, and efficient manner possible.
   5. Support all provider management processes, including but not limited to enrollment, re-enrollment, EFT enrollment, EDI enrollment and testing, remittance advices, and managed care reporting.
   6. Maintain all computer-generated correspondence.
5. **Claims Entry and Receipt**
   1. Accept claims and other transactions via hard copy and electronic media. Electronic media claims are accepted in the form of submission through standard Electronic Data Interchange processes.
   2. Comply with all federal requirements for transaction standards and operating rules.
   3. Receive and maintain control over electronic claims transaction.
   4. Provide imaging of paper claims.
   5. Develop and maintain screening instructions for each claim type. Screen all hard copy claims upon receipt. This includes:
      1. Date-stamp the claims.
      2. Sort and batch the claims.
      3. Screen the claims.
      4. Assign claim control numbers.
      5. Scan and image the claims.
   6. Deny entry of a paper claim into the MMIS unless it contains the Agency defined data elements. Return claims not meeting these criteria to the provider.
   7. Screen all claims to ensure they are submitted on the correct claim form and the paper claim form is an original.
   8. Log all claims returned to the provider to verify initial receipt.
   9. Provide data entry through both batch and online mode.
   10. Establish a quality control plan and internal procedures to ensure that all input to the system is captured timely and that all inputs to the claim input function are free from data entry errors.
   11. Produce claim control and audit trail reports during any stage of the claims processing cycle, adjustment and financial transaction data as requested which consists of:
       1. Inventory management analysis by claim type, processing location and age.
       2. Input control listings.
       3. Records of unprocessable claims.
       4. Inquiry screens, including pertinent header and detail claim data and status.
       5. Claims entry statistics.
       6. Data entry operator statistics, including volume, speed, errors and accuracy.
   12. Maintain an electronic image of all claims, attachments, adjustment requests and other documents. Retain all original claims and attachments until the quality of the imaged copies has been verified by the Core MMIS contractor and for no less than 90 days from transaction control number date.
   13. Produce electronic copies of claims, claim attachments and adjustments and provide secure storage with ability to retrieve copies for state users upon request.
   14. Identify and perform online correction to claims suspended because of data entry errors.
   15. Develop quality control procedures for imaging operations to ensure that imaged copies are legible. Submit written quality control plan to the Agency for review.
   16. Provide to the Agency claim inventory reports that will document the number of claims in each of the claims suspense area each day.
   17. Assume responsibility for marketing of the EDI concept to providers. Obtain written agreements from new providers wishing to submit claims via electronic media and ensure existing EDI agreements remain in effect.
   18. Ensure that EDI transmittals contain control totals and that all submitted records are loaded on the file.
   19. Accept claims from eligible, enrolled Medicaid Providers only. Accept submission of claims from providers, of the appropriate claim type and format for the submitting provider.
   20. Notify the provider after receipt of the transmission, of those claims accepted for further processing, of those claims rejected and the nature of the errors.
   21. Test providers’ readiness for EDI participation and allow only those providers passing testing standards to submit EDI claims.
   22. Provide and adequately staff an Electronic Data Interchange (EDI) Helpdesk call center exclusively for the Iowa Medicaid business that works closely with providers, system vendors, billing agents and clearinghouses to support EDI transactions (ANSI X12 healthcare transactions. The EDI Helpdesk shall be open from 8:00 a.m. to 5:00 p.m. Central Time (CT) for providers.
   23. Coordinate the activities of the EDI helpdesk with the Provider Services contractor to perform site visits, in the cases where phone support is not sufficient to resolve or educate the providers.
   24. Offer assistance and technical support to providers, trading partners and submitters who submit electronic transactions for the Medicaid Program. This assistance includes but is not limited to:
       1. Assist providers in determining the best method of electronic transaction submission.
       2. Enroll providers for electronic transaction submission.
       3. Provide transmission assistance to billing agents, clearinghouses and software vendors.
       4. Test submission software with the Agency trading partners.
       5. Identify and troubleshoot technical problems related to EDI transactions.
       6. Provide confirmation of electronic transaction submission.
       7. Provide assistance to support direct data entry of claims and other transactions through the web portal.

1. **Claims Adjudication**
   1. Maintain a claims pricing and adjudication module function to ensure that claims are processed in accordance with all established Iowa policies. This functional area includes claim edit and audit processing, claim pricing and claim suspense resolution processing.
   2. Provide that claims and transactions that will be entered into the MMIS from the claims entry function include claims that are recycled after correction and claims released to editing after a certain time period based on defined edit criteria, online entry of claim corrections to the fields in error, online forcing or overriding of certain edits provider, Member and reference data related to the suspended claims.
   3. The payment instruments and processes used to pay claims (i.e., EFT transactions) will be produced by the MMIS, the file is then sent to the Agency’s financial institution.
   4. Maintain control over all transactions during their entire processing cycle. Monitor, track and maintain positive control over the location of claims, adjustments and financial transactions from receipt to final disposition.
   5. Provide accurate and complete registers and audit trails of all processing activities.
   6. Maintain inventory controls and audit trails for all claims and other transactions entered into the system to ensure processing to completion.
   7. Control attachments required for claims adjudication include but are not limited to:
      1. Third-party liability and Medicare Explanation of Benefits.
      2. Sterilization, abortion and hysterectomy consent forms.
      3. Prior authorization treatment plans and emergency room reports.
   8. Ensure the capture all inputs timely and accurately.
   9. Ensure that every valid claim for a covered service provided by an enrolled provider to any eligible Member is processed and adjudicated.
   10. Process all claims entered into the MMIS to the point of payment or denial.
   11. Support program management and utilization review by editing claims against the prior authorization file to ensure that payment is made only for treatments or services which are medically necessary, appropriate and cost-effective.
   12. Edit all claims for eligible Member, eligible provider, eligible service and correct reimbursement schedule.
   13. Provide real-time adjudication of all claims entered manually.
   14. Provide real-time claims status information to the provider through the web portal or EDI transaction response.
   15. Provide plain English explanations of all claim edits or warnings triggered by the adjudication process.
   16. Maintain business rules of all claim edits in plain English.
   17. Process and adjudicate all claims and claim adjustments in accordance with the Agency program policy.
   18. Run a payment cycle weekly or as directed by the Agency.
   19. Process credits and adjustments to provider payments.
   20. Process NEMT Capitation Payments and receive and store encounter data.
   21. Adjudicate claims based on the rate effective on the date of service unless otherwise directed by the Agency.
   22. Research and develop special payment circumstances including determining the proper payment amount for the service.
   23. Provide claim histories and copies of claims to the Agency upon request.
   24. Account for all claims entered into the MMIS system and identify the individual disposition status.
   25. Process any claims or partial claims that were not used to meet the medically needy spenddown amount.
   26. Accept and process all Medicare Part A and B crossover claims pursuant to the Agency standards.
   27. Maintain a minimum of 60 months of adjudicated (paid and denied) claims history and all claims for lifetime procedures on a current, active, online claims history file for use in audit processing, online inquiry and update and make available printed claims including the entire claim record. Maintain the remainder of converted adjudicated claims history off-line in a format that is easily retrievable.
   28. Support multiple methodologies for pricing claims as established by the Agency.
   29. Accurately calculate the payment amount for each service according to the rules and limitations applicable to each claim type and provider type.
   30. Identify the allowable reimbursement for claims according to the date-specific pricing data and reimbursement methodologies contained on applicable provider or reference files for the date-of-service on the claim.
   31. Recommend for Agency approval specific edit parameters.
   32. Configure the fee schedules, per diems, DRG rates, APC rates and other rates and rules established by the Agency.
   33. Calculate Members cost sharing responsibilities including co-payments and deductibles. Apply Member liability to the claim as per the rules of the Agency.
   34. Track total annual cost-sharing for Member household and limit cost-sharing to the amount allowed by federal or state law.
   35. Deduct TPL amounts as appropriate when pricing claims.
   36. Deduct Member spenddown amounts as appropriate when pricing claims.
   37. Price claims according to the policies of the program the Member is enrolled in at the time of service and edit for concurrent program enrollments.
   38. Offset service plan payments for HCBS waivers (e.g., claims by provider) by any existing monthly client participation amount.
   39. Provide adequate qualified staff to resolve suspended claims.
   40. Suspend for review, claims from providers designated for prepayment review, claims containing procedure codes or diagnosis codes designated for prepayment review and other claims due to edits in the system.
   41. Recycle any claim type prior to denial, at the request of the Agency. Send recycled claims through the adjudication process at scheduled intervals. Deny claims after the Agency specified number of days.
   42. Conduct online real-time claims suspense resolution capabilities for all claim types.
   43. Receive approval from the Agency before establishing any new claim adjudication rules or changing the disposition status of existing claim adjudication rules in the system.
   44. Maintain an online resolution manual detailing the steps used in reviewing and resolving each error code. Update the resolutions manual as changes are made to claims processing procedures.
   45. Identify potential and existing third-party liability (including Medicare) and avoid paying the claim if it is for a covered service under a third party resource for applicable claim types.
   46. Maintain business rules.
   47. Perform overrides of claim edits and audits in accordance with the Agency-approved guidelines.
   48. Apply established edits to claims pursuant to the Agency criteria. Add, change or delete edits as directed by the Agency. Suspend claims for manual review and pricing if the claim cannot be automatically priced.
   49. Override timely filing requirements if the failure to meet the timely filing requirements is due to retroactive Member eligibility determination, delays in filing with other third parties or because the claim is a resubmitted claim. Exceptions may be granted by the Agency for other reasons such as court ordered payment, Member or provider appeal, after the claim has been denied and the provider has made an inquiry.
   50. Apply and maintain MMIS editing rules, pre-adjudication verifications (required elements present), Member-level editing (eligibility, benefits and overage), reference (procedure, diagnosis, Drug DD) and pricing (business rules), duplicate check and utilization review (duplicate claims/service limit exceed) and provider (enrollment and billing services).
2. **Encounter**
   1. Accept encounter data from all Medicaid MCOs, PAHPs, and the NEMT broker conducting business in the State of Iowa who are required to submit encounter data to the Contractor. Encounter data is used in evaluating service utilization and Member access to care.
   2. Reject individual encounter records that fail the Agency encounter edits. The encounter submitters are responsible for timely resolution of errors reported by the Contractor and re-submitting the encounter records found to be in error.
   3. Maintain the encounter data for federal reporting, quality assessment, and actuarial analysis.
   4. Receive, process and load encounter data into the repository. Produce and send encounter reports to the health and dental plans, and the NEMT broker and assist in reconciling errors.
   5. Organize and provide data to analyze Member access to health, dental, and NEMT services and the quality of care.
   6. Ensure accuracy and adequacy of encounter data received.
   7. Produce encounter data files and reports.
   8. Accept and log attestation from each contracting entity including MCOs, PAHPs, and the NEMT broker for encounter data submission as required by 42 CFR § 438.606.
   9. Process edits against the encounter file to ensure the data is technically correct.
   10. Generate error reports for each plan.
   11. Create and send to the MCOs, PAHPs, and the NEMT broker detailed reports on the results of the edit processing, providing them with the necessary information to identify the invalid data on their monthly encounter file and prepare it for resubmission.
   12. Incorporate managed care encounter data received from the managed care organizations into the MMIS reporting system.
   13. Maintain a minimum of five years of encounter data history for all encounter data.
   14. Count EPSDT screenings based on the procedure code on the encounter claim on accepted input files and retain for inclusion on the CMS-416.
   15. Produce and send encounter data files to the Agency contractors as required by the Agency.
   16. Accept, test and integrate into the T-MSIS files managed care encounter data from Iowa Medicaid contracts, including ***hawk-i*** enrollment and encounter data on a frequency required by CMS.
   17. Transfer encounter data extract updates to the data warehouse for reporting weekly.
   18. Accept and process encounter data in standard transaction formats.
   19. Provide a monthly report detailing the receipt and disbursement of encounter data files. The report should identify encounter file name, business partner, date of receipt or production, and disposition of the file (rejected or accepted).
   20. Develop timeliness measurements and reporting. Timely submission shall be measured from the date that a record is received by EDI; the date shall be captured and passed to MMIS. In addition, MMIS shall also receive the claim’s ID for encounters that fail EDI validation.
   21. Implement additional validation edits as the Agency identifies issues in the data.
   22. Enhance current data to make it more useable. This includes but is not limited to adding data elements that are not currently populated by MMIS but could be.
   23. Provide analysis and development support to the Encounter Data Officer, to enhance encounter data processes, procedures and data validation edits
   24. Receive and process Pharmacy Point of Sale encounters from the POS contractor.
   25. Collect, edit, store, and provide access to encounter shadow claims. Contractor shall provide processing for encounter shadow claims, including but not limited to:
       * + 1. Perform edits level 1-4, as follows:

Type 1: EDI syntax integrity testing – Testing of the EDI file for valid segments, segment order, element attributes, testing for numeric values in numeric data elements, validation of X12 or NCPDP syntax, and compliance with X12 and NCPDP rules. This will validate the basic syntactical integrity of the EDI submission.

Type 2: HIPAA syntactical requirement validation – Testing for HIPAA Implementation Guide-specific syntax requirements, such as limits on repeat counts, used and not used qualifiers, codes, elements and segments. Also included in this type is testing for HIPAA required or intra-segment situational data elements, testing for non-medical code sets as laid out in the Implementation Guide, and values and codes noted in the Implementation Guide via an X12 code list or table.

Type 3: Balancing – Testing the transaction for balanced field totals, financial balancing of claims or remittance advice, and balancing of summary fields, if appropriate. An example of this includes items such as all claim line item amounts equal the total claim amount. (See pages 19-22, Healthcare Claim Payment/Advice – 835 Implementation Guide for balancing requirements of the 835 transaction.)

Type 4: Situation Rules – The testing of specific inter-segment situations described in the HIPAA Implementation Guides, such that: If A occurs then B must be populated. This is considered to include the validation of situational fields given values or situations present elsewhere in the file. Example: if the claim is for an accident, the accident date must be present.

* + - * 1. Collaborate with Agency data management staff to determine how best to store these claims.

1. **Reference**
   1. Maintain a Reference Data module that contains rates and pricing information, and is used to determine allowable payments to providers, control edits, and audits and support other MMIS functions. Reference tables are used in the prior authorization and claims adjudication processes.
   2. Provide coding and pricing verification during claims processing for all approved claim types, assistance programs and reimbursement methodologies including capitated programs.
   3. Maintain flexibility in reference parameters and file capacity to make the MMIS capable of easily accommodating changes in the Medicaid program. Support the claims processing function by providing information used in the adjudication and pricing of claims.
   4. Support the data requirements of other MMIS applications such as claims processing, information access and decision support, utilization review and quality assurance, POS and prospective and retrospective DUR.
   5. Provide a master file of valid procedure, diagnosis, revenue and drug codes for use in the verification and pricing of Medicaid claims.
   6. Provide a means of reporting any information from the files.
   7. Provide and maintain customary charge data for provider's Medicaid customary charges.
   8. Provide and maintain prevailing charge data for Medicaid charges.
   9. Place benefit limits and maintain relationship edits on procedure, drug, diagnosis, DRG and APC codes. Use service limit codes and indicators on the procedure and diagnosis records to control benefit utilization.
   10. Enhance reference data to include additional attributes or code sets as needed to effectively manage state and federal payment rules.
   11. Maintain Revenue codes in the following manner:
       1. Maintain a revenue code data set for use in processing claims.
       2. Accommodate pricing action codes and effective end dates for each revenue code.
       3. Provide English descriptions of each revenue code in the revenue data set.
   12. Maintain current and historical reference data for all procedure codes and modifiers that include at a minimum the following elements:
       1. Date-specific pricing segments including a pricing action code for each segment showing effective dates and end dates.
       2. The Agency specified restrictions on conditions to be met for a claim to be paid such as provider types, Member age and gender restrictions, place of service, appropriate modifiers, aid category and assistance program.
       3. Pricing information such as maximum amount, fee schedule amounts and relative value scale (RVS) indicators with unlimited segments showing effective dates and end dates.
       4. Prior authorization codes with unlimited segments showing effective and end dates.
       5. English descriptions of procedure codes.
       6. "Global" indicators for codes that include reimbursement for pre- and post- procedure visits and services.
       7. Other information such as accident-related indicators for possible TPL, federal cost-sharing indicators and prior authorization required.
   13. Maintain procedure information that sets adjudication limitations and medical policy restrictions for automatic pricing of medical procedures according to the effective date.
   14. Identify when prior authorization and pre-procedure review approval is required.
   15. Restrict the use of procedure codes to those providers qualified to perform them.
   16. Accommodate variable pricing methodologies for identical procedure codes based on provider specific data.
   17. Maintain the previous and current diagnosis data set of medical diagnosis codes utilizing the International Classification of Diseases, Clinical Modification (ICD-CM) version required by HIPAA and Diagnostic and Statistical Manual (DSM) coding systems, which can maintain relational edits for each diagnosis code including:
       1. Age
       2. Gender
       3. Place of service
       4. Prior authorization codes with effective and end dates
       5. Inpatient length of stay criteria
       6. English description of the diagnosis code
       7. Effective date
       8. End date
   18. Maintain a master file of valid procedure, diagnosis, drug and revenue codes with attributes and appropriate pricing information for use in claims processing.
   19. Perform batch and online updates to all reference files in the MMIS subject to Agency approval via the workflow process. Notify the Agency electronically with results of file updates.
   20. Maintain online access to all reference files with inquiry by the appropriate code.
   21. Maintain the procedure, diagnosis, drug, DRG, APC, revenue code, medical criteria and other files. Provide access based on variable, user-defined select and sort criteria with all pertinent record contents.
   22. Make mass updates to the allowed fee or rate effective on a certain date.
   23. Maintain the per diem rates for hospitals with Medicaid-certified physical rehabilitation units as specified by the Agency. Update the rates as required by the Agency.
   24. Provide online inquiry and update capability for all files.
   25. Produce audit trail reports in the media required by the Agency showing before and after image of changed data, the ID of the person making the change and the change date.
   26. Edit all update transactions either batch or online for data validity and reasonableness as specified by the Agency. Report all errors from batch updates to the Agency.
   27. Accommodate multiple reimbursement methodologies including but not limited to DRG, APC, fee schedules and per diem.
   28. Maintain pricing files based on:
       1. Customary
       2. Fee schedule
       3. Per diem rates
       4. DRGs
       5. APCs
       6. Capitation rates for managed care plans
       7. Administrative fees for primary care management, medical home and others as designated by the Agency
       8. Multiple rates for long term care providers.
       9. Encounter rates for federally qualified health centers and rural health centers.
   29. Maintain and update the DRG-based prospective payment file for inpatient hospital services and update the base rates periodically as authorized by the Agency. Apply an economic index to the base rates as authorized by the Agency.
   30. Maintain and update DRG and APC data sets which contain at a minimum by peer group, facility and effective date, unlimited occurrences of:
       1. Price by code.
       2. High and low cost outlier thresholds.
       3. High and low length-of-stay outlier thresholds.
       4. Mean length-of-stay.
   31. Maintain the fee schedules in the reference file and update on an annual basis or as authorized by the Agency including applying an economic index to the fee schedule rates.
   32. Reimburse the following providers on the basis of a fee schedule, ambulance providers, ambulatory surgical centers, audiologists, chiropractors, community mental health centers, dentists, durable medical equipment and medical supply dealers, independent laboratories, maternal health clinics, hospital-based outpatient programs, nurse midwives, orthopedic shoe dealers, physical therapists, physicians, podiatrists, psychologists and screening centers.
   33. Reimburse optometrists, opticians and hearing aid dealers on the basis of a fee schedule for professional services plus the cost of materials at a fixed fee or at product acquisition costs.
   34. Reimburse managed care providers, contractors and the non-emergency NEMT broker on a monthly Capitation basis based on rates provided by the Agency.
   35. Maintain edit and audit criteria in the rules engine providing a user-controlled method of implementing service frequency and quantity limitations, service conflicts for selected procedures and diagnoses and online update capability.
   36. Maintain a user-controlled claim edit and audit disposition data set with disposition information for each edit used in claims processing including disposition (pay, suspend, deny) by submission medium within claim type, description of errors EOB codes, suspend location and online update capability.
2. **Prior Authorization Management**
   1. Maintain the prior authorization management module with responsibilities for medical and dental services shared between the Agency, the QIO contractor, and the Contractor.
   2. Operate a prior authorization system to load authorizations and track utilization of authorized services.
   3. Maintain edit disposition to deny claims for services that require prior authorization (PA) if no PA is identified or active.
   4. Accept prior authorizations requests through electronic data interchanges or the health information exchange using standard transaction sets. Apply business rules to determine if the prior authorization is approved, denied, or requires manual review.
   5. Direct PA requests that need manual review to the appropriate prior authorization contractor as directed by the Agency.
   6. Scan, image and forward paper PA requests received from providers to the appropriate prior authorization contractor as directed by the Agency.
3. **Third Party Liability Management**
   1. Maintain the Third-Party Liability (TPL) module to manage the private health insurance and other third party resources of Iowa’s Medicaid Members and ensure that Medicaid is the payor of last resort. The module processes and maintains all data associated with cost avoidance and recovering funds from third parties. Iowa Medicaid uses both a cost recovery process usually referred to as “pay and chase” and a cost avoidance process in managing its TPL activities. The information maintained by the module includes Member TPL resource data, insurance carrier data, and post payment recovery tracking data. The claims processing function uses the TPL coverage type during claims adjudication.
   2. Generate TPL and trauma lead letters per the Agency policy and produce a report of all letters.
   3. Generate a file of all paid claims and Member eligibility monthly.
   4. Process all files weekly or as directed by the Agency (TPL updates and claims updates) from Revenue Collection contractor.
   5. Process TPL updates manually entered by Revenue Collection contractor.
   6. Accept and process absent parent file from Child Support Recovery Unit weekly or as directed by the Agency.
   7. Update Member files to include the TPL plan and coverage information for HIPP Members.
   8. Manage the premium payment process.
   9. Create and issue HIPP remittance advice.
   10. Produce state-defined reports.
   11. Create a Member file for HIPP enrollees who are not Medicaid Members (i.e., AIDS/HIV, HIPP).
4. **Program Management Reporting**
   1. Maintain the Program Management Reporting module to provide statistical information on key Medicaid program functions. Production reports are designed to assist management and administrative personnel monitoring of the MMIS and the performance of the Contractor. This does not include preparation of federal reports.
   2. Produce all required reports and information in accordance with the timeframes and requirements specified by the Agency.
   3. Assume all costs associated with producing special reports that require no changes to the system such as reports generated through the use of reporting capabilities inherent to the system.
   4. Upon request, model proposed program modifications and report to the Agency financial, access, and utilization impacts.
   5. Review all process summaries to verify accuracy and consistency within and between reports before delivery of the reports to the Agency.
   6. Make recommendations on improvements to reporting process and assist the Agency in designing reports.
   7. Provide the flexibility to add, change or discontinue benefit plans, categories of service, special programs, Member aid categories, provider types and provider specialties and other reporting data elements. Carry through corresponding changes in affected reports without additional cost to the Agency.
   8. Produce ad hoc reports on request.
   9. Produce on a timeline approved by the Agency data extracts for delivery to external entities.
   10. When an error in a report is identified either by the Core MMIS contractor or by the Agency, provide an explanation as to the reason for the error. Correct and rerun the reports at the Core MMIS contractor's expense, when the reason for an error in a report is the error of the Core MMIS contractor’s system.
5. **Federal Reporting Management**
   1. Generate required reports to support federal reporting on demand and scheduled within timeframes and formats required by the state including but not limited to:
      1. CMS 21 report Quarterly State Children’s Health Insurance Program Statement of Expenditures for Title XXI.
      2. CMS 21B
      3. CMS21E statistical report
      4. Quarterly ethnicity report
      5. CMS 64 - Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program
      6. CMS 37 Quarterly Projections for the Medical Assistance Program
      7. T-MSIS Data extracts shall be produced and transmitted in the formats identified by CMS.
      8. CMS 372 cost neutrality assessment for waivers and other specified waiver reports.
      9. CMS 416 report information in accordance with the federal specifications and the Agency specifications.
      10. SF269 Federal Financial Status Report
   2. Support Payment Error Rate Measurement (PERM). In compliance with CMS quarterly claims sample frequency requirements, send the required data to the statistical contractor (SC) according to the claims extract approach using CMS-approved formats, media and security procedures.
   3. Modify reports supporting federal reporting as requested by the Agency. Modifications are made available within timeframes required by the state.
   4. Generate CMS 64 Variance and CMS 21 Variance reports as specified by the state for the current and three prior quarters. The variance reports shall be made available within timeframes and formats required by the Agency.
   5. Conduct research and respond to questions from CMS, OIG and state auditors regarding the T-MSIS data and federal reports.
   6. Prepare and deliver to the Agency the Quarterly Report of Abortions (CMS 64.9b).
   7. Prepare and deliver the report on expenditures under the Money Follows the Person program to the Agency.
   8. Identify and report the Federal Financial Participation (FFP) rate for each claim line.
   9. Produce a report of pharmacy drug rebate amounts for inclusion on federal reports.
   10. Regenerate, at no cost to the Agency, the T-MSIS file and federal reports when errors are identified or when there has been a mass adjustment of federal reports codes.
6. **Financial Reporting and Management**
   1. Maintain the financial management module function to support accounts payable and accounts receivable activities including issuance of check-write and EFT files and remittance advices.
   2. Wells Fargo is the entity that produces and transmits the electronic fund transfers. The Contractor is responsible for producing checks for mailing.
   3. Include the following data in the claims reporting function:
      1. All the claim records from each processing cycle.
      2. Online entered, non-claim-specific financial transactions, such as recoupment’s, mass adjustments, cash transactions.
      3. Provider, Member and reference data from the MMIS.
      4. Individual claim records for all claims not paid through the MMIS.
   4. Perform mass adjustments as directed by the Agency.
   5. Provide electronic funds transfer and electronic remittance advices.
   6. Provide paper checks and remittance advices to specific provider groups as directed by the Agency.
   7. Provide electronic copy of the check payment register to the Agency following each check write, in the format and content approved by the Agency.
   8. Run a check-write payment cycle and EFT authorization on a schedule determined by the Agency.
   9. Issue remittance advices to all providers pursuant to the Agency guidelines and timeframes.
   10. Produce and mail an Explanation of Medicaid Benefits (EOMB) each month to a statistically valid random sample using an Agency-approved sampling methodology of Members who received Medicaid benefits. This sample is combined with Agency-specified targeted Members or a group of claims and the EOMB is mailed to each appropriate Member. The EOMB lists all the Medicaid services the Member received the previous month, including date of service, provider, procedure and amount paid.
   11. Run a minimum of three cycles per week of claim history print requests and run a minimum of five cycles per week of Member history requests and a minimum of one cycle per week for purged claim history requests.
   12. Provide the Agency with electronic copies of remittance advices and EOMB forms.
   13. Provide the Department of Inspections and Appeals a file of all checks paid out and Electronic Fund Transfers (EFTs) made.
   14. Produce electronic file of monthly billings for entities responsible for the non-federal share of claims.
   15. Print billings for entities responsible for the non-federal share of claims as directed by the Agency.
   16. Identify the non-federal share of ICF/ID provider fee assessment and ensure these amounts are not transferred to the accounts receivable system for collection by the Agency. Provide the ability to recoup and issue hold harmless add-on payments.
   17. Maintain the table of Integrated Information for Iowa (I/3) financial accounting system codes in the system.
   18. Extract information required for billing entities responsible for the non-federal share of benefit expenditures for download to an SQL-server based A/R system.
   19. Produce and mail a paper report and invoice to entities responsible for the non-federal share of benefit expenditures with instructions to send the checks for payment to the Agency.
   20. Accept and process the Department of Administrative Services Vendor Offset file received weekly from the Agency.
   21. Transmit accounts that cannot be collected (e.g., provider overpayments) to the Revenue Collection contractor.
   22. Generate provider remittance advices in electronic, paper (currently less than 1500 providers) and PDF media. Electronic remittance advices shall meet ANSI X12 835 standards. Include all of the information identified below on the remittance advice. For the ANSI X12 835 format, information is limited to available fields on the authorized format.
       1. An itemization of submitted claims that were paid, denied or adjusted and any financial transactions that were processed for that provider, including subtotals and totals.
       2. An itemization of suspended claims.
       3. Adjusted claim information showing both the original claim information and an explanation of the adjustment reason code.
       4. The name of the insurance company, the name of the insured and the policy number for claims rejected due to TPL coverage on file for the Member.
       5. Explanatory Messages relating to the claim payment cutback or denial.
       6. Summary section containing earnings information regarding the number of claims paid, denied, suspended, adjusted, in process and financial transactions for the current payment period, month-to-date and year-to-date.
       7. Explanation of Benefits payment Messages for claim header and for claim detail lines.
       8. Patient account and medical records numbers, where available.
       9. Any additional fields as described by the Agency.
   23. Provide the capability to insert informational Messages on remittance advices or a supplemental document to accompany payment, with multiple Messages available on a user-maintainable Message text file, with selectable print parameters such as provider type, claim type and payment cycle date(s).
   24. Provide the flexibility to suppress the generation of zero-pay checks and EFTS but to generate associated remittance advices.
   25. Provide to the state each provider's 1099 information annually.
   26. Accommodate manually issued checks by the state and the required posting to the specific provider's account to adjust the provider's 1099 earnings data and set up recoupment criteria.
   27. Enter lien and assignment information to be used in directing or splitting payments to the provider and lien holder.
   28. Identify providers with credit balances and no claim activity during the Agency-specified number of months and generate a quarterly report of credit account balance audits.
   29. Generate overpayment letters to providers when establishing accounts receivable.
   30. Provide paper, envelopes, check stock and all services associated with printing and mailing Residential Care Facility (RCF) letters and checks, including lien holder provider checks.
   31. Provide reports on all financial transactions by source, including TPL recoveries, fraud and abuse recoveries, provider payments, drug rebates.
   32. Transmit financial data electronically from the MMIS directly to the Agency or the entity responsible for producing EFT.
   33. Manage the billing process for entities responsible for the non-federal share of specified services.
   34. Accumulate paid claims and Information on each claim line including Member’s county of legal settlement.
   35. Produce and mail a paper report and invoice to entities as directed by the Agency.
   36. Produce an electronic file for entities as directed by the Agency.
   37. Manage account receivable function to track all amounts due the Agency as a result of a transaction processed by the MMIS and POS.
7. **Program Integrity Management**
   1. Provide weekly or as required by the Agency, a file of all paid claims to Program Integrity contractor and the Department of Inspection and Appeals Medicaid Fraud Control Unit (MFCU).
   2. Provide weekly or as required by the Agency, a copy of the provider claims history profile report to the Department of Inspection and Appeals (DIA).
   3. Produce for the DIA an electronic summary of LTC.
   4. Provide to the MFCU weekly or as directed by the Agency, an electronic copy of all checks paid and Electronic Fund Transfers (EFTs) made.
   5. Manage data interfaces between the Service Utilization and Review module managed by the Program Integrity contractor and the MMIS system.
8. **Managed Health Care**
   1. Accept and process Member eligibility updates. Based upon Member eligibility, enroll or disenroll Members in MCOs, PAHPs, PACE organizations, and the NEMT broker according to Agency rules.
   2. Accept and process MCO, PAHP, PACE, and NEMT broker provider data from Provider Services contractor.
   3. Calculate and issue administrative, incentive and Capitation Payments to the MCOs, PAHPs, PACE organizations, and the NEMT broker.
   4. Adjudicate fee-for-service claims in accordance with the Agency rules.
   5. Generate reports as required by the Agency.
   6. Manage the payment process and issue the payments.
   7. Resolve Capitation Payment errors.
   8. Issue enrollment rosters.
   9. Send electronic remittance advices to the MCOs, PAHPs, and NEMT broker.
   10. Send paid claims and encounter data to actuarial contractor.
   11. Apply Managed Health Care (MHC) rules for assignment exclusion as the system of record for such rules.
   12. Maintain all file interfaces/exchanges to ensure that MHC assignments are timely processed at month end cycle.
   13. Process retroactive corrections or fixes, for Members that lose eligibility during month end process, or that become reinstated.
   14. Generate and send EPSDT file to IDPH with MCO enrollment data.
   15. Generate and send EO1 (COBA) file to CMS.
9. **Eligibility Verification Information System (ELVS)**
   1. Support and maintain the ELVS Interactive Voice Response System (IVRS).
   2. Ensure that the ELVS IVRS is updated with current accurate information from the MMIS. The data elements included and the frequency of updating will be approved by the Agency.
   3. Send the necessary data elements to the ELVS IVRS.
   4. Provide Member eligibility and provider information through the IVRS. Voice response is available to all providers with a touch-tone telephone.
   5. Provide Member assignment information for Members assigned to an MCO.
   6. Provide appropriate safeguards to protect the confidentiality of eligibility information, conform to all state and federal confidentiality laws and ensure that state data security standards are met.
   7. Ensure the system checks Member identification using predefined access keys approved by the Agency.
   8. Provide automated logging of all transactions and produce reports as required by the Agency.
   9. Track and identify caller statistics, including provider type, provider number, number of inquiries made, duration and errors or incomplete calls.
   10. Coordinate with the Agency to assure sufficient communication capabilities to accommodate all providers requiring utilization of the system.
   11. Coordinate with telecommunication and software vendors to resolve operational and performance issues.
   12. Override the system pronunciation of names as necessary to correct computer generated pronunciation.
   13. Notify the Agency designees of operational issues within one hour of identification.
   14. Provide knowledge transfer to the Provider Services contractor in the use of IVRS options and respond to questions from Provider Services contractor.
10. **Workflow Management**
    1. Maintain and update as necessary the current IME workflow processes.
    2. Reconfigure workflows as required to support revised business processes.
    3. Create the process for assigning and transferring claims within the workflow.
    4. Monitor activities and distribute workloads.
    5. Destroy source documents according to procedures defined by the Agency.
    6. Conduct training for Agency staff and other IME Units for workflow management system.
11. **Change Management Process**
12. A Change Management Request (CMR) shall be used to identify all changes for system maintenance, to include but not be limited to:
13. Repair defects.
14. Perform routine maintenance on reference files.
15. Complete or repair functionality that never worked.
16. Make additions and modifications to business rules.
17. Make additions and modifications to benefit plans.
18. Make additions and modifications to workflow processes.
19. Manage user security levels of access.
20. A Change Service Request (CSR) will be used to identify all changes for system enhancements, to include but not be limited to:
21. Make enhancements to system functionality.
22. Make modifications to the Agency enterprise modules.
23. Utilize the workflow management tool to track and generate reports on the progress of all CMRs and CSRs. Duties include but are not limited to:
24. Image and include all attachments pertinent to each CMR and CSR, including request, business and technical requirements, test plan and test results and approval sign-off.
25. Provide notification to affected parties when a CMR or CSR status changes.
26. Maintain all changes made by the Agency or the Contractor to each CMR or CSR, identifying the change made, the person making the change and the date and time of the change.
27. Provide status report coding changes, attach test results and record all notes from the Agency and Contractor staff related to each CMR or CSR.
28. Produce Change Control Reports that are downloadable to other formats such as Excel. Information to be captured shall include at a minimum the following:
29. Change Management Request number
30. Modification description
31. Modification related notes or comments
32. Request date
33. Requester
34. Modification start dates
35. Assigned resource(s)
36. Hours worked to date
37. Documentation impact and status
38. Testing status
39. Agency approval of the modification
40. Implementation date
41. Be responsive to all requests from the Agency for system modification, whether categorized as maintenance, defect, enhancement or modification.
42. Complete CMRs and CSRs on or before requested completion dates.
43. Provide clear and complete responses to all CSRs including:
44. Definition of the problem
45. Proposed solution
46. Proposed approach to implement the solution
47. Proposed schedule for completion
48. Constraints and assumptions
49. Financial impact
50. Stakeholder impact (e.g., providers, Members, Agency)
51. Estimated effort detailed by:
52. Labor in hours
53. Hours per task
54. Hours per full-time equivalent (FTE)
55. Equipment
56. General and administrative support in hours
57. Ongoing support requirements
58. Provider knowledge transfer
59. Documentation
60. Maintain documented and proven code promotion procedures for promoting changes from the initiation of unit testing, through the final implementation to production. The promotion procedure must maintain separation of duties between solution developers and production promotion to ensure modifications are well tested prior to moving to production.
61. Maintain documented version control procedures that include the performance of regression tests whenever a code change or new software version is installed, including maintaining an established baseline of test cases, to be executed before and after each update, to identify differences.
62. Maintain adequate staffing levels to ensure CMRs are completed within the specified timeframe determined by the Agency.
63. Ensure that all CSRs are addressed within timeframe determined by the Agency.
64. Update documentation and operational procedures impacted by the change management process.
65. Provide a status report to the Agency that includes new CMRs/CSRs, closed CMRs/CSRs, and the status for high priority CMRs/CSRs. The report shall include emergency production fixes and system outages during the reporting period. The report shall include performance standard results as requested by the Agency. The report should be delivered to the Agency at a frequency to be determined by the Agency.

# 1.3.1.4 Legacy Transition Services

Legacy transition services support the transition from the legacy system to each new module iteratively. When a new module is deployed to production, the corresponding legacy functionality or service will be retired. In order to retire the corresponding legacy functionality, the Contractor shall:

1. Fully cooperate with the Agency and each module vendor.
2. Develop and comply with a transition plan detailing the activities necessary to transfer functionality responsibility to each module vendor.
3. Make system changes and customizations, and testing to support the integration with each new module.

# 1.3.1.5 Turnover Phase

Within this final phase of the Contract, the Contractor turns over operations to a new contractor near the end of the Contract term. This phase is activated when the Agency enters into a contract with a new entity (such as a newly awarded contractor) and begins the process of transferring responsibility for operations to that entity.

Once the turnover phase begins, the Contractor shall:

1. Fully cooperate with the Agency and new entity.
2. Develop and comply with a turnover plan detailing the activities necessary to transfer responsibility for operations to the new entity.
3. Provide the required turnover services. This will include meeting with the incoming vendor(s) and devising work schedules that are agreeable for both the Agency and the incoming vendor(s).
4. Provide knowledge transfer to the new entity in the operation of the MMIS. Such knowledge transfer shall be completed at least one month prior to the end of the Contract. Such knowledge transfer shall include:
   1. Data entry, imaging and claims processing.
   2. Computer operations.
   3. Controls and balancing procedures.
   4. Exception claims processing.
   5. Other manual procedures.
5. Turn over all:
   1. Paper claims and paper claim adjustments.
   2. Paper provider files.
   3. Paper file maintenance forms.
   4. Paper financial records.
   5. All reports associated with the contract throughout the Operations Phase shall be provided to the Agency and placed in a location on the DHS network, as determined by the Agency.
   6. A turnover results report.

1.3.2 Performance Measures.

The Contractor shall:

1. Transition
   1. Submit transition, system implementation, and operations planss to the Agency for approval within 15 business days after execution of this Contract, unless specified otherwise. The Contractor shall receive final approval no later than 10 business days after first submission.
   2. Submit the remaining plans to the Agency for approval within 20 business days after execution of this Contract. The Contractor shall receive final approval no later than 10 business days after first submission.
   3. Submit SOPs to the Agency for approval within 25 business days after the execution of this Contract. The Contractor shall receive final approval no later than 10 business days after first submission.
2. Quality Assurance/Quality Improvement
   1. Perform quality assurance reviews on a minimum of 25% of the operational procedures quarterly, with 100% reviewed annually.
   2. If the accuracy rate is less than 98%, a corrective action plan shall be submitted to the Agency within ten business days of the quality review for the Agency’s approval.
   3. Meet ninety-eight percent of the corrective action commitments within the agreed upon timeframe.
3. Mailroom and Courier Service
   1. Return claims lacking a procedure and diagnosis code to the provider within one business day.
   2. Imaged claims shall be available for processing and viewing within 5 business days of receipt.
   3. Do not enter a claim in MMIS (with the exception of Medicare crossover claims) unless it contains the Member ID number, provider ID number and signature of the provider or his authorized representative. Do not accept a facsimile stamp unless it is initialed by the provider or his/her authorized representative. Return claims not meeting these criteria to the provider within one business day.
   4. One hundred percent of claims and all other documents will be scanned and available within the system within ten business days of receipt.
4. Member Management
   1. Update the Member eligibility database with electronically received data and provide the Agency with update and error reports within 24 hours of receipt of daily updates. Update within two hours of receipt of data for batch-processing environment. Resolve eligibility transactions that fail the update process within 24 hours of error detection.
   2. Refer to the Agency all eligibility transactions that fail the update process and cannot be resolved by Contractor staff pursuant to edit rules or State-approved standards, within one business day of attempted error resolution.
   3. Perform online updates for hardcopy update transactions to Member data, except presumptive eligibility records, within one business day of receipt.
   4. Add records for presumptively eligible individuals to the Member eligibility file the same day as the eligibility determination.
   5. Maintain a ninety-eight percent keying accuracy rate for online updates.
   6. Identify and correct keying errors in online updates within one business day of identifying the error.
   7. Produce and send notices to Members based on adverse actions for denied ambulance and rehabilitation claims and denied and modified prior authorizations within three business days of decision on the claim.
   8. Provide a weekly report to the Agency of all NOD to Members that were sent to Members based on adverse actions for denied ambulance and rehabilitation claims and denied and modified prior authorizations within five business days of the NOD.
   9. Issue NOD to Members within 24 hours of the determination of the denial of ambulance claims and rehabilitation therapy services claims for occupational therapy, physical therapy and speech therapy.
   10. Create and or update operational procedure manuals within 10 business days of the approval of the implementation procedure or change by the Agency.
   11. Produce state-defined reports within the Agency required timeframe.
5. Medically Needy
   1. All claims will be applied to the medically needy spenddown accounts according to the following timelines:
      1. Within 24 hours of adjudication cycle for all Medicaid covered claims.
      2. Within 48 hours of adjudication cycle for all Non-Medicaid covered claims.
   2. Identify at least ninety-five percent of the appropriate claims for the medically needy spenddown account for approved medically needy clients.
   3. Create and or update operational procedure manuals within 10 business days of the implementation procedure or change by the Agency.
   4. Produce state-defined reports within the required timeframe as defined by the Agency.
6. Provider Management
   1. Produce and mail provider 1099s by January 31st of each calendar year.
   2. Produce and make provider mailing labels available for printing in the State data center within one business day of request.
   3. Create and/or update operational procedure manuals within 10 business days of the approval of the implementation procedure or change by the Agency.
   4. Produce state-defined reports within the required timeframe as determined by the Agency.
7. Claims Entry and Receipt
   1. Data enter ninety-eight percent of all hard copy claims and adjustment and or void requests within two business days of receipt.
   2. Log, image and assign a unique control number to every claim, attachment and adjustment and or void, prior authorization and other documents submitted by providers all of which must be viewable in the MMIS within five business days of receipt.
   3. Return hard copy and clean claims that fail the prescreening process within one business day of receipt.
   4. Maintain at least a ninety-six percent keying accuracy rate for data entered documents.
   5. Maintain a ninety-nine percent accuracy rate for electronic claims receipt and transmission.
   6. Produce and provide to the Agency all daily, weekly and monthly claims entry statistics reports within one business day of production of the reports.
   7. Provide access to imaged claims, attachments and adjustments and or voids, prior authorizations and other documents to all users immediately upon completion of the imaging. Response time for accessing imaged documents at the desktop must not exceed ten seconds.
   8. Return an electronic receipt and or notification for claims submitted electronically within four business hours of receipt.
   9. All EDI claims, including Medicare crossover claims, must be processed within 1 business day after receipt.
   10. Create and or update operational procedure manuals within 10 business days of the approval of the implementation procedure or change by the Agency.
   11. Produce state-defined reports within the required timeframe as determined by the Agency.
   12. Maintain a service level (SL) percentage of at least 90 percent for incoming Core and EDI helpdesk calls as calculated by the following formula:

SL= ((T – (A+B)/T)\*100)

Where T = all calls that enter the queue

A= calls that are answered after 30 seconds

B= calls that are abandoned after 30 seconds

* 1. Ninety-five percent of all EDI inquiries submitted through e-mail or direct secure messaging receive outreach (personal message response or phone response) within 1 business day.
  2. Ninety-five percent of all provider clean claims are able to clear EDI editing and continue to be uploaded and processed in the system.

1. Claims Adjudication
   1. Ninety percent of all clean claims must be adjudicated for payment or denial within 10 calendar days of receipt.
   2. Ninety-nine percent of all clean claims must be adjudicated for payment or denial within 60 calendar days of receipt.
   3. One hundred percent of all claims must be adjudicated for payment or denial within 120 calendar days of receipt.
   4. One hundred percent of all clean provider-initiated adjustment requests must be adjudicated within 10 business days of receipt.
   5. Claims processed in error shall be reprocessed within 10 business days of identification of the error.
   6. Produce state-defined reports within the timeframes established in the Agency-approved reporting plan.
2. Encounter
   1. Process and report disposition of encounter file edit review to the submitting managed care organization within three business days of receipt.
   2. Provide encounter data files, in acceptable format, to the Agency recognized contractors within five business days of end of designated reporting period.
   3. Report deficiency findings from MCOs, PAHPs, and the NEMT broker encounters to the Agency within five business days from the end of the reporting quarter.
   4. Create and or update operational procedure manuals within 10 business days of the approval of the implementation procedure or change by the Agency.
   5. Produce state-defined reports within the required timeframe as determined by the Agency.
3. Reference
   1. Produce state-defined reports within the required timeframe as determined by the Agency.
   2. Update the CLIA laboratory designations within one business day of receipt of file.
   3. Perform online updates to reference data within one business day of receipt and the Agency authorization or on a schedule as approved by the Agency.
   4. Process procedure, diagnosis and other electronic file updates to the reference databases within two business days of receipt and approval or upon a schedule approved by the Agency.
   5. Provide updated error reports and audit trails to the Agency within one business day of completion of the update.
   6. Update, edit and adjudication documentation within three business days of the request from the Agency.
   7. Update error text file documentation within three business days of the Agency approval of the requested change.
   8. Maintain a ninety-nine percent accuracy rate for all reference file updates.
   9. Notify the Agency and correct errors within one business day of error detection.
   10. Create and or update operational procedure manuals within 10 business days of the approval of the procedure implementation or change by the Agency.
   11. Produce state-defined reports within the required timeframe as determined by the Agency.
4. Prior Authorization Management
   1. Process all single transaction prior authorizations within three minutes of the receipt of the transaction and return the status of the prior authorization to the provider.
   2. Complete all prior authorization batch interface updates from prior authorization entities within one business day of receipt of file if there are no critical errors.
   3. Forward all prior authorization requests to the appropriate prior authorization entities within four hours.
   4. Create and or update operational procedure manuals within 10 business days of the approval of the procedure implementation or change by the Agency.
   5. Produce state-defined reports within the required timeframe as determined by the Agency.
5. Third Party Liability Management
   1. Create and or update operational procedure manuals within 10 business days of the approval of the procedure implementation or change by the Agency.
   2. Generate TPL and trauma lead letters within 24 hours of receipt.
   3. Process TPL updates within 24 hours of receipt from the Revenue Collection contractor.
   4. Update Member files to include the TPL plan and coverage information for HIPP Members within 24 hours of receipt from the HIPP unit.
   5. Generate a file of all paid claims and Member eligibility by the fifth business day of each month for the previous month.
   6. Produce state-defined reports within the required timeframe as determined by the Agency.
   7. The initial accuracy measurement upon submission of all documents and reports will be determined by the Agency.
6. Program Management Reporting
   1. All standard production reports must be available on line for review by the Agency staff pursuant to the following schedule:
      1. Daily reports – by 6:00 AM of the following business day.
      2. Weekly reports – by 6:00 AM of the next business day after the scheduled production date.
      3. Monthly reports – by 6:00 AM of the first business day after month end cycle.
      4. Quarterly reports – by 6:00 AM of the fifth business day after quarterly cycle.
      5. Annual reports – by 6:00 AM of the (10th) business day after year end cycle (state fiscal year, federal fiscal year, waiver year or calendar year).
      6. Balancing reports are to be provided to the Agency within two business days after completion of the program management reporting production run.
   2. Model results are to be returned to the Agency within two business days of receipt of proposed business rules, or as Directed by the Agency.
   3. Deliver model reports timely for 90% of all requests.
   4. When an error in a report is identified either by the Core MMIS contractor or by the Agency, provide an explanation as to the reason for the error within one business day and correct the report within one business day following the date the error was identified unless the Agency authorizes additional time for correction.
   5. Data files for all reports must be made available on the state data center servers and accessible online within one business day of completion.
   6. Produce state-defined reports within the required timeframe as determined by the Agency.
   7. The initial accuracy measurement upon submission of all documents and reports will be determined by the Agency.
7. Federal Reporting Management
   1. Produce federal reports on the following schedule:
      1. Quarterly reports – by 6:00 AM of the first business day following the final regular pay cycle of the quarter.
      2. Annual reports – by 6:00 AM of the fifth business day after last pay cycle of the reporting year (state fiscal year, federal fiscal year, waiver year or calendar year).
   2. Produce PERM data within the required timeframe determined by the Agency.
   3. Modify changes to federal reports within five business days of request by the state.
   4. Respond to questions from CMS, OIG and state auditors within the timeframes determined by the Agency.
   5. Produce state-defined reports within the required timeframe determined by the Agency.
   6. The initial accuracy measurement upon submission of all documents and reports will be determined by the Agency.
8. Financial Reporting Management
   1. Produce state-defined reports including, but not limited to accounts payable and receivable reports, within the required timeframe determined by the Agency.
   2. Produce, post and mail the Explanation of Medicaid Benefits (EOMB) within five business days of the pay cycle.
   3. Produce, post and mail all remittance advices within one business day of the pay cycle.
   4. Perform mass adjustments within five business days of being directed to do so by the Agency.
   5. Deliver the EFT and check file as directed by the Agency.
   6. Deliver the file of charges to entities responsible for the non-federal share of benefit expenditures to the state’s accounts receivable system within one business day of the last pay cycle of the month.
   7. Print and mail RCF letters and checks, including lien holder provider checks as determined by the Agency.
   8. The initial accuracy measurement upon submission of all documents and reports will be determined by the Agency.
9. Program Integrity Management
   1. All required reports must be available online for review by the Agency staff pursuant to the following schedule:
      1. Daily reports - by 10:00 AM of the following business day.
      2. Weekly reports – by 10:00AM of the next business day after the scheduled production date.
      3. Create and or update operational procedure manuals within 10 business days of the approval of the procedure implementation or change by the Agency.
      4. Produce the state-defined reports within the required timeframe as determined by the Agency.
10. Managed Health Care
    1. Process payments on a schedule approved by the Agency.
    2. Meet a 100 percent accuracy rate for all Capitation rate assignments.
    3. Meet a ninety-eight percent accuracy rate on appropriate payment or denial of fee-for-service claims.
    4. Produce state-defined reports within the required timeframe determined by the Agency.
11. ELVS IVRS
    1. Assure a response time of less than five seconds on the ELVS IVRS referred to as ELVS. Response time is determined by measuring the elapsed time from speaking or entering the requested provider and Member information to receipt of a response.
    2. The IVRS referred to as ELVS must be available ninety-eight percent of the time, 24 hours a day and seven days a week.
    3. Update IVRS referred to as ELVS upon receipt of a change in eligibility.
    4. Update ELVS information near real-time as claims are adjudicated and cost sharing responsibilities change.
    5. Correction of system pronunciation of names within one business day of identification of problem.
    6. Update voice response scripts to correct errors within one business day of identification of problem.
    7. Notify the Agency designees of operational issues within one hour of identification.
    8. Produce the state-defined reports within the required timeframe determined by the Agency.
    9. The initial accuracy measurement upon submission of all documents and reports will be determined by the Agency.
12. Change Management Process
    1. Within 10 business days of receipt of a CSR for an enhancement or modification, provide a written response in a Statement of Understanding (SOU) demonstrating understanding of the request and a schedule for completion or a more thorough assessment of the impact of the change on operations and contract cost per contract year as designated by the Agency
    2. Provide updates to all documentation within 10 business days after the Agency approves the enhancement or modification for production.
    3. Notify the Agency within 24 hours of discovering an issue or defect. Failure to do so will result in sanctions being assessed. The contractor will be responsible for the research, coding and testing of the issue or defect. Prior to implementing any changes in production, the contractor must present the test results to the Agency for approval. This work must be done without impacting scheduled Agency requests.
    4. Ensure submitters are satisfied with the timeliness, communication, accuracy and result of the CSR process ninety-five percent of the time.

**1.4 Monitoring and Review**

**1.4.1 Agency Monitoring Clause.** The Contract Manager or designee will:

* Verify Invoices and supporting documentation itemizing work performed prior to payment;
* Determine compliance with general contract terms, conditions, and requirements; and
* Assess compliance with Deliverables, performance measures, or other associated requirements based on the following:
  + The Agency’s representative will perform at minimum monthly desk monitoring of deliverables, reports, and results to determine the success of the Contractor.
  + The Agency’s representative will sign-off on completed Scope of Work items, provide feedback on progress and determine if other measures are required to ensure achievement of items approved and documented.

**1.4.2 Agency Review** **Clause.** The Contract Manageror designee will use the results of monitoring activities and other relevant data to assess the Contractor’s overall performance and compliance with the Contract. At a minimum, the Agency will conduct a review annually; however, reviews may occur more frequently at the Agency’s discretion. As part of the review(s), the Agency may require the Contractor to provide additional data,may perform on-site reviews, and may consider information from other sources.

The Agency may require one or more meetings to discuss the outcome of a review. Meetings may be held in person. During the review meetings, the parties will discuss the Deliverables that have been provided or are in process under this Contract, achievement of the performance measures, and any concerns identified through the Agency’s contract monitoring activities.

**1.5 Contract Payment Clause.**

**1.5.1 Pricing.** In accordance with the payment terms outlined in this section and the Contractor’s completion of the Scope of Work as set forth in this Contract, the Contractor will be compensated as follows:

*{To be determined.}*

**1.5.2 Payment Methodology.**

1. Transition Costs. The Contractor may invoice transition costs in two equal installments according to the following milestones:
   1. The first milestone shall be the Agency acceptance of the finalized work plans, SOPs, and VSQ.
   2. The second milestone shall be the Contractor’s successful transition to Operations, as determined by the Agency.
2. NCCI, EDI, and Imaging/scanning Solution Implementation Costs. The Contractor may invoice each implementation cost upon the Contractor’s successful implementation of each solution, as determined by the Agency.
3. Operations Costs. The Contractor will be paid a fixed monthly amount for services rendered and an hourly rate for approved CSRs, in accordance with the pricing set forth in Special Contract Attachment 3.1 (i.e., the Cost Proposal).
   1. Deliverables and Performance Measure Withholding Payment. The Contractor may invoice 92% of the fixed amount each month. The Agency will withhold 8% of the monthly amount to assure the Contractor meets required Deliverables and Performance Measures as follows:
      1. Section 1.3.2.G Claims Entry- 2% of the monthly amount
      2. Section 1.3.2.H Claims Adjudication - 2% of the monthly amount
      3. Section 1.3.2.M Program Management Reporting - 2% of the monthly amount
      4. Section 1.3.2.Q Managed Health Care - 2% of the monthly amount

In order to claim the withhold amount, the Contractor must show in the monthly performance report that each performance measure has been met. Determination of whether performance measures have been met is strictly and solely at the discretion of the Agency.

* 1. CSR payments are not subject to the 8% withhold.
  2. Withholding of Final Payment. The Agency may withhold the last full monthly payment due at the end of the Contract until such time as the Contractor has fully completed all Turnover activities and completely closed out the Contract.

1.5.3 Timeframes for Regular Submission of Initial and Adjusted Invoices. The Contractor shall submit an Invoice for services rendered in accordance with this Contract. Invoice(s) shall be submitted monthly. Unless a longer timeframe is provided by federal law, and in the absence of the express written consent of the Agency, all Invoices shall be submitted within six months from the last day of the month in which the services were rendered. All adjustments made to Invoices shall be submitted to the Agency within ninety (90) days from the date of the Invoice being adjusted. Invoices shall comply with all applicable rules concerning payment of such claims.

1.5.4 Submission of Invoices at the End of State Fiscal Year. Notwithstanding the timeframes above, and absent (1) longer timeframes established in federal law or (2) the express written consent of the Agency, the Contractor shall submit all Invoices to the Agency for payment by August 1st for all services performed in the preceding state fiscal year (the State fiscal year ends June 30).

1.5.5 Payment of Invoices. The Agency shall verify the Contractor’s performance of the Deliverables and timeliness of Invoices before making payment. The Agency will not pay Invoices that are not considered timely as defined in this Contract. If the Contractor wishes for untimely Invoice(s) to be considered for payment, the Contractor may submit the Invoice(s) in accordance with instructions for the Long Appeal Board Process to the State Appeal Board for consideration. Instructions for this process may be found at: <http://www.dom.state.ia.us/appeals/general_claims.html>.

The Agency shall pay all approved Invoices in arrears. The Agency may pay in less than sixty (60) days, but an election to pay in less than sixty (60) days shall not act as an implied waiver of Iowa law.

**1.5.6 Reimbursable Expenses.** Unless otherwise agreed to by the parties in an amendment or change order to the Contract that is executed by the parties, the Contractor shall not be entitled to receive any other payment or compensation from the State for any Deliverables provided by or on behalf of the Contractor pursuant to this Contract. The Contractor shall be solely responsible for paying all costs, expenses, and charges it incurs in connection with its performance under this Contract.

***1.6 Insurance Coverage.***

The Contractor and any subcontractor shall obtain the following types of insurance for at least the minimum amounts listed below:

|  |  |  |
| --- | --- | --- |
| **Type of Insurance** | **Limit** | **Amount** |
| General Liability (including contractual liability) written on occurrence basis | General Aggregate  Product/Completed  Operations Aggregate  Personal Injury  Each Occurrence | $2 Million  $1 Million  $1 Million  $1 Million |
| Automobile Liability (including any auto, hired autos, and non-owned autos) | Combined Single Limit | $1 Million |
| Excess Liability, Umbrella Form | Each Occurrence  Aggregate | $1 Million  $1 Million |
| Workers’ Compensation and Employer Liability | As required by Iowa law | As Required by Iowa law |
| Property Damage | Each Occurrence  Aggregate | $1 Million  $1 Million |
| Professional Liability | Each Occurrence  Aggregate | $2 Million  $2 Million |

***1.7 Business Associate Agreement.*** The Contractor, acting as the Agency’s Business Associate, performs certain services on behalf of or for the Agency pursuant to this Contract that require the exchange of information that is protected by the Health Insurance Portability and Accountability Act of 1996, as amended, and the federal regulations published at 45 CFR part 160 and 164. The Business Associate agrees to comply with the Business Associate Agreement Addendum (BAA), and any amendments thereof, as posted to the Agency’s website:<http://dhs.iowa.gov/HIPAA/baa>. This BAA, and any amendments thereof, is incorporated into the Contract by reference.

By signing this Contract, the Business Associate consents to receive notice of future amendments to the BAA through electronic mail. The Business Associate shall file and maintain a current electronic mail address with the Agency for this purpose. The Agency may amend the BAA by posting an updated version of the BAA on the Agency’s website at: <http://dhs.iowa.gov/HIPAA/baa>, and providing the Business Associate electronic notice of the amended BAA. The Business Associate shall be deemed to have accepted the amendment unless the Business Associate notifies the Agency of its non-acceptance in accordance with the Notice provisions of the Contract within 30 days of the Agency’s notice referenced herein. Any agreed alteration of the then current Agency BAA shall have no force or effect until the agreed alteration is reduced to a Contract amendment that must be signed by the Business Associate, Agency Director, and the Agency Security and Privacy Officer.

1.8 ***Qualified Service Organization.*** The Contractor acknowledges that it will be receiving, storing, processing, or otherwise dealing with confidential patient records from programs covered by 42 CFR part 2, and the Contractor acknowledges that it is fully bound by those regulations. The Contractor will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by 42 CFR part 2. “Qualified Service Organization” as used in this Contract has the same meaning as the definition set forthin 42 CFR § 2.11.

**SECTION 2. GENERAL TERMS FOR SERVICES CONTRACTS**

*2.1 Definitions.* Definitions in this section correspond with capitalized terms in the Contract.

**“Acceptance”** means that the Agency has determined that one or more Deliverables satisfy the Agency’s Acceptance Tests. Final Acceptance means that the Agency has determined that all Deliverables satisfy the Agency’s Acceptance Tests. Non-acceptance means that the Agency has determined that one or more Deliverables have not satisfied the Agency’s Acceptance Tests.

**“Acceptance Criteria”** means the Specifications, goals, performance measures, testing results and/or other criteria designated by the Agency and against which the Deliverables may be evaluated for purposes of Acceptance or Non-acceptance thereof.

**“Acceptance Tests” or “Acceptance Testing”** mean the tests, reviews, and other activities that are performed by or on behalf of the Agency to determine whether the Deliverables meet the Acceptance Criteria or otherwise satisfy the Agency, as determined by the Agency in its sole discretion.

**“Applicable Law”** means all applicable federal, state, and local laws, rules, ordinances, regulations, orders, guidance, and policies in place at Contract execution as well as any and all future amendments, changes, and additions to such laws as of the effective date of such change. Applicable Law includes, without limitation, all laws that pertain to the prevention of discrimination in employment and in the provision of services (e.g., Iowa Code ch. 216 and Iowa Code § 19B.7). For employment, this would include equal employment opportunity and affirmative action, and the use of targeted small businesses as subcontractors of suppliers. The term Applicable Law also encompasses the applicable provisions of Section 508 of the Rehabilitation Act of 1973, as amended, and all standards and requirements established by the Architectural and Transportation Barriers Access Board and the Iowa Office of the Chief Information Officer.

**“Bid Proposal” or “Proposal”** means the Contractor’s proposal submitted in response to the Solicitation, if this Contract arises out of a competitive process.

**“Business Days”** means any day other than a Saturday, Sunday, or State holiday as specified by Iowa Code §1C.2.

**“Confidential Information”** means, subject to any applicable State and federal laws and regulations, including but not limited to Iowa Code Chapter 22, any confidential or proprietary information or trade secrets disclosed by either party (a “Disclosing Party”) to the other party (a “Receiving Party”) that, at the time of disclosure, is designated as confidential (or like designation), is disclosed in circumstances of confidence, or would be understood by the parties, exercising reasonable business judgment, to be confidential. Regardless of whether or not the following information is designated as confidential, the term Confidential Information includes information that could be used to identify recipients or applicants of Agency services and recipients of Contract services including Protected Health Information (45 C.F.R. § 160.103) and Personal Information (Iowa Code § 715C.1(11)), Agency security protocols and procedures, Agency system architecture, information that could compromise the security of the Agency network or systems, and information about the Agency’s current or future competitive procurements, including the evaluation process prior to the formal announcement of results.

Confidential Information does not include any information that: (1) was rightfully in the possession of the Receiving Party from a source other than the Disclosing Party prior to the time of disclosure of the information by the Disclosing Party to the Receiving Party; (2) was known to the Receiving Party prior to the disclosure of the information by the Disclosing Party; (3) was disclosed to the Receiving Party without restriction by an independent third party having a legal right to disclose the information; (4) is in the public domain or shall have become publicly available other than as a result of disclosure by the Receiving Party in violation of this Agreement or in breach of any other agreement with the Disclosing Party; (5) is independently developed by the Receiving Party without any reliance on Confidential Information disclosed by the Disclosing Party; or (6) is disclosed by the Receiving Party with the written consent of the Disclosing Party.

**“Contract”** means the collective documentation memorializing the terms of the agreement between the Agency and the Contractor identified in the Contract Declarations and Execution Section and includes the signed Contract Declarations and Execution Section, the General Terms for Services Contracts, the Special Terms, and any Special Contract Attachments, as these documents may be amended from time to time.

**“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.

**“Deliverables**” means all of the services, goods, products, work, work product, data, items, materials and property to be created, developed, produced, delivered, performed, or provided by or on behalf of, or made available through, the Contractor (or any agent, contractor or subcontractor of the Contractor) in connection with this Contract. This includes data that is collected on behalf of the Agency.

**“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.

**“Force Majeure”** means an event that no human foresight could anticipate or which if anticipated, is incapable of being avoided. Circumstances must be abnormal and unforeseeable, so that the consequences could not have been avoided through the exercise of all due care. The delay or impossibility of performance must be beyond the control and without the fault or negligence of the parties. Force Majeure does not include: financial difficulties of the Contractor or any parent, subsidiary, affiliated or associated company of the Contractor; claims or court orders that restrict the Contractor’s ability to deliver the Deliverables contemplated by this Contract; strikes; labor unrest; or supply chain disruptions.

***“*Invoice*”*** means a Contractor’s claim for payment. At the Agency’s discretion, claims may be submitted on an original invoice from the Contractor or may be submitted on a claim form acceptable to the Agency, such as a General Accounting Expenditure (GAX) form.

**“Solicitation”** means the formal or informal procurement (and any Addenda thereto) identified in the Contracts Declarations and Execution Section that was issued to solicit the Bid Proposal leading to this Contract.

**“Special Contract Attachments”** means any attachment to this Contract.

**“Special Terms”** means the Section of the Contract entitled “Special Terms” that contains terms specific to this Contract, including but not limited to the Scope of Work and contract payment terms. If there is a conflict between the General Terms for Services Contracts and the Special Terms, the Special Terms shall prevail.

**“Specifications”** means all specifications, requirements, technical standards, performance standards, representations, and other criteria related to the Deliverables stated or expressed in this Contract, the Documentation, the Solicitation, and the Bid Proposal. Specifications shall include the Acceptance Criteria and any specifications, standards, or criteria stated or set forth in any applicable state, federal, foreign, and local laws, rules and regulations. The Specifications are incorporated into this Contract by reference as if fully set forth in this Contract.

**“State”** means the State of Iowa, the Agency, and all State of Iowa agencies, boards, and commissions, and when this Contract is available to political subdivisions, any political subdivisions of the State of Iowa.

***2.2 Duration of Contract.***The term of the Contract shall begin and end on the dates specified in the Contract Declarations and Execution Section, unless extended or terminated earlier in accordance with the termination provisions of this Contract. The Agency may, in its sole discretion, amend the end date of this Contract by exercising any applicable extension by giving the Contractor a written extension at least sixty (60) days prior to the expiration of the initial term or renewal term.

*2.3 Scope of Work.* The Contractor shall provide Deliverables that comply with and conform to the Specifications. Deliverables shall be performed within the boundaries of the United States.

***2.4 Compensation.***

**2.4.1 Withholding Payments.** In addition to pursuing any other remedy provided herein or by law, the Agency may withhold compensation or payments to the Contractor, in whole or in part, without penalty to the Agency or work stoppage by the Contractor, in the event the Agency determines that: (1) the Contractor has failed to perform any of its duties or obligations as set forth in this Contract; (2) any Deliverable has failed to meet or conform to any applicable Specifications or contains or is experiencing a Deficiency; or (3) the Contractor has failed to perform Close-Out Event(s). No interest shall accrue or be paid to the Contractor on any compensation or other amounts withheld or retained by the Agency under this Contract.

**2.4.2 Erroneous Payments and Credits.** The Contractor shall promptly repay or refund the full amount of any overpayment or erroneous payment within thirty (30) Business Days after either discovery by the Contractor or notification by the Agency of the overpayment or erroneous payment.

**2.4.3** **Offset Against Sums Owed by the Contractor.** In the event that the Contractor owes the State any sum under the terms of this Contract, any other contract or agreement, pursuant to a judgment, or pursuant to any law, the State may, in its sole discretion, offset any such sum against: (1) any sum Invoiced by, or owed to, the Contractor under this Contract, or (2) any sum or amount owed by the State to the Contractor, unless otherwise required by law. The Contractor agrees that this provision constitutes proper and timely notice under any applicable laws governing offset.

***2.5 Termination.***

**2.5.1 Termination for Cause by the Agency.** The Agency may terminate this Contract upon written notice for the breach by the Contractor or any subcontractor of any material term, condition or provision of this Contract, if such breach is not cured within the time period specified in the Agency’s notice of breach or any subsequent notice or correspondence delivered by the Agency to the Contractor, provided that cure is feasible. In addition, the Agency may terminate this Contract effective immediately without penalty and without advance notice or opportunity to cure for any of the following reasons:

**2.5.1.1** The Contractor furnished any statement, representation, warranty, or certification in connection with this Contract, the Solicitation, or the Bid Proposal that is false, deceptive, or materially incorrect or incomplete;

**2.5.1.2** The Contractor or any of the Contractor’s officers, directors, employees, agents, subsidiaries, affiliates, contractors or subcontractors has committed or engaged in fraud, misappropriation, embezzlement, malfeasance, misfeasance, or bad faith;

**2.5.1.3** The Contractor or any parent or affiliate of the Contractor owning a controlling interest in the Contractor dissolves;

**2.5.1.4** The Contractor terminates or suspends its business;

**2.5.1.5** The Contractor’s corporate existence or good standing in Iowa is suspended, terminated, revoked or forfeited, or any license or certification held by the Contractor related to the Contractor’s performance under this Contract is suspended, terminated, revoked, or forfeited;

**2.5.1.6** The Contractor has failed to comply with any applicable international, federal, state (including, but not limited to Iowa Code Chapter 8F), or local laws, rules, ordinances, regulations, or orders when performing within the scope of this Contract;

**2.5.1.7** The Agency determines or believes the Contractor has engaged in conduct that: (1) has or may expose the Agency or the State to material liability; or (2) has caused or may cause a person’s life, health, or safety to be jeopardized;

**2.5.1.8** The Contractor infringes or allegedly infringes or violates any patent, trademark, copyright, trade dress, or any other intellectual property right or proprietary right, or the Contractor misappropriates or allegedly misappropriates a trade secret;

**2.5.1.9** TheContractor fails to comply with any applicable confidentiality laws, privacy laws, or any provisions of this Contract pertaining to confidentiality or privacy; or

**2.5.1.10** Any of the following has been engaged in by or occurred with respect to the Contractor or any corporation, shareholder or entity having or owning a controlling interest in the Contractor:

* Commencing or permitting a filing against it which is not discharged within ninety (90) days, of a case or other proceeding seeking liquidation, reorganization, or other relief with respect to itself or its debts under any bankruptcy, insolvency, or other similar law now or hereafter in effect; or filing an answer admitting the material allegations of a petition filed against it in any involuntary case or other proceeding commenced against it seeking liquidation, reorganization, or other relief under any bankruptcy, insolvency, or other similar law now or hereafter in effect with respect to it or its debts; or consenting to any such relief or to the appointment of or taking possession by any such official in any voluntary case or other proceeding commenced against it seeking liquidation, reorganization, or other relief under any bankruptcy, insolvency, or other similar law now or hereafter in effect with respect to it or its debts;
* Seeking or suffering the appointment of a trustee, receiver, liquidator, custodian or other similar official of it or any substantial part of its assets;
* Making an assignment for the benefit of creditors;
* Failing, being unable, or admitting in writing the inability generally to pay its debts or obligations as they become due or failing to maintain a positive net worth and such additional capital and liquidity as is reasonably adequate or necessary in connection with the Contractor’s performance of its obligations under this Contract; or
* Taking any action to authorize any of the foregoing.

**2.5.2 Termination Upon Notice.** Following a thirty (30) day written notice, the Agency may terminate this Contract in whole or in part without penalty and without incurring any further obligation to the Contractor. Termination can be for any reason or no reason at all.

**2.5.3 Termination Due to Lack of Funds or Change in Law.** Notwithstanding anything in this Contract to the contrary, and subject to the limitations set forth below, the Agency shall have the right to terminate this Contract without penalty and without any advance notice as a result of any of the following:

**2.5.3.1** The legislature or governor fail in the sole opinion of the Agency to appropriate funds sufficient to allow the Agency to either meet its obligations under this Contract or to operate as required and to fulfill its obligations under this Contract; or

**2.5.3.2** If funds are de-appropriated, reduced, not allocated, or receipt of funds is delayed, or if any funds or revenues needed by the Agency to make any payment hereunder are insufficient or unavailable for any other reason as determined by the Agency in its sole discretion; or

**2.5.3.3** If the Agency’s authorization to conduct its business or engage in activities or operations related to the subject matter of this Contract is withdrawn or materially altered or modified; or

**2.5.3.4** If the Agency’s duties, programs or responsibilities are modified or materially altered; or

**2.5.3.5** If there is a decision of any court, administrative law judge or an arbitration panel or any law, rule, regulation, or order is enacted, promulgated, or issued that materially or adversely affects the Agency’s ability to fulfill any of its obligations under this Contract.

The Agency shall provide the Contractor with written notice of termination pursuant to this section.

**2.5.4** **Other remedies.** The Agency’s right to terminate this Contract shall be in addition to and not exclusive of other remedies available to the Agency, and the Agency shall be entitled to exercise any other rights and pursue any remedies, in law, at equity, or otherwise.

**2.5.5 Limitation of the State’s Payment Obligations.** In the event of termination of this Contract for any reason by either party (except for termination by the Agency pursuant to Section 2.5.1, *Termination for Cause by the Agency*) the Agency shall pay only those amounts, if any, due and owing to the Contractor hereunder for Deliverables actually and satisfactorily provided in accordance with the provisions of this Contract up to and including the date of termination of this Contract and for which the Agency is obligated to pay pursuant to this Contract; provided however, that in the event the Agency terminates this Contract pursuant to Section 2.5.3, *Termination Due to Lack of Funds or Change in Law*, the Agency’s obligation to pay the Contractor such amounts and other compensation shall be limited by, and subject to, legally available funds. Payment will be made only upon submission of Invoices and proper proof of the Contractor’s claim. Notwithstanding the foregoing, this section in no way limits the rights or remedies available to the Agency and shall not be construed to require the Agency to pay any compensation or other amounts hereunder in the event of the Contractor’s breach of this Contract or any amounts withheld by the Agency in accordance with the terms of this Contract. The Agency shall not be liable, under any circumstances, for any of the following:

**2.5.5.1** The payment of unemployment compensation to the Contractor’s employees;

**2.5.5.2** The payment of workers’ compensation claims, which occur during the Contract or extend beyond the date on which the Contract terminates;

**2.5.5.3** Any costs incurred by the Contractor in its performance of the Contract, including, but not limited to, startup costs, overhead, or other costs associated with the performance of the Contract;

**2.5.5.4** Any damages or other amounts associated with the loss of prospective profits, anticipated sales, goodwill, or for expenditures, investments, or commitments made in connection with this Contract; or

**2.5.5.5** Any taxes the Contractor may owe in connection with the performance of this Contract, including, but not limited to, sales taxes, excise taxes, use taxes, income taxes, or property taxes.

**2.5.6 Contractor’s Contract Close-Out Duties.** Upon receipt of notice of termination, at expiration of the Contract, or upon request of the Agency (hereafter, “Close-Out Event”), the Contractor shall:

**2.5.6.1** Cease workunder this Contract and take all necessary or appropriate steps to limit disbursements and minimize costs, and furnish a report within thirty (30) days of the Close-Out Event, describing the status of all work performed under the Contract and such other matters as the Agency may require.

**2.5.6.2** Immediately cease using and return to the Agency any property or materials, whether tangible or intangible, provided by the Agency to the Contractor.

**2.5.6.3** Cooperate in good faith with the Agency and its employees, agents, and independent contractors during the transition period between the Close-Out Event and the substitution of any replacement service provider.

**2.5.6.4** Immediately return to the Agency any payments made by the Agency for Deliverables that were not rendered or provided by the Contractor.

**2.5.6.5** Immediately deliver to the Agency any and all Deliverables for which the Agency has made payment (in whole or in part) that are in the possession or under the control of the Contractor or its agents or subcontractors in whatever stage of development and form of recordation such property is expressed or embodied at that time.

**2.5.7 Termination for Cause by the Contractor.** TheContractor may only terminate this Contract for the breach by the Agency of any material term of this Contract, if such breach is not cured within sixty (60) days of the Agency’s receipt of the Contractor’s written notice of breach.

***2.6 Change Order Procedure.*** The Agency may at any time request a modification to the Scope of Work using a change order. The following procedures for a change order shall be followed:

**2.6.1** **Written Request.** The Agency shall specify in writing the desired modifications to the same degree of specificity as in the original Scope of Work.

**2.6.2 The Contractor’s Response.** The Contractor shall submit to the Agency a firm cost proposal for the requested change order within five (5) Business Days of receiving the change order request.

**2.6.3 Acceptance of the Contractor Estimate.** If the Agency accepts the cost proposal presented by the Contractor, the Contractor shall provide the modified Deliverable subject to the cost proposal included in the Contractor response. The Contractor’s provision of the modified Deliverables shall be governed by the terms and conditions of this Contract.

**2.6.4 Adjustment to Compensation.** The parties acknowledge that a change order for this Contract may or may not entitle the Contractor to an equitable adjustment in the Contractor’s compensation or the performance deadlines under this Contract.

***2.7 Indemnification.***

**2.7.1 By the Contractor.** The Contractor agrees to indemnify and hold harmless the State and its officers, appointed and elected officials, board and commission members, employees, volunteers, and agents (collectively the “Indemnified Parties”), from any and all costs, expenses, losses, claims, damages, liabilities, settlements, and judgments (including, without limitation, the reasonable value of the time spent by the Attorney General’s Office,) and the costs, expenses, and attorneys’ fees of other counsel retained by the Indemnified Parties directly or indirectly related to, resulting from, or arising out of this Contract, including but not limited to any claims related to, resulting from, or arising out of:

**2.7.1.1** Any breach of this Contract;

**2.7.1.2** Any negligent, intentional, or wrongful act or omission of the Contractor or any agent or subcontractor utilized or employed by the Contractor;

**2.7.1.3** The Contractor’s performance or attempted performance of this Contract, including any agent or subcontractor utilized or employed by the Contractor;

**2.7.1.4** Any failure by the Contractor to make all reports, payments, and withholdings required by federal and state law with respect to social security, employee income and other taxes, fees, or costs required by the Contractor to conduct business in the State of Iowa;

**2.7.1.5** Any claim of misappropriation of a trade secret or infringement or violation of any intellectual property rights, proprietary rights, or personal rights of any third party, including any claim that any Deliverable or any use thereof (or the exercise of any rights with respect thereto) infringes, violates, or misappropriates any patent, copyright, trade secret, trademark, trade dress, mask work, utility design, or other intellectual property right or proprietary right of any third party.

***2.8 Insurance.***

**2.8.1 Insurance Requirements.** The Contractor, and any subcontractor, shall maintain in full force and effect, with insurance companies licensed by the State of Iowa, at the Contractor’s expense, insurance covering its work during the entire term of this Contract, which includes any extensions or renewals thereof. The Contractor’s insurance shall, among other things:

**2.8.1.1** Be occurrence based and shall insure against any loss or damage resulting from or related to the Contractor’s performance of this Contract regardless of the date the claim is filed or expiration of the policy.

**2.8.1.2** Name the State of Iowa and the Agency as additional insureds or loss payees on the policies for all coverages required by this Contract, with the exception of Workers’ Compensation, or the Contractor shall obtain an endorsement to the same effect; and

**2.8.1.3** Provide a waiver of any subrogation rights that any of its insurance carriers might have against the State on the policies for all coverages required by this Contract, with the exception of Workers’ Compensation.

The requirements set forth in this section shall be indicated on the certificates of insurance coverage supplied to the Agency.

**2.8.2** **Types and Amounts of Insurance Required.** Unless otherwise requested by the Agency in writing, the Contractor shall cause to be issued insurance coverages insuring the Contractor and/or subcontractors against all general liabilities, product liability, personal injury, property damage, and (where applicable) professional liability in the amount specified in the Special Terms for each occurrence. In addition, the Contractor shall ensure it has any necessary workers’ compensation and employer liability insurance as required by Iowa law.

**2.8.3 Certificates of Coverage.** The Contractor shall submit certificates of the insurance, which indicate coverage and notice provisions as required by this Contract, to the Agency upon execution of this Contract. The Contractor shall maintain all insurance policies required by this Contract in full force and effect during the entire term of this Contract, which includes any extensions or renewals thereof, and shall not permit such policies to be canceled or amended except with the advance written approval of the Agency. The insurer shall state in the certificate that no cancellation of the insurance will be made without at least a thirty (30) day prior written notice to the Agency. The certificates shall be subject to approval by the Agency. Approval of the insurance certificates by the Agency shall not relieve the Contractor of any obligation under this Contract**.**

**2.8.4 Notice of Claim.** Contractor shall provide prompt notice to the Agency of any claim related to the contracted services made by a third party. If the claim matures to litigation, the Contractor shall keep the Agency regularly informed of the status of the lawsuit, including any substantive rulings. The Contractor shall confer directly with the Agency about and before any substantive settlement negotiations.

***2.9 Ownership and Security of Agency Information*.**

**2.9.1 Ownership and Disposition of Agency Information.** Any information either supplied by the Agency to the Contractor, or collected by the Contractor on the Agency’s behalf in the course of the performance of this Contract, shall be considered the property of the Agency (“Agency Information”). The Contractor will not use the Agency Information for any purpose other than providing services under the Contract, nor will any part of the information and records be disclosed, sold, assigned, leased, or otherwise provided to third parties or commercially exploited by or on behalf of the Contractor. The Agency shall own all Agency Information that may reside within the Contractor’s hosting environment and/or equipment/media.

**2.9.2 Foreign Hosting and Storage Prohibited.** Agency Information shall be hosted and/or stored within the continental United States only.

**2.9.3** **Access to Agency Information that is Confidential Information**. The Contractor’s employees, agents, and subcontractors may have access to Agency Information that is Confidential Information to the extent necessary to carry out responsibilities under the Contract. Access to such Confidential Information shall comply with both the State’s and the Agency’s policies and procedures. In all instances, access to Agency Information from outside of the United States and its protectorates, either by the Contractor, including a foreign office or division of the Contractor or its affiliates or associates, or any subcontractor, is prohibited.

**2.9.4 No Use or Disclosure of Confidential Information.** Confidential Information collected, maintained, or used in the course of performance of the Contract shall only be used or disclosed by the Contractor as expressly authorized by law and only with the prior written consent of the Agency, either during the period of the Contract or thereafter. The Contractor shall immediately report to the Agency any unauthorized use or disclosure of Confidential Information. The Contractor may be held civilly or criminally liable for improper use or disclosure of Confidential Information.

**2.9.5** **Contractor Breach Notification Obligations.** The Contractor agrees to comply with all applicable laws that require the notification of individuals in the event of unauthorized use or disclosure of Confidential Information or other event(s) requiring notification in accordance with applicable law. In the event of a breach of the Contractor's security obligations or other event requiring notification under applicable law, the Contractor agrees to follow Agency directives, which may include assuming responsibility for informing all such individuals in accordance with applicable laws, and to indemnify, hold harmless, and defend the State of Iowa against any claims, damages, or other harm related to such breach.

**2.9.6** **Compliance of Contractor Personnel.** The Contractor and the Contractor’s personnel shall comply with the Agency’s and the State’s security and personnel policies, procedures, and rules, including any procedure which the Agency’s personnel, contractors, and consultants are normally asked to follow. The Contractor agrees to cooperate fully and to provide any assistance necessary to the Agency in the investigation of any security breaches that may involve the Contractor or the Contractor’s personnel. All services shall be performed in accordance with State Information Technology security standards and policies as well as Agency security protocols and procedures. By way of example only, see Iowa Code 8B.23, <http://secureonline.iowa.gov/links/index.html>, and <https://ocio.iowa.gov/home/standards>.

**2.9.7 Subpoena.** In the event that a subpoena or other legal process is served upon the Contractor for records containing Confidential Information, the Contractor shall promptly notify the Agency and cooperate with the Agency in any lawful effort to protect the Confidential Information.

**2.9.8** **Return and/or** **Destruction of Information.** Upon expiration or termination of the Contract for any reason, the Contractor agrees to comply with all Agency directives regarding the return or destruction of all Agency Information and any derivative work. Delivery of returned Agency Information must be through a secured electronic transmission or by parcel service that utilizes tracking numbers. Such information must be provided in a format useable by the Agency. Following the Agency’s verified receipt of the Agency Information and any derivative work, the Contractor agrees to physically and/or electronically destroy or erase all residual Agency Information regardless of format from the entire Contractor’s technology resources and any other storage media. This includes, but is not limited to, all production copies, test copies, backup copies and /or printed copies of information created on any other servers or media and at all other Contractor sites. Any permitted destruction of Agency Information must occur in such a manner as to render the information incapable of being reconstructed or recovered. The Contractor will provide a record of information destruction to the Agency for inspection and records retention no later than thirty (30) days after destruction.

**2.9.9** **Contractor’s Inability to Return and/or Destroy Information.** If for any reason the Agency Information cannot be returned and/or destroyed upon expiration or termination of the Contract, the Contractor agrees to notify the Agency with an explanation as to the conditions which make return and/or destruction not possible or feasible. Upon mutual agreement by both parties that the return and/or destruction of the information is not possible or feasible, the Contractor shall make the Agency Information inaccessible. The Contractor shall not use or disclose such retained Agency Information for any purposes other than those expressly permitted by the Agency. The Contractor shall provide to the Agency a detailed description as to the procedures and methods used to make the Agency Information inaccessible no later than thirty (30) days after making the information inaccessible. If the Agency provides written permission for the Contractor to retain the Agency Information in the Contractor’s information systems, the Contractor will extend the protections of this Contract to such information and limit any further uses or disclosures of such information.

**2.9.10 Contractors that are Business Associates.** If the Contractor is the Agency’s Business Associate, and there is a conflict between the Business Associate Agreement and this Section 2.9, the provisions in the Business Associate Agreement shall control.

***2.10 Intellectual Property.***

**2.10.1 Ownership and Assignment of Other Deliverables.** The Contractor agrees that the State and the Agency shall become the sole and exclusive owners of all Deliverables. The Contractor hereby irrevocably assigns, transfers and conveys to the State and the Agency all right, title and interest in and to all Deliverables and all intellectual property rights and proprietary rights arising out of, embodied in, or related to such Deliverables, including copyrights, patents, trademarks, trade secrets, trade dress, mask work, utility design, derivative works, and all other rights and interests therein or related thereto. The Contractor represents and warrants that the State and the Agency shall acquire good and clear title to all Deliverables, free from any claims, liens, security interests, encumbrances, intellectual property rights, proprietary rights, or other rights or interests of the Contractor or of any third party, including any employee, agent, contractor, subcontractor, subsidiary, or affiliate of the Contractor. The Contractor (and Contractor’s employees, agents, contractors, subcontractors, subsidiaries and affiliates) shall not retain any property interests or other rights in and to the Deliverables and shall not use any Deliverables, in whole or in part, for any purpose, without the prior written consent of the Agency and the payment of such royalties or other compensation as the Agency deems appropriate. Unless otherwise requested by the Agency, upon completion or termination of this Contract, the Contractor will immediately turn over to the Agency all Deliverables not previously delivered to the Agency, and no copies thereof shall be retained by the Contractor or its employees, agents, subcontractors, or affiliates, without the prior written consent of the Agency.

**2.10.2 Waiver.** To the extent any of the Contractor’s rights in any Deliverables are not subject to assignment or transfer hereunder, including any moral rights and any rights of attribution and of integrity, the Contractor hereby irrevocably and unconditionally waives all such rights and enforcement thereof and agrees not to challenge the State’s rights in and to the Deliverables.

**2.10.3 Further Assurances.** At the Agency’s request, the Contractor will execute and deliver such instruments and take such other action as may be requested by the Agency to establish, perfect, or protect the State’s rights in and to the Deliverables and to carry out the assignments, transfers and conveyances set forth in Section 2.10, *Intellectual Property*.

**2.10.4 Publications.** Prior to completion of all services required by this Contract, the Contractor shall not publish in any format any final or interim report, document, form, or other material developed as a result of this Contract without the express written consent of the Agency. Upon completion of all services required by this Contract, the Contractor may publish or use materials developed as a result of this Contract, subject to confidentiality restrictions, and only after the Agency has had an opportunity to review and comment upon the publication. Any such publication shall contain a statement that the work was done pursuant to a contract with the Agency and that it does not necessarily reflect the opinions, findings, and conclusions of the Agency.

**2.10.5 Federal License.**  As this Contract is at least partially federally funded, the federal government reserves a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, or otherwise use and to authorize others to use for federal government purposes, software and associated documentation designed, developed or installed in whole or in part with federal funds pursuant to this Contract.

***2.11 Warranties.***

**2.11.1 Construction of Warranties Expressed in this Contract with Warranties Implied by Law.** Warranties made by the Contractor in this Contract, whether: (1) this Contract specifically denominates the Contractor's promise as a warranty; or (2) the warranty is created by the Contractor's affirmation or promise, by a description of the Deliverables to be provided, or by provision of samples to the Agency, shall not be construed as limiting or negating any warranty provided by law, including without limitation, warranties that arise through the course of dealing or usage of trade. The warranties expressed in this Contract are intended to modify the warranties implied by law only to the extent that they expand the warranties applicable to the Deliverables provided by the Contractor. With the exception of Subsection 2.11.3, the provisions of this section apply during the Warranty Period as defined in the Contract Declarations and Execution Section.

**2.11.2 Contractor represents and warrants that:**

**2.11.2.1** All Deliverables shall be wholly original with and prepared solely by the Contractor; or it owns, possesses, holds, and has received or secured all rights, permits, permissions, licenses, and authority necessary to provide the Deliverables to the Agency hereunder and to assign, grant and convey the rights, benefits, licenses, and other rights assigned, granted, or conveyed to the Agency hereunder or under any license agreement related hereto without violating any rights of any third party;

**2.11.2.2** The Contractor has not previously and will not grant any rights in any Deliverables to any third party that are inconsistent with the rights granted to the Agency herein; and

**2.11.2.3** The Agency shall peacefully and quietly have, hold, possess, use, and enjoy the Deliverables without suit, disruption, or interruption.

**2.11.3 The Contractor represents and warrants that:**

**2.11.3.1** The Deliverables (and all intellectual property rights and proprietary rights arising out of, embodied in, or related to such Deliverables); and

**2.11.3.2** The Agency’s use of, and exercise of any rights with respect to, the Deliverables (and all intellectual property rights and proprietary rights arising out of, embodied in, or related to such Deliverables), do not and will not, under any circumstances, misappropriate a trade secret or infringe upon or violate any copyright, patent, trademark, trade dress or other intellectual property right, proprietary right or personal right of any third party. The Contractor further represents and warrants there is no pending or threatened claim, litigation, or action that is based on a claim of infringement or violation of an intellectual property right, proprietary right or personal right or misappropriation of a trade secret related to the Deliverables. The Contractor shall inform the Agency in writing immediately upon becoming aware of any actual, potential, or threatened claim of or cause of action for infringement or violation or an intellectual property right, proprietary right, or personal right or misappropriation of a trade secret. If such a claim or cause of action arises or is likely to arise, then the Contractor shall, at the Agency’s request and at the Contractor’s sole expense:

* Procure for the Agency the right or license to continue to use the Deliverable at issue;
* Replace such Deliverable with a functionally equivalent or superior Deliverable free of any such infringement, violation, or misappropriation;
* Modify or replace the affected portion of the Deliverable with a functionally equivalent or superior Deliverable free of any such infringement, violation, or misappropriation; or
* Accept the return of the Deliverable at issue and refund to the Agency all fees, charges, and any other amounts paid by the Agency with respect to such Deliverable. In addition, the Contractor agrees to indemnify, defend, protect, and hold harmless the State and its officers, directors, employees, officials, and agents as provided in the Indemnification Section of this Contract, including for any breach of the representations and warranties made by the Contractor in this section.

The warranty provided in this Section 2.11.3 shall be perpetual, shall not be subject to the contractual Warranty Period, and shall survive termination of this Contract. The foregoing remedies provided in this subsection shall be in addition to and not exclusive of other remedies available to the Agency and shall survive termination of this Contract.

**2.11.4 The Contractor represents and warrants that the Deliverables shall:**

**2.11.4.1** Be free from material Deficiencies; and

**2.11.4.2** Meet, conform to, and operate in accordance with all Specifications and in accordance with this Contract during the Warranty Period, as defined in the Contract Declarations and Execution Section. During the Warranty Period the Contractor shall, at its expense, repair, correct or replace any Deliverable that contains or experiences material Deficiencies or fails to meet, conform to or operate in accordance with Specifications within five (5) Business Days of receiving notice of such Deficiencies or failures from the Agency or within such other period as the Agency specifies in the notice. In the event the Contractor is unable to repair, correct, or replace such Deliverable to the Agency’s satisfaction, the Contractor shall refund the fees or other amounts paid for the Deliverables and for any services related thereto. The foregoing shall not constitute an exclusive remedy under this Contract, and the Agency shall be entitled to pursue any other available contractual, legal, or equitable remedies. The Contractor shall be available at all reasonable times to assist the Agency with questions, problems, and concerns about the Deliverables, to inform the Agency promptly of any known Deficiencies in any Deliverables, repair and correct any Deliverables not performing in accordance with the warranties contained in this Contract, notwithstanding that such Deliverables may have been accepted by the Agency, and provide the Agency with all necessary materials with respect to such repaired or corrected Deliverable.

**2.11.5** The Contractor represents, warrants and covenants that all services to be performed under this Contract shall be performed in a professional, competent, diligent, and workmanlike manner by knowledgeable, trained, and qualified personnel, all in accordance with the terms and Specifications of this Contract and the standards of performance considered generally acceptable in the industry for similar tasks and projects. In the absence of a Specification for the performance of any portion of this Contract, the parties agree that the applicable Specification shall be the generally accepted industry standard. So long as the Agency notifies the Contractor of any services performed in violation of this standard, the Contractor shall re-perform the services at no cost to the Agency, such that the services are rendered in the above-specified manner, or if the Contractor is unable to perform the services as warranted, the Contractor shall reimburse the Agency any fees or compensation paid to the Contractor for the unsatisfactory services.

**2.11.6** The Contractor represents and warrants that the Deliverables will comply with all Applicable Law.

**2.11.7** **Obligations Owed to Third Parties.** The Contractor represents and warrants that all obligations owed to third parties with respect to the activities contemplated to be undertaken by the Contractor pursuant to this Contract are or will be fully satisfied by the Contractor so that the Agency will not have any obligations with respect thereto.

***2.12 Acceptance of Deliverables.***

**2.12.1 Acceptance of Written Deliverables.** For the purposes of this section, written Deliverables means documents including, but not limited to project plans, planning documents, reports, or instructional materials (“Written Deliverables”). Although the Agency determines what Written Deliverables are subject to formal Acceptance, this section generally does not apply to routine progress or financial reports. Absent more specific Acceptance Criteria in the Special Terms, following delivery of any Written Deliverable pursuant to the Contract, the Agency will notify the Contractor whether or not the Deliverable meets contractual specifications and requirements. Written Deliverables shall not be considered accepted by the Agency, nor does the Agency have an obligation to pay for such Deliverables, unless and until the Agency has notified the Contractor of the Agency’s Final Acceptance of the Written Deliverables. In all cases, any statements included in such Written Deliverables that alter or conflict with any contractual requirements shall in no way be considered as changing the contractual requirements unless and until the parties formally amend the Contract.

**2.12.2. Acceptance of Software Deliverables.** Except as otherwise specified in the Scope of Work, all Deliverables pertaining to software and related hardware components (“Software Deliverables”) shall be subject to the Agency’s Acceptance Testing and Acceptance, unless otherwise specified in the Scope of Work. Upon completion of all work to be performed by the Contractor with respect to any Software Deliverable, the Contractor shall deliver a written notice to the Agency certifying that the Software Deliverable meets and conforms to applicable Specifications and is ready for the Agency to conduct Acceptance Testing; provided, however, that the Contractor shall pretest the Software Deliverable to determine that it meets and operates in accordance with applicable Specifications prior to delivering such notice to the Agency. At the Agency’s request, the Contractor shall assist the Agency in performing Acceptance Tests at no additional cost to the Agency. Within a reasonable period of time after the Agency has completed its Acceptance Testing, the Agency shall provide the Contractor with written notice of Acceptance or Non-acceptance with respect to each Software Deliverable that was evaluated during such Acceptance Testing. In the event the Agency provides notice of Non-acceptance to the Contractor with respect to any Software Deliverable, the Contractor shall correct and repair such Software Deliverable and submit it to the Agency within ten (10) days of the Contractor’s receipt of notice of Non-acceptance so that the Agency may re-conduct its Acceptance Tests.

In the event the Agency determines, after re-conducting its Acceptance Tests with respect to any Software Deliverable that the Contractor has attempted to correct or repair pursuant to this section, that such Software Deliverable fails to satisfy its Acceptance Tests, then the Agency shall have the continuing right, at its sole option, to: (1) require the Contractor to correct and repair such Software Deliverable within such period of time as the Agency may specify in a written notice to the Contractor; (2) refuse to accept such Software Deliverable without penalty and without any obligation to pay any fees or other amounts associated with such Software Deliverable (or receive a refund of any fees or amounts already paid with respect to such Software Deliverable); (3) accept such Software Deliverable on the condition that any fees or other amounts payable with respect thereto shall be reduced or discounted to reflect, to the Agency’s satisfaction, the Deficiencies present therein and any reduced value or functionality of such Software Deliverable or the costs likely to be incurred by the Agency to correct such Deficiencies; or (4) terminate this Contract and/or seek any and all available remedies, including damages. Notwithstanding the provisions of Section 2.5.1, *Termination for Cause by the Agency*, of this Contract, the Agency may terminate this Contract pursuant to this section without providing the Contractor with any notice or opportunity to cure provided for in the termination provisions of this Contract. The Agency’s right to exercise the foregoing rights and remedies, including termination of this Contract, shall remain in effect until Acceptance Tests are successfully completed to the Agency’s satisfaction and the Agency has provided the Contractor with written notice of Final Acceptance.

**2.12.3 Notice of Acceptance and Future Deficiencies.** The Contractor’s receipt of any notice of Acceptance, including Final Acceptance, with respect to any Deliverable shall not be construed as a waiver of any of the Agency’s rights to enforce the terms of this Contract or require performance in the event the Contractor breaches this Contract or any Deficiency is later discovered with respect to such Deliverable.

***2.13 Contract Administration.***

**2.13.1 Independent Contractor.** The status of the Contractor shall be that of an independent contractor. The Contractor, its employees, agents, and any subcontractors performing under this Contract are not employees or agents of the State or any agency, division, or department of the State simply by virtue of work performed pursuant to this Contract. Neither the Contractor nor its employees shall be considered employees of the Agency or the State for federal or state tax purposes simply by virtue of work performed pursuant to this Contract. The Agency will not withhold taxes on behalf of the Contractor (unless required by law).

**2.13.2 Incorporation of Documents.** To the extent this Contract arises out of a Solicitation, the parties acknowledge that the Contract consists of these contract terms and conditions as well as the Solicitation and the Bid Proposal. The Solicitation and the Bid Proposal are incorporated into the Contract by reference. If the Contractor proposed exceptions or modifications to the Sample Contract attached to the Solicitation or to the Solicitation itself, these proposed exceptions or modifications shall not be incorporated into this Contract unless expressly set forth herein. If there is a conflict between the Contract, the Solicitation, and the Bid Proposal, the conflict shall be resolved according to the following priority, ranked in descending order: (1) the Contract; (2) the Solicitation; (3) the Bid Proposal.

**2.13.3 Intent of References to Bid Documents.** To the extent this Contract arises out of a Solicitation, the references to the parties' obligations, which are contained in this Contract, are intended to supplement or clarify the obligations as stated in the Solicitation and the Bid Proposal. The failure of the parties to make reference to the terms of the Solicitation or the Bid Proposal in this Contract shall not be construed as creating a conflict and will not relieve the Contractor of the contractual obligations imposed by the terms of the Solicitation and the Contractor’s Bid Proposal. Terms offered in the Bid Proposal, which exceed the requirements of the Solicitation, shall not be construed as creating an inconsistency or conflict with the Solicitation or the Contract. The contractual obligations of the Agency are expressly stated in this document. The Bid Proposal does not create any express or implied obligations of the Agency.

**2.13.4 Compliance with the Law.** The Contractor, its employees, agents, and subcontractors shall comply at all times with all Applicable Law. All such Applicable Law is incorporated into this Contract as of the effective date of the Applicable Law. The Contractor and Agency expressly reject any proposition that future changes to Applicable Law are inapplicable to this Contract and the Contractor’s provision of Deliverables and/or performance in accordance with this Contract. When providing Deliverables pursuant to this Contract the Contractor, its employees, agents, and subcontractors shall comply with all Applicable Law.

**2.13.4.1** The Contractor, its employees, agents, and subcontractors shall not engage in discriminatory employment practices which are forbidden by Applicable Law. Upon the State’s written request, the Contractor shall submit to the State a copy of its affirmative action plan, containing goals and time specifications, and non-discrimination and accessibility plans and policies regarding services to clients as required under 11 Iowa Admin. Code chapter 121.

**2.13.4.2** In the event the Contractor contracts with third parties for the performance of any of the Contractor obligations under this Contract as set forth in Section 2.13.9, the Contractor shall take such steps as necessary to ensure such third parties are bound by the terms and conditions contained in this Section 2.13.4.

**2.13.4.3** Notwithstanding anything in this Contract to the contrary, the Contractor’s failure to fulfill any requirement set forth in this Section 2.13.4 shall be regarded as a material breach of this Contract and the State may cancel, terminate, or suspend in whole or in part this Contract. The State may further declare the Contractor ineligible for future state contracts in accordance with authorized procedures or the Contractor may be subject to other sanctions as provided by law or rule.

**2.13.4.4** The Contractor, its employees, agents, and subcontractors shall also comply with all Applicable Law regarding business permits and licenses that may be required to carry out the work performed under this Contract.

**2.13.4.5** If all or a portion of the funding used to pay for the Deliverables is being provided through a grant from the Federal Government, the Contractor acknowledges and agrees that pursuant to applicable federal laws, regulations, circulars, and bulletins, the awarding agency of the Federal Government reserves certain rights including, without limitation, a royalty-free, non-exclusive and irrevocable license to reproduce, publish or otherwise use, and to authorize others to use, for Federal Government purposes, the Deliverables developed under this Contract and the copyright in and to such Deliverables.

**2.13.5 Procurement.** The Contractor shall use procurement procedures that comply with all applicable federal, state, and local laws and regulations.

**2.13.6 Non-Exclusive Rights.** This Contract is not exclusive. The Agency reserves the right to select other contractors to provide Deliverables similar or identical to those described in the Scope of Work during the entire term of this Contract, which includes any extensions or renewals thereof.

**2.13.7 Amendments.** This Contract may only be amended by mutual written consent of the parties, with the exception of (1) the Contract end date, which may be extended under the Agency’s sole discretion, and (2) the Business Associate Agreement, which may be modified or replaced on notice pursuant to Section 1.5, *Business Associate Agreement.* Amendments shall be executed on a form approved by the Agency that expressly states the intent of the parties to amend this Contract. This Contract shall not be amended in any way by use of terms and conditions in an Invoice or other ancillary transactional document. To the extent that language in a transactional document conflicts with the terms of this Contract, the terms of this Contract shall control.

**2.13.8 No Third Party Beneficiaries.** There are no third party beneficiaries to this Contract. This Contract is intended only to benefit the State and the Contractor.

**2.13.9 Use of Third Parties.** The Agency acknowledges that the Contractor may contract with third parties for the performance of any of the Contractor’s obligations under this Contract. The Contractor shall notify the Agency in writing of all subcontracts relating to Deliverables to be provided under this Contract prior to the time the subcontract(s) become effective. The Agency reserves the right to review and approve all subcontracts. The Contractor may enter into these contracts to complete the project provided that the Contractor remains responsible for all Deliverables provided under this Contract. All restrictions, obligations, and responsibilities of the Contractor under this Contract shall also apply to the subcontractors and the Contractor shall include in all of its subcontracts a clause that so states. The Agency shall have the right to request the removal of a subcontractor from the Contract for good cause.

**2.13.10 Choice of Law and Forum.** The laws of the State of Iowa shall govern and determine all matters arising out of or in connection with this Contract without regard to the conflict of law provisions of Iowa law. Any and all litigation commenced in connection with this Contract shall be brought and maintained solely in Polk County District Court for the State of Iowa, Des Moines, Iowa, or in the United States District Court for the Southern District of Iowa, Central Division, Des Moines, Iowa, wherever jurisdiction is appropriate. This provision shall not be construed as waiving any immunity to suit or liability including without limitation sovereign immunity in State or Federal court, which may be available to the Agency or the State of Iowa.

**2.13.11 Assignment and Delegation.** The Contractor may not assign, transfer, or convey in whole or in part this Contract without the prior written consent of the Agency. For the purpose of construing this clause, a transfer of a controlling interest in the Contractor shall be considered an assignment. The Contractor may not delegate any of its obligations or duties under this Contract without the prior written consent of the Agency. The Contractor may not assign, pledge as collateral, grant a security interest in, create a lien against, or otherwise encumber any payments that may or will be made to the Contractor under this Contract.

**2.13.12 Integration.** This Contract represents the entire Contract between the parties. The parties shall not rely on any representation that may have been made which is not included in this Contract.

**2.13.13 No Drafter.** No party to this Contract shall be considered the drafter of this Contract for the purpose of any statute, case law, or rule of construction that would or might cause any provision to be construed against the drafter.

**2.13.14 Headings or Captions.** The paragraph headings or captions used in this Contract are for identification purposes only and do not limit or construe the contents of the paragraphs.

**2.13.15 Not a Joint Venture.** Nothing in this Contract shall be construed as creating or constituting the relationship of a partnership, joint venture, (or other association of any kind or agent and principal relationship) between the parties hereto. No party, unless otherwise specifically provided for herein, has the authority to enter into any contract or create an obligation or liability on behalf of, in the name of, or binding upon another party to this Contract.

**2.13.16 Joint and Several Liability.** If the Contractor is a joint entity, consisting of more than one individual, partnership, corporation, or other business organization, all such entities shall be jointly and severally liable for carrying out the activities and obligations of this Contract, for any default of activities and obligations, and for any fiscal liabilities.

**2.13.17 Supersedes Former Contracts or Agreements.** This Contract supersedes all prior contracts or agreements between the Agency and the Contractor for the Deliverables to be provided in connection with this Contract.

**2.13.18 Waiver.** Except as specifically provided for in a waiver signed by duly authorized representatives of the Agency and the Contractor, failure by either party at any time to require performance by the other party or to claim a breach of any provision of the Contract shall not be construed as affecting any subsequent right to require performance or to claim a breach.

**2.13.19 Notice.** With the exception of the Business Associate Agreement, as set forth in Section 1.5, *Business Associate Agreement*, any notices required by the Contract shall be given in writing by registered or certified mail, return receipt requested, by receipted hand delivery, by Federal Express, courier or other similar and reliable carrier which shall be addressed to each party’s Contract Manager as set forth in the Contract Declarations and Execution Section. From time to time, the parties may change the name and address of a party designated to receive notice. Such change of the designated person shall be in writing to the other party.

Each such notice shall be deemed to have been provided:

* At the time it is actually received in the case of hand delivery;
* Within one (1) day in the case of overnight delivery, courier or services such as Federal Express with guaranteed next-day delivery; or
* Within five (5) days after it is deposited in the U.S. Mail.

**2.13.20 Cumulative Rights.** The various rights, powers, options, elections, and remedies of any party provided in this Contract, shall be construed as cumulative and not one of them is exclusive of the others or exclusive of any rights, remedies or priorities allowed either party by law, and shall in no way affect or impair the right of any party to pursue any other equitable or legal remedy to which any party may be entitled.

**2.13.21 Severability.** If any provision of this Contract is determined by a court of competent jurisdiction to be invalid or unenforceable, such determination shall not affect the validity or enforceability of any other part or provision of this Contract.

**2.13.22 Time is of the Essence.** Time is of the essence with respect to the Contractor’s performance of the terms of this Contract. The Contractor shall ensure that all personnel providing Deliverables to the Agency are responsive to the Agency’s requirements and requests in all respects.

**2.13.23 Authorization.** The Contractor represents and warrants that:

**2.13.23.1** It has the right, power, and authority to enter into and perform its obligations under this Contract.

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

**2.13.24 Successors in Interest.** All the terms, provisions, and conditions of the Contract shall be binding upon and inure to the benefit of the parties hereto and their respective successors, assigns, and legal representatives.

**2.13.25 Records Retention and Access.**

**2.13.25.1 Financial Records.** The Contractor shall maintain accurate, current, and complete records of the financial activity of this Contract which sufficiently and properly document and calculate all charges billed to the Agency during the entire term of this Contract, which includes any extensions or renewals thereof, and for a period of at least seven (7) years following the date of final payment or completion of any required audit (whichever is later). If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the seven (7) year period, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular seven (7) year period, whichever is later. The Contractor shall permit the Agency, the Auditor of the State of Iowa or any other authorized representative of the State and where federal funds are involved, the Comptroller General of the United States or any other authorized representative of the United States government, to access and examine, audit, excerpt and transcribe any directly pertinent books, documents, papers, electronic or optically stored and created records, or other records of the Contractor relating to orders, Invoices or payments, or any other Documentation or materials pertaining to this Contract, wherever such records may be located. The Contractor shall not impose a charge for audit or examination of the Contractor’s books and records. Based on the audit findings, the Agency reserves the right to address the Contractor’s board or other managing entity regarding performance and expenditures. When state or federal law or the terms of this Contract require compliance with the OMB Circular, or other similar provision addressing proper use of government funds, the Contractor shall comply with these additional records retention and access requirements:

**2.13.25.1.1** Records of financial activity shall include records that adequately identify the source and application of funds. When the terms of this Contract require matching funds, cash contributions made by the Contractor and third-party in-kind (property or service) contributions, these funds must be verifiable from the Contractor’s records. These records must contain information pertaining to contract amount, obligations, unobligated balances, assets, liabilities, expenditures, income, and third-party reimbursements.

**2.13.25.1.2** The Contractor shall maintain accounting records supported by source documentation that may include but are not limited to cancelled checks, paid bills, payroll, time and attendance records, and contract award documents.

**2.13.25.1.3** The Contractor, in maintaining project expenditure accounts, records and reports, shall make any necessary adjustments to reflect refunds, credits, underpayments or overpayments, as well as any adjustments resulting from administrative or compliance reviews and audits. Such adjustments shall be set forth in the financial reports filed with the Agency.

**2.13.25.1.4** The Contractor shall maintain a sufficient record keeping system to provide the necessary data for the purposes of planning, monitoring, and evaluating its program.

**2.13.25.2** The Contractor shall retain all non-medical and medical client records for a period of seven (7) years from the last date of service for each patient; or in the case of a minor patient or client, for a period consistent with that established by Iowa Code § 614.1(9), whichever is greater.

**2.13.26 Audits.** Local governments and non-profit subrecipient entities that expend $750,000 or more in a year in federal awards (from all sources) shall have a single audit conducted for that year in accordance with the provisions of the OMNI Circular, OMB Uniform Guidance: Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards at 2 C.F.R. 200. A copy of the final audit report shall be submitted to the Agency if either the schedule of findings and questioned costs or the summary schedule of prior audit findings includes any audit findings related to federal awards provided by the Agency. If an audit report is not required to be submitted per the criteria above, the subrecipient must provide written notification to the Agency that the audit was conducted in accordance with Government Auditing Standards and that neither the schedule of findings and questioned costs nor the summary schedule of prior audit findings includes any audit findings related to federal awards provided by the Agency. See the OMNI Circular, Section 200.330, Subrecipient and Contractor Determinations for a discussion of subrecipient versus contractor (vendor) relationships. The Contractor shall provide the Agency with a copy of any written audit findings or reports, whether in draft or final form, within two (2) Business Days following receipt by the Contractor. The requirements of this paragraph shall apply to the Contractor as well as any subcontractors. **2.13.27** **Reimbursement of Audit Costs.** If the Auditor of the State of Iowa notifies the Agency of an issue or finding involving the Contractor’s noncompliance with laws, rules, regulations, and/or contractual agreements governing the funds distributed under this Contract, the Contractor shall bear the cost of the Auditor’s review and any subsequent assistance provided by the Auditor to determine compliance. The Contractor shall reimburse the Agency for any costs the Agency pays to the Auditor for such review or audit.

**2.13.28 Staff Qualifications and Background Checks.** The Contractor shall be responsible for assuring that all persons, whether they are employees, agents, subcontractors, or anyone acting for or on behalf of the Contractor, are properly licensed, certified, or accredited as required under applicable state law and the Iowa Administrative Code. The Contractor shall provide standards for service providers who are not otherwise licensed, certified, or accredited under state law or the Iowa Administrative Code.

The Agency reserves the right to conduct and/or request the disclosure of criminal history and other background investigation of the Contractor, its officers, directors, shareholders, and the Contractor’s staff, agents, or subcontractors retained by the Contractor for the performance of Contract services.

**2.13.29 Solicitation.** The Contractor represents and warrants that no person or selling agency has been employed or retained to solicit and secure this Contract upon an agreement or understanding for commission, percentage, brokerage, or contingency excepting bona fide employees or selling agents maintained for the purpose of securing business.

**2.13.30 Obligations Beyond Contract Term.** All obligations of the Agency and the Contractor incurred or existing under this Contract as of the date of expiration or termination will survive the expiration or termination of this Contract. Contract sections that survive include, but are not necessarily limited to, the following: (1) Section 2.4.2, *Erroneous Payments and Credits*; (2) Section 2.5.5, *Limitation of the State’s Payment Obligations*; (3) Section 2.5.6, *Contractor’s Contract Close-Out Duties*; (4) Section 2.7, *Indemnification*, and all subparts thereof; (5) Section 2.9, *Ownership and Security of Agency Information*, and all subparts thereof; (6) Section 2.10, *Intellectual Property*, and all subparts thereof; (7) Section 2.13.10, *Choice of Law and Forum*; (8) Section 2.13.16, *Joint and Several Liability*; (9) Section 2.13.20, *Cumulative Rights*; (10) Section 2.13.24 *Successors In Interest*; (11) Section 2.13.25, *Records Retention and Access*, and all subparts thereof; (12) Section 2.13.26, *Audits*; (13) Section 2.13.27, *Reimbursement of Audit Costs*; (14) Section 2.13.35, *Repayment Obligation*; and (15) Section 2.13.39, *Use of Name or Intellectual Property*.

**2.13.31 Counterparts.** The parties agree that this Contract has been or may be executed in several counterparts, each of which shall be deemed an original and all such counterparts shall together constitute one and the same instrument.

**2.13.32 Delays or Potential Delays of Performance.** Whenever the Contractor encounters any difficulty which is delaying or threatens to delay the timely performance of this Contract, including but not limited to potential labor disputes, the Contractor shall immediately give notice thereof in writing to the Agency with all relevant information with respect thereto. Such notice shall not in any way constitute a basis for an extension of the delivery schedule or be construed as a waiver by the Agency or the State of any rights or remedies to which either is entitled by law or pursuant to provisions of this Contract. Failure to give such notice, however, may be grounds for denial of any request for an extension of the delivery schedule because of such delay. Furthermore, the Contractor will not be excused from failure to perform that is due to a Force Majeure unless and until the Contractor provides notice pursuant to this provision.

**2.13.33 Delays or Impossibility of Performance Based on a Force Majeure.** Neither party shall be in default under the Contract if performance is prevented, delayed, or made impossible to the extent that such prevention, delay, or impossibility is caused by a Force Majeure. If a delay results from a subcontractor’s conduct, negligence or failure to perform, the Contractor shall not be excused from compliance with the terms and obligations of the Contract unless the subcontractor or supplier is prevented from timely performance by a Force Majeure as defined in this Contract.

If a Force Majeure delays or prevents the Contractor’s performance, the Contractor shall immediately use its best efforts to directly provide alternate, and to the extent possible, comparable performance. Comparability of performance and the possibility of comparable performance shall be determined solely by the Agency.

The party seeking to exercise this provision and not perform or delay performance pursuant to a Force Majeure shall immediately notify the other party of the occurrence and reason for the delay. The parties shall make every effort to minimize the time of nonperformance and the scope of work not being performed due to the unforeseen events. Dates by which performance obligations are scheduled to be met will be extended only for a period of time equal to the time lost due to any delay so caused.

**2.13.34 Right to Address the Board of Directors or Other Managing Entity.** The Agency reserves the right to address the Contractor’s board of directors or other managing entity of the Contractor regarding performance, expenditures, and any other issue the Agency deems appropriate.

**2.13.35 Repayment Obligation.** In the event that any State and/or federal funds are deferred and/or disallowed as a result of any audits or expended in violation of the laws applicable to the expenditure of such funds, the Contractor shall be liable to the Agency for the full amount of any claim disallowed and for all related penalties incurred. The requirements of this paragraph shall apply to the Contractor as well as any subcontractors.

**2.13.36 Reporting Requirements.** If this Contract permits other State agencies and political subdivisions to make purchases off of the Contract, the Contractor shall keep a record of the purchases made pursuant to the Contract and shall submit a report to the Agency on a quarterly basis. The report shall identify all of the State agencies and political subdivisions making purchases off of this Contract and the quantities purchased pursuant to the Contract during the reporting period.

**2.13.37 Immunity from Liability.** Every person who is a party to the Contract is hereby notified and agrees that the State, the Agency, and all of their employees, agents, successors, and assigns are immune from liability and suit for or from the Contractor’s and/or subcontractors’ activities involving third parties and arising from the Contract.

**2.13.38 Public Records.** The laws of the State require procurement and contract records to be made public unless otherwise provided by law.

**2.13.39 Use of Name or Intellectual Property.** The Contractor agrees it will not use the Agency and/or State’s name or any of their intellectual property, including but not limited to, any State, state agency, board or commission trademarks or logos in any manner, including commercial advertising or as a business reference, without the expressed prior written consent of the Agency and/or the State.

**2.13.40 Taxes.** The State is exempt from Federal excise taxes, and no payment will be made for any

taxes levied on the Contractor’s employees’ wages. The State is exempt from State and local sales and use taxes on the Deliverables.

**2.13.41 No Minimums Guaranteed.** The Contract does not guarantee any minimum level of purchases or any minimum amount of compensation.

*2.14 Contract Certifications.* The Contractor will fully comply with obligations herein. If any conditions within these certifications change, the Contractor will provide written notice to the Agency within twenty-four (24) hours from the date of discovery.

**2.14.1 Certification of Compliance with Pro-Children Act of 1994.** The Contractor must comply with Public Law 103-227, Part C Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act). This Act requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the 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 Women, Infants, and Children (WIC) coupons are redeemed.

The Contractor further agrees that the above language will be included in any subawards that contain provisions for children’s services and that all subgrantees shall certify compliance accordingly. Failure to comply with the provisions of this law may result in the imposition of a civil monetary penalty of up to $1,000.00 per day.

**2.14.2 Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion—Lower Tier Covered Transactions**

By signing this Contract, the Contractor is providing the certification set out below:

**2.14.2.1** 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 Agency or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

**2.14.2.2** The Contractor shall provide immediate written notice to the Agency if at any time the Contractor learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.

**2.14.2.3** 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. Contact the Agency for assistance in obtaining a copy of those regulations.

**2.14.2.4** The Contractor agrees by signing this Contract 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.

**2.14.2.5** The Contractor further agrees by signing this Contract 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.

**2.14.2.6** 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.

**2.14.2.7** 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.

**2.14.2.8** Except for transactions authorized under Section 2.14.2.4 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.

**2.14.2.9** The Contractor certifies, by signing this Contract, 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.

Where the Contractor is unable to certify to any of the statements in this certification, such Contractor shall attach an explanation to this Contract.

**2.14.3 Restriction on Lobbying.**

This section is applicable to all federally-funded contracts.

Title 45 of the Code of Federal Regulations, Part 93 sets conditions on the use of Federal funds supporting this Contract. The Contractor shall comply with all requirements of CFR Part 93 which is incorporated herein as if fully set forth. No appropriated funds supporting this Contract may be expended by the Contractor for payment of any person for influencing or attempting to influence an employee of the agency (as defined in 5 U.S.C.552(f)), a member of Congress in connection with the award of this Contract, the making of any federal funding grant award connected to this Contract, the making of any Federal loan connected to this Contract, the entering into any cooperative agreement connected to this Contract, and the extension, continuation, or modification of this Contract.

**2.14.3.1** The Contractor shall file with the Agency a certification form, set forth in Appendix A of 45 CFR Part 93, certifying the Contractor, including any subcontractor(s) at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) have not made, and will not make, any payment prohibited under 45 CFR § 93.100.

**2.14.3.2** The Contractor shall file with the Agency a disclosure form, set forth in Appendix B of 45 CFR Part 93, in the event the Contractor or subcontractor(s) at any tier (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) has made or has agreed to make any payment using non-appropriated funds, including profits from any covered Federal action, which would be prohibited under 45 CFR §93.100 if paid for with appropriated funds. All disclosure forms shall be forwarded from tier to tier until received by the Contractor and shall be treated as a material representation of fact upon which all receiving tiers shall rely.

**2.14.3.3** The Contractor shall file with the Agency subsequent disclosure forms at the end of each calendar quarter in which there occurs any event that requires disclosure or materially affects the accuracy of the information contained in any disclosure form previously filed. Such events include:

**2.14.3.3.1** A cumulative increase of $25,000 or more in the amount paid or expected to be paid to influence a covered Federal action;

**2.14.3.3.2** A change in the person(s) or individual(s) influencing or attempting to influence a covered Federal action; and

**2.14.3.3.3** A change in the officer(s), employee(s), or Member(s) contacted to influence or attempt to influence a covered Federal action.

**2.14.3.4** The Contractor may be subject to civil penalties if the Contractor fails to comply with the requirements of 45 CFR Part 93. An imposition of a civil penalty does not prevent the Agency from taking appropriate enforcement actions which may include, but not necessarily be limited to, termination of the Contract.

**2.14.4 Certification Regarding Drug Free Workplace**

**2.14.4.1 Requirements for Contractors Who are Not Individuals.**  If the Contractor is not an individual, the Contractor agrees to provide a drug-free workplace by:

**2.14.4.1.1** Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited in the Contractor’s workplace and specifying the actions that will be taken against employees for violations of such prohibition;

**2.14.4.1.2** Establishing a drug-free awareness program to inform employees about:

* The dangers of drug abuse in the workplace;
* The Contractor’s policy of maintaining a drug- free workplace;
* Any available drug counseling, rehabilitation, and employee assistance programs; and
* The penalties that may be imposed upon employees for drug abuse violations;

**2.14.4.1.3** 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 Subsection 2.14.4.1.1;

**2.14.4.1.4** Notifying the employee in the statement required by Subsection2.14.4.1.1that as a condition of employment on such contract, the employee will:

* Abide by the terms of the statement; and
* Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction;

**2.14.4.1.5** Notifying the contracting agency within ten (10) days after receiving notice under the second unnumbered bullet of Subsection 2.14.4.1.4 from an employee or otherwise receiving actual notice of such conviction;

**2.14.4.1.6** 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

**2.14.4.1.7** Making a good faith effort to continue to maintain a drug-free workplace through implementation of this section.

**2.14.4.2 Requirement for Individuals.**  If the Contractor is an individual, by signing the Contract, the Contractor agrees not to engage in the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance in the performance of the Contract.

**2.14.4.3 Notification Requirement.** TheContractor shall, within thirty (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)**:**

**2.14.4.3.1** Take appropriate personnel action against such employee up to and including termination; or

**2.14.4.3.2** 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.

**2.14.5 Conflict of Interest.** The Contractor represents, warrants, and covenants that no relationship exists or will exist during the Contract period between the Contractor and the Agency that is a conflict of interest. No employee, officer, or agent of the Contractor or subcontractor shall participate in the selection or in the award or administration of a subcontract if a conflict of interest, real or apparent, exists. The provisions of Iowa Code chapter 68B shall apply to this Contract. The Contractor shall establish safeguards to prevent employees, consultants, or members of governing bodies from using their positions for purposes that are, or give the appearance of being, motivated by the desire for private gain for themselves or others with whom they have family, business, or other ties.

In the event the Contractor becomes aware of any circumstances that may create a conflict of interest the Contractor shall immediately take such actions to mitigate or eliminate the risk of harm caused by the conflict or appearance of conflict. The Contractor shall promptly, fully disclose and notify the Agency of any circumstances that may arise that may create a conflict of interest or an appearance of conflict of interest. Such notification shall be submitted to the Agency in writing within seven (7) Business Days after the conflict or appearance of conflict is discovered.

In the event the Agency determines that a conflict or appearance of a conflict exists, the Agency may take any action that the Agency determines is necessary to mitigate or eliminate the conflict or appearance of a conflict. Such actions may include, but are not limited to:

**2.14.5.1** Exercising any and all rights and remedies under the Contract, up to and including terminating the Contract with or without cause; or

**2.14.5.2** Directing the Contractor to implement a corrective action plan within a specified time frame to mitigate, remedy and/or eliminate the circumstances which constitute the conflict of interest or appearance of conflict or interest; or

**2.14.5.3** Taking any other action the Agency determines is necessary and appropriate to ensure the integrity of the contractual relationship and the public interest.

The Contractor shall be liable for any excess costs to the Agency as a result of the conflict of interest.

**2.14.6 Certification Regarding Sales and Use Tax.** By executing this Contract, the Contractor certifies it is either (1) registered with the Iowa Department of Revenue, collects, and remits Iowa sales and use taxes as required by Iowa Code chapter 423; or (2) not a “retailer” or a “retailer maintaining a place of business in this state” as those terms are defined in Iowa Code § 423.1(42) and (43). The Contractor also acknowledges that the Agency may declare the Contract void if the above certification is false. The Contractor also understands that fraudulent certification may result in the Agency or its representative filing for damages for breach of contract.

# SECTION 3. SPECIAL CONTRACT ATTACHMENTS

**Attachment 3.1 Pricing Schedule**

**Attachment 3.2 Collocation**

**Attachment 3.3 Sample Report Monitoring Tool**

**Attachment 3.4 Sample Monthly Performance Reporting Tool**

**Attachment 3.5 Vendor Security Questionnaire**

# Attachment 3.1: Pricing Schedule

*(TBD)*

{To be completed when contract is drafted.}

# Attachment 3.2: Collocation

As part of the Contract agreement the Agency will provide the following to Contractor staff housed at the Iowa Medicaid Enterprise (IME) permanent facility:

|  |  |
| --- | --- |
| * Cubicles with shelving/storage/desk lighting/desk tops/chairs \*(see note) | * Printing, envelopes, and postage for correspondence directly related to the Iowa Medicaid Program |
| * Telephones and telephone service | * DHS Standard Forms |
| * Standard DHS Desktop PC or Laptop with docking station | * Access to copiers including copy supplies, network printers, and Fax |
| * Keyboard and mouse | * Access to storage |
| * LAN/Internet Access | * Access to shredding |
| * Software List (see table below) | * Access to IME training equipment |
| * Access to IME laptops for occasional use | * Access to break rooms and conference rooms |

\* Note: Work surfaces throughout the building have been installed at the “standard” height. If a Contractor employee is tall or short the work surface can be adjusted for that employee up or down. If an employee has pain due to equipment they are using, an ergonomic evaluation can be completed at the Contractor’s expense. If special equipment is needed based on the ergonomic evaluation, purchase of equipment is at the Contractor’s expense. If any change is needed due to a medical necessity, a note from the employee’s doctor is required. This includes lights out or on, work surfaces raised for standing purposes (more than an inch or two), etc.

**Mailroom Equipment**

|  |  |
| --- | --- |
| **Model** | **PURPOSE / CURRENT SOFTWARE** |
| Kodak 660 K4198-9760 | Scanner |
| Kodak 660 K4198-7029 | Scanner |
| Agissar Model RV-050 | Mail opener |
| Agissar Model RV-050 | Mail opener |
| Agissar Model RV-050 | Mail opener |
| 176416 FMC Syntron J-50 Jogger | Floor Jogger |
| Slicer OPEX Model 206 Enveloponer | Omation Floor Slicer |
| Martin Yale 400 (exchange 7) | Tabletop Jogger |
| Martin Yale 400 (exchange 8) | Tabletop Jogger |
| S/N 004692 production year 2016 | Tabletop Chopper (Agissar) |
| S/N 004691 production year 2016 | Tabletop Chopper (Agissar) |

**OnBase Imaging Servers/Machines**

|  |  |
| --- | --- |
| **SYSTEM** | **PURPOSE / CURRENT SOFTWARE** |
| Adobe LiveCycle | Adobe LiveCycle |
| Data Warehouse | Data Warehouse AdHoc Server |
| Data Warehouse | Data Warehouse Development AdHoc Server |
| Data Warehouse | Data Warehouse Collection Server |
| Data Warehouse | Data Warehouse Remote Desktop Server |
| Mailroom T9 | DocIT Server 2 |
| Mailroom T9 | TM/OM Server |
| Mailroom T9 | AIX |
| Mailroom T9 | Web Reverse Proxy |
| Mailroom T9 | IP/Accura Server 1 |
| Mailroom T9 | IP/Accura Server 2 |
| Mailroom T9 | IQ Server 1 |
| Mailroom T9 | IQ Server 2 |
| Mailroom T9 | Decision Server |
| Mailroom T9 | Exchange Server 2 |
| Mailroom T9 | Exchange Server 1 |
| Mailroom T9 | DocIT Server 1 |
| Mailroom T9 | Exchange 7 Scan Station |
| Mailroom T9 | Exchange 8 Scan Station |
| Mailroom T9 | AnywhereUSB Hub |
| Mailroom T9 Test | AIX |
| Mailroom T9 Test | Web Reverse Proxy |
| Mailroom T9 Test | Test Server 1 |
| Mailroom T9 Test | Test Server 2 |
| Mailroom T9 Test | Test Scan Station |
| Monarch Production | Web Server |
| Monarch Production | SQL Server |
| Monarch Test | Web Server |
| Monarch Test | SQL Server |
| OnBase Development | SQL Server |
| OnBase Development | Onbase File Server |
| OnBase Production | Cold DIP Server |
| OnBase Production | Onbase File Server |
| OnBase Production | Web Server |
| OnBase Production | Workflow Server |
| OnBase Production | SQL Server |
| OnBase Test | Cold DIP Server |
| OnBase Test | Onbase File Server |
| OnBase Test | Web Server |
| OnBase Test | Workflow Server |
| OnBase Test | SQL Server |

**Software List**

Below is a list of Agency-licensed systems and software available for use on Agency computers.

|  |  |
| --- | --- |
| **Name of System/Software** | **Business Purpose** |
| Adobe Acrobat Professional | Review/Formatting Documents |
| Adobe LifeCycle Designer ES4 | Automation of Adobe Templates |
| Adobe LifeCycle ES4 | Automation of Adobe Templates |
| Paradatec License Server | License Server - Imaging/Scanning Solution |
| ProFTPD | FTP Server for AIX - Imaging/Scanning Solution |
| RecoStar 4.7 | Server Processing Software - Imaging/Scanning Solution |
| RSH Daemon | RSH Server - Imaging/Scanning Solution |
| Apache 2 | Web Server for AIX - Imaging/Scanning Solution |
| Cold Fusion 10 | Reporting - Imaging/Scanning Solution |
| Cygwin | System Support Software - Imaging/Scanning Solution |
| ImageMagick | Image Manipulation for Electronic Document Management System |
| OnBase Client | User Access & Development Software - Electronic Document Management System |
| OnBase Office Products | Server Software - Electronic Document Management System |
| OnBase Report Services | Server Software - Electronic Document Management System |
| OnBase RightFax | Server Software - Electronic Document Management System |
| OnBase SDK | Electronic Document Management System |
| OnBase Server Components | Server Software - Electronic Document Management System |
| OnBase Server Components | User Development Software - Electronic Document Management System |
| OnBase Studio | User Development Software - Electronic Document Management System |
| OnBase Unity Click Once | Server Software - Electronic Document Management System |
| Datawatch Monarch | Custom Report Solution & auto report delivery |
| Datawatch Server | Custom Report Solution & auto report delivery |
| ActivePerl | Scripting - Imaging/Scanning Solution |
| AnywhereUSB Configuration Utility | AnywhereUSB Connectivity - Imaging/Scanning Solution |
| AnywhereUSB Configuration Utility | AnywhereUSB Connectivity - Imaging/Scanning Solution |
| IMPA | File Transfers (Sharing Data) |
| MMIS | Payment System |
| MS Project | Project Tracking Software |
| MS SOAP Toolkit | Electronic Document Management System |
| Notepad++ | Text Editor/Development |
| PDF995 | Custom Print Batching & Delivery to DAS |
| RightFax | Method for Provider to submit Documents into OnBase |
| SnagIt | Aid with Documentation |
| SQL 2008 R2 Client Tools | Electronic Document Management System |
| SQL 2008 R2 Full | Electronic Document Management System |
| SQL Anywhere 16 | User Development Software - Imaging/Scanning Solution |
| SQL Anywhere 16 | Database - Imaging/Scanning Solution |
| Sybase ASE Open Client 12.5 | User Development Software - Imaging/Scanning Solution |
| Sybase ASE Open Client 12.5 | Database - Imaging/Scanning Solution |
| Visio | Flow Chart Software |
| WinZip 12.5 | Compression and encryption software |
| WinZip 14.5 | Compression and encryption software |
| WinZip 15.5 | Compression and encryption software |
| ConText | Text Editor/Development |
| FileZilla | File Transfers for Imaging/Scanning Solution |
| HTML-Kit | Text Editor/Development |
| puTTY | Terminal Access to AIX for Imaging/Scanning Solution |
| WinSCP | File Transfers for Imaging/Scanning Solution |
| OS/390 | Payment System - Mainframe |
| SYNCSORT | Payment System - Mainframe |
| IDCAMS | Payment System - Mainframe |
| WAAPDSUT | Payment System - Mainframe |
| ICETOOL | Payment System - Mainframe |
| ZEKE | Payment System - Mainframe |
| CONNECT DIRECT / NDM | Payment System - Mainframe |
| SAVR$ | Payment System - Mainframe |
| FTP | File transfers between servers and systems |
| VISUAL STUDIO | Project documentation |
| MS-OFFICE | Project documentation |
| FDB | Update MMIS system with 'First Data Bank' drug information |
| 3M GROUPER | Update MMIS system with DRG information |
| APC GROUPER | Update MMIS system with APC information |
| NdWorkbench | MMIS Data Dictionary and Migration updates |
| WINSCP | File transfers between servers and systems |

# Attachment 3.3: Sample Report Monitoring Tool

Note: this sample is for illustrative purposes only.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Report** | **Frequency** | **Due Date/Time** | **Copy Provided to** | **Contract Section** |
| 1.3.1.1 General Obligations | | | | |
| Vendor Security Questionnaire | One-time | April 16, 2018 |  |  |
| Attestation of passed information security risk assessment.  Attestation of passed network penetration scan  Attestation of passed web application security scan | Annually | April 16, 2018 and July 1 each year thereafter |  |  |
| Disaster Recovery and Business Continuity Plan | Annually | April 16, 2018 and July 1 each year thereafter |  |  |
| Quality Assurance and Corrective Actions Report | Quarterly |  |  |  |
| Performance Report | Monthly |  |  |  |
| 1.3.1.2 Transition | | | | |
| Project Work Plans | TBD |  |  |  |
| Operational Readiness Checklist | One-time |  |  |  |
| 1.3.1.3 Operations | | | | |
|  |  |  |  |  |
|  |  |  |  |  |
|  | | | | |

# Attachment 3.4: Sample Monthly Performance Reporting Tool

# Note: this sample is for illustrative purposes only.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Business Area** | **Contract Section** | **Performance Standard** | **Total Completed within timeframes** | **Standard Met (Y/N)** |
| Transition |  | Submit transition, systems implantation, and operations plans to the Agency for approval within 15 business days after Contract execution. |  |  |
|  |  |  |  |  |
| Claims Adjudication |  | Ninety percent of all clean claims must be adjudicated for payment or denial within 10 calendar days of receipt. |  |  |
|  |  |  |  |  |
| Managed Health Care |  | Meet a 100 percent accuracy rate for all Capitation rate assignments. |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**REPORTING**

|  |  |  |  |
| --- | --- | --- | --- |
| **Report due during the month** | **Due Date/Time** | **Accepted by the Agency (Y/N)** | **Standard Met (Y/N)** |
|  |  |  |  |
|  |  |  |  |

# Attachment 3.5: Vendor Security Questionnaire

|  |  |  |  |
| --- | --- | --- | --- |
| **Question** | | | (Enter Name and Date) |
| **Response** |
| **Data Ownership and Protection** | | | |
| 1 | **In what geographic location(s) is DHS data stored, and how rapidly will DHS be notified if this changes?** | |  |
| 2 | **How does DHS get its data if the Vendor goes out of business or DHS terminates the contract?** | |  |
| 3 | **How does the Vendor detect changes to the integrity of DHS data and what measures are in place to ensure DHS data is not lost or destroyed?** | |  |
| 4 | **What happens to DHS data if the Vendor is purchased by another company?** | |  |
| 5 | **How is DHS data protected while it is stored? Is it encrypted? Does DHS control the encryption key?** | |  |
| 6 | **How does the Vendor detect and report a compromise to DHS data or services?** | |  |
| 7 | **What protections does the Vendor provide for protected health information (“PHI”) (as the term is defined in the Health Insurance Portability and Accountability Act of 1996, (“HIPAA”) regulations, and personally identifiable information (“PII”) (which more generally encompasses any individually identifiable information, regardless of whether it relates to health care)?** | |  |
| 8 | **How does the Vendor ensure deleted data cannot be recreated?** | |  |
| 9 | **Will DHS data be provided to cloud service providers you utilize? How can DHS be assured cloud service providers meet the same standards for security?** | |  |
| 10 | **What means are provided for DHS to audit the Vendor’s access to DHS data and services and the Vendor’s service provider access to DHS data and services, if applicable?** | |  |
| 11 | **If the Vendor is currently not using a cloud environment but plans to implement in the future, will DHS be notified of the cloud environment and be provided the opportunity to review the services? If not, so state.** | |  |
| **User Identity Management and Federation** | | | |
| 12 | **How does the Vendor identify users?** |  | |
| 13 | **What credentials are required to access DHS data and applications (e.g. username and password)?** |  | |
| 14 | **What two-factor authentication mechanisms do you support?** |  | |
| **Regulatory Compliance** | | | |
| 15 | **Is the Vendor a HIPAA covered entity?** |  | |
| 16 | **Does any of the Vendor staff receive HIPAA training? Please explain.** |  | |
| 17 | **Would the Vendor be considered a business associate under HIPAA? In any circumstance, or specifically in relation to this exchange?** |  | |
| 18 | **Does Vendor staff receive HIPAA training? Please explain.** |  | |
| 19 | **Is Vendor FedRAMP Compliance Certified?** |  | |
| 20 | **How does the Vendor demonstrate regulatory compliance with regards to data security and privacy?** |  | |
| 21 | **Is the Vendor audited by third parties? What audit or security framework is used?** |  | |
| 22 | **What is the Vendor’s information security risk assessment and management process?** |  | |
| **Business Continuity and Resiliency** | | | |
| 23 | **How does the Vendor ensure DHS can continue doing business at all times, even if there is a permanent catastrophic failure or natural or man-made disaster where DHS data or services are located?** |  | |
| 24 | **What standards does the Vendor follow for business continuity (e.g. ASIS/BSI BCM.01:2010)? Is the Vendor certified?** |  | |
| 25 | **Does the Vendor have a business continuity plan?** |  | |
| 26 | **How often is the business continuity plan tested?** |  | |
| 27 | **How are backups of DHS data protected and are off-site backups utilized? What facilities store off-site backups?** |  | |
| 28 | **What guarantees are provided for recovery time objectives (RTO) and recovery point objectives (RPO)?** |  | |
| **User Privacy and Secondary Uses of Data** | | | |
| 29 | **What is the Vendor’s privacy policy covering information other than PHI and PII?** |  | |
| 30 | **Do you collect data about DHS activity and DHS employee activity in your system and use that data for purposes outside the scope of your contracted services with DHS??** |  | |
| **Service and Data Integration** | | | |
| 31 | **How does DHS access DHS data and services from the DHS office?** |  | |
| 32 | **How is DHS data encrypted as it flows across the network between the DHS location and the Vendor’s?** |  | |
| 33 | **What is the Vendor’s FIPS 140-2 compliancy status?** |  | |
| 34 | **Is data at rest on the Vendor’s servers encrypted in a manner consistent with** [***HHS Guidance to Render Unsecured PHI Unusable, Unreadable, or Indecipherable to Unauthorized Individuals?***](http://www.hhs.gov/hipaa/for-professionals/breach-notification/guidance/index.html) |  | |
| 35 | **Is data transmitted to DHS encrypted in a manner consistent with** [***HHS Guidance to Render Unsecured PHI Unusable, Unreadable, or Indecipherable to Unauthorized Individuals?***](http://www.hhs.gov/hipaa/for-professionals/breach-notification/guidance/index.html) |  | |
| 36 | **How does the Vendor monitor data flowing into the Vendor’s network for malware and other attacks?** |  | |
| 37 | **What tools and procedures does the Vendor utilize for intrusion detection and how is this capability tested for functionality at the hardware, network, and database levels.** |  | |
| **Multi-Tenancy** | | | |
| 37 | **How does the Vendor separate DHS data and services from those of other clients?** |  | |
| 38 | **In what ways could the Vendor’s other client’s affect the quality of the service or service levels provided to DHS?** |  | |
| 39 | **What resources will DHS be sharing with other clients?** |  | |
| 40 | **How does the Vendor manage the software upgrade process? What are DHS responsibilities?** |  | |
| **Infrastructure and Application Security** | | | |
| 41 | **Who owns and operates the Vendor’s data centers and what physical and environment security measures are in place?** |  | |
| 42 | **What parts of the Vendor’s infrastructure are owned and operated by the Vendor and what parts are obtained from a service provider?** |  | |
| 43 | **What standards are followed for hardening network equipment, operating systems, and applications?** |  | |
| 44 | **Who has access to the systems providing DHS data and services? How is this access controlled?** |  | |
| 45 | **How does the Vendor perform vulnerability and risk assessments?** |  | |
| 46 | **How does the Vendor use third-party penetration testing for assessing infrastructure and application security?** |  | |
| 47 | **When equipment is retired or replaced for repair, how does the vendor purge any resident DHS data prior to disposal.** |  | |
| 48 | **Explain how the vendor has implemented secure application development techniques in order to ensure security is established at the beginning of development in order to minimize known vulnerability types and eliminate website vulnerabilities identified in the latest published OWASP Top 10 list?** |  | |
| **Non-production Environment Exposure** | | | |
| 49 | **How many copies are made of DHS data and where are these copies located?** |  | |
| 50 | **Who has access to copies of DHS data?** |  | |
| 51 | **Which copies are de-identified and which are not?** |  | |
| 52 | **How are copies of DHS data protected?** |  | |
| 53 | **What capabilities are provided to DHS to audit the Vendor’s access to copies of DHS data?** |  | |