**First Amendment to the Iowa Department of Human Services**

**Takeover of Core Medicaid Management Information System Services**

This Amendment to RFP Number MED-18-004 is effective as of January 9, 2018. The RFP is amended as follows:

**Revision 1: Issuing Officer Address is corrected on pages 1 and 9 of the RFP.**

**Revision 2: Procurement Timetable on page 2 is amended as follows:**

|  |  |
| --- | --- |
| Bidder Written Questions Due By | Date and Time for Second Round of Questions: January 12, 2018 4:00 p.m.  Date and Time for Third Round of Questions: January 31, 2018 4:00 p.m. |
| Agency Responses to Questions Issued By | Date for Second Round of Responses:  January 23, 2018  Date for Third Round of Responses:  February 7, 2018 |

**Revision 3: Subsection 3.1, Bid Proposal Formatting, Paper Size Specifications, is amended to read:**

8.5" x 11" paper (one side only). Complex charts, graphs, and diagrams may be provided on legal-sized or larger paper, but it must fold down neatly into the 8.5" x 11" paper size within the bound proposal.

**Revision 4: Subsection 3.1, Bid Proposal Formatting, Page Limit, is increased to 250 pages.**

**Revision 5: Subsection 3.3 Cost Proposal, second paragraph, third sentence, is amended to read as follows:**

Bidders are instructed that the Agency will not accept costs exceeding $450,000 for transition costs (exclusive of the NCCI and EDI Solution Implementation costs) that may be incurred in the Transition Period.

**Revision 6: Attachment D, Certification Regarding Drug Free Workplace, first sentence, is amended to read as follows:**

1. **Requirements for Contractors Who are Not Individuals.** If the bidder is not an individual, by signing and submitting this Bid Proposal, the bidder agrees to provide a drug-free workplace by:

**Revision 7: Attachment G, Cost Proposal, is hereby deleted and replaced.**

**Revision 8: Attachment H: Sample Contract, Subsection 1.3.1.1.A.1.c is amended to read as follows:**

c. Claims Operations and Mailroom Manager. Responsible for day to day claims processing operations, mailroom operations, and personnel. Minimum qualifications include:

**Revision 9: Attachment H: Sample Contract, Subsection 1.3.1.1.A.1.f is hereby deleted, and subsequent subsections renumbered.**

**Revision 10: Attachment H: Sample Contract, Subsection 1.3.1.1.A.2.g is amended to read as follows:**

g. Comply with all timelines in the Agency-approved project work plans; and

**Revision 11: Attachment H: Sample Contract, Subsection 1.3.1.1.B.1.d is amended to read as follows:**

d. The Contractor shall utilize the Agency-provided accurate, robust NDC crosswalk for reimbursement of physician administered drugs.

**Revision 12: Attachment H: Sample Contract, New Subsection 1.3.1.1.B.1.k is added, and subsequent subsections are hereby renumbered:**

1. The Contractor shall staff the IME Core helpdesk during Business Hours, for OnBase, MMIS, Imaging, and ELVS IVRS user technical assistance, to include but not limited to:
   * 1. Maintain a log of e-mail and telephone inquiries, including the user name, date of receipt, date of response, nature of inquiry, and disposition of inquiry. The log shall be made available for review by the Agency at any time.
     2. Respond to phone and email inquiries from users requiring assistance;
     3. Identify, troubleshoot, and resolve system-related technical issues reported by users via phone or email.
     4. Escalate issues requiring further IT support to the appropriate Agency contact; and
     5. Follow issues to resolution and contact the user once the issues are resolved.

**Revision 13: Attachment H: Sample Contract, Subsection 1.3.1.1.B.1.m.iii is amended to add the following text at the beginning of the subsection:**

iii. For Contractor-provided EDI solution,

**Revision 14: Attachment H: Sample Contract, Subsection 1.3.1.1.B.1.p is amended to read as follows:**

o. The Contractor shall support system modifications (including workflow, business rules, data capture) needed as requested, following Agency-approved procedures. IME Units will make system requests through their unit manager.

**Revision 15: Attachment H: Sample Contract, Subsection 1.3.1.2.A.1.f.i is amended to read as follows:**

* + 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 and external Contractor systems;

**Revision 16: Attachment H: Sample Contract, Subsection 1.3.1.2.A.2.d is amended to read as follows:**

d. SOPs shall be reviewed with the Agency no less than annually.

**Revision 17: Attachment H: Sample Contract, Subsection 1.3.1.3.A is hereby deleted and replaced as follows:**

1. **Mailroom and Courier Service**
   1. Operate the mailroom located at the IME facility, to include but not limited to: receive all incoming mail, and 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 between the IME and the DHS Hoover building twice daily, and as requested for special circumstances, and 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.
   5. Route the documents to the appropriate IME Unit for handling after imaging.
   6. Enter a batch control activation record for each new batch for hardcopy claim documents.
   7. Monitor the online batch control process in order to establish control of claims receipts as soon as they enter the mailroom to ensure that claims are not lost or delayed in processing.
   8. Maintain the batch control file in order to monitor a batch of claims in the system as soon as the claims are batched.
   9. Process all outgoing mail through the IME mailroom, including regular daily mail and small-volume mailings.
   10. 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).
   11. Provide audit acceptable operations for processing mail containing checks.

**Revision 18: Attachment H: Sample Contract, New Subsection 1.3.1.3.B.5 is added, and subsequent subsections are hereby renumbered:**

1. Generate Notices of Decision (NODs) in a nightly batch, for denied ambulance claims and rehabilitation therapy services claims for occupational therapy, physical therapy and speech therapy, and send files to DAS for printing.

**Revision 19: Attachment H: Sample Contract, Subsection 1.3.1.3.D.2 is amended to read as follows:**

1. Implement process improvements in the MMIS system and support Agency IMPA updates to simplify administrative processes for providers, as requested.

**Revision 20: Attachment H: Sample Contract, Subsection 1.3.1.3.D.5 is amended to read as follows:**

1. Implement system changes to support provider management processes, including but not limited to enrollment, re-enrollment, EFT enrollment, EDI enrollment and testing, remittance advices, and managed care reporting.

**Revision 21: Attachment H: Sample Contract, Subsections 1.3.1.3.E (6-8) are hereby deleted, and subsequent subsections renumbered.**

**Revision 22: Attachment H: Sample Contract, New Subsection 1.3.1.3.F.3 is added, and subsequent subsections are hereby renumbered:**

1. Screen all claims to ensure they are submitted on the correct claim form, that paper claim forms are originals, and that claims contain the Agency-defined data elements. Deny claims within the MMIS that do not pass initial screening.

**Revision 23: Attachment H: Sample Contract, Subsection 1.3.1.3.F.14, is amended to read as follows:**

1. Provide adjudication of all claims entered manually in a nightly batch cycle.

**Revision 24: Attachment H: Sample Contract, New Subsection 1.3.1.3.G.11 is added, and subsequent subsections are hereby renumbered:**

1. Report deficiency findings from MCOs, PAHPs, and the NEMT broker encounters to the Agency, to include but not limited to:
   * 1. Timeliness. Calculate and report the measure of encounter submission timeliness and report deficiencies in timely data submission as well as timely data correction (encounters that failed edit validation).
     2. Accuracy. Accepted compared to rejected (failed validation edits), and percentage of accuracy.
     3. Completeness. Measure and report the number of files and encounters submitted before the monthly cut-off date.

**Revision 25: Attachment H: Sample Contract, Subsection 1.3.1.3.J.7, is amended to read as follows:**

1. Upload Member files to include the TPL plan and coverage information for HIPP Members.

**Revision 26: Attachment H: Sample Contract, Subsection 1.3.1.3.L.2, is amended to read as follows:**

1. Payment Error Rate Measurement (PERM). The Contractor shall provide support to the Agency during the CMS PERM project on a tri-annual basis and throughout each PERM cycle, as requested. This includes but is not limited to:
   * + 1. Provide timely review on all cases that were identified by the auditors and assigned to the Contractor, to include but not limited to:
          1. Research Agency-assigned claims and encounters with potential errors;
          2. Provide findings with detailed explanation and documentation of agreement or disagreement with the PERM auditor’s findings to the Agency; and
          3. Explain in detail any disputes with CMS findings to the Agency liaison with supporting rationale from the Iowa Administrative Code (IAC), as necessary.
       2. Comply with information protocols and response timeframes determined by the Agency.
       3. Make system changes as identified based on PERM findings.

**Revision 27: Attachment H: Sample Contract, Subsection 1.3.1.3.M.9, is amended to read as follows:**

1. Produce and transfer provider remittance advices to Agency Data Warehouse for upload to IMPA pursuant to the Agency guidelines and timeframes.

**Revision 28: Attachment H: Sample Contract, Subsection 1.3.1.3.P.11, is amended to read as follows:**

1. Coordinate with Agency telecommunication and software vendors to resolve operational and performance issues.

**Revision 29: Attachment H: Sample Contract, Subsection 1.3.1.3.P.12 is hereby deleted, and subsequent subsections renumbered.**

**Revision 30: Attachment H: Sample Contract, Subsection 1.3.2 is hereby deleted and replaced as follows:**

1.3.2 Performance Measures.

The Contractor shall:

1. Transition
   1. Submit transition, system implementation, and operations plans 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.
   4. Update SOPs with any changes to the methods and procedures used by the Contractor within 10 business days of the change.
2. Quality Assurance/Quality Improvement
   1. Perform quality assurance reviews on a minimum of 25% of the Contractor’s operational procedures quarterly, with 100% reviewed annually.
   2. Maintain a ninety-nine percent (99%) accuracy rate for electronic claims receipt and transmission.
   3. Maintain at least a ninety-six percent (96%) keying accuracy rate for data-entered documents.
   4. Maintain a ninety-nine percent (99%) accuracy rate for all reference file updates.
   5. Meet a ninety-eight percent (98%) accuracy rate on appropriate payment, or denial, of fee-for-service claims.
   6. Meet a ninety-eight percent (98%) accuracy rate for all capitation rate assignments.
   7. Meet a ninety-eight percent (98%) accuracy rate for all MMIS reports.
   8. If any of the above accuracy rates are not met, submit a corrective action plan to the Agency within ten business days of the quality review for the Agency’s approval.
   9. Meet ninety-eight percent (98%) of the corrective action commitments within the agreed upon timeframe.
3. Mailroom and Courier Service
   1. Imaged documents and claims shall be available for processing and viewing within 5 business days of receipt.
   2. 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. Add records for presumptively eligible individuals to the Member eligibility file the same day as the eligibility determination.
   4. 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 (95%) of the appropriate claims for the medically needy spenddown account for approved medically needy clients.
   3. 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. 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. Deny claims that do not pass pre-screening within six business days of receipt.
   4. Produce and provide to the Agency all daily, weekly and monthly claims entry statistics reports within one business day of production of the reports.
   5. Provide access to imaged claims, attachments and adjustments and or voids, prior authorizations and other documents to all users within 2 business days of completion of the imaging.
   6. Return an electronic receipt and or notification for claims submitted electronically within four business hours of receipt.
   7. All EDI claims, including Medicare crossover claims, shall be processed within 1 business day after receipt.
   8. Produce state-defined reports within the required timeframe as determined by the Agency.
   9. Ninety-five percent of all EDI inquiries submitted through e-mail or direct secure messaging shall receive outreach (personal message response or phone response) within 1 business day.
8. 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 claims applicable to any active provider not on hold 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.
9. 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. Produce state-defined reports within the required timeframe as determined by the Agency.
10. 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. Notify the Agency and correct errors within one business day of error detection.
    9. Produce state-defined reports within the required timeframe as determined by the Agency.
11. 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. Produce state-defined reports within the required timeframe as determined by the Agency.
12. Third Party Liability Management
    1. Generate TPL and trauma lead letters in a nightly batch for diagnosis codes identified in the claim.
    2. Process TPL updates within 24 hours of receipt from the Revenue Collection contractor.
    3. Upload Member files to include the TPL plan and coverage information for HIPP Members within 24 hours of receipt from the HIPP unit.
    4. Generate a file of all paid claims and Member eligibility by the fifth business day of each month for the previous month.
    5. Produce state-defined reports within the required timeframe as determined by the Agency.
13. Program Management Reporting
    1. Make available all standard production reports 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 tenth business day after month end cycle.
       4. Quarterly reports – by 6:00 AM of the tenth business day after quarterly cycle.
       5. Annual reports – by 6:00 AM of the tenth 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.
14. 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. Support PERM efforts within the Agency-determined timeframes.
    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.
15. 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 and mail the Explanation of Medicaid Benefits (EOMB) by the 15th calendar day of each month.
    3. Produce and transfer all remittance advices to Agency Data Warehouse for upload to IMPA 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.
16. 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. Produce the state-defined reports within the required timeframe as determined by the Agency.
17. Managed Health Care
    1. Process payments within Agency-approved timelines.
    2. Produce state-defined reports within the required timeframe determined by the Agency.
18. ELVS IVRS
    1. Assure a response time of less than five seconds on the ELVS IVRS. 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. Update ELVS IVRS upon receipt of a change in eligibility.
    3. Notify the Agency designees of operational issues within one hour of identification.
19. Change Management Process
    1. Within 10 business days of receipt of a complete 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.

**Revision 31: Attachment H: Sample Contract, Subsection 1.5.2.C.1.d is hereby deleted, New Subsection 1.5.2.C.1.a is added, and subsequent subsections are hereby renumbered:**

* + 1. Section 1.3.2.B Quality Assurance/Quality Improvement - 2% of the monthly amount