

## Core Unit

### Key Performance Indicators

	SFY 2006	SFY 2007
# of Claims paid	20,667,408	18,868,263
# of Claims denied	1,536,999	2,076,365
Avg. Days From Receipt to Payment	9.6	8.1
IME Web Portal (Eligibility Verification)	2,011,892	2,194,399
IME Web Portal (Claims Status Inquiry)	145,659	181,059
ELVS (Eligibility Verification)	2,367,538	2,588,079

### Other Performance Measures

#### Mailroom

Maintain at least a ninety-five percent (95%) keying accuracy rate for data entered documents.

Log, image and assign a unique control number to every claim, attachment, adjustment/void, prior authorization and other documents submitted by providers within one (1) business day of receipt.

Return hard copy claims that fail the prescreening process within one (5) business day of receipt.

Produce and provide to DHS all daily, weekly and monthly claims entry statistics reports within one (1) business day of production of the reports.

Provide access to imaged documents to all users within one (1) business day of completion of the imaging. Response time for accessing imaged documents at the desktop must not exceed ten (10) seconds.

#### **Claims Processing**

Ninety-nine percent (99%) of all clean claims must be adjudicated for payment, denial or budget relief within sixty- (60) calendar days of receipt.

One hundred percent (100%) of all claims must be adjudicated for payment, denial or budget relief within one hundred and twenty- (120) calendar days of receipt.

One hundred percent (100%) of all clean provider-initiated adjustment requests must be adjudicated within ten (10) business days of receipt.

## Core Unit

Claims processed in error must be reprocessed within ten- (10) business days of identification of the error or upon a schedule approved by the State.

All claims will be applied to the Medically Needy spenddown accounts within 24 hours of adjudication cycle for all Medicaid covered claims

All claims will be applied to the Medically Needy spenddown accounts within 48 hours of adjudication cycle for all Non-Medicaid covered claims

Assure ninety-five percent (95%) accuracy in identifying all appropriate claims for the Medically Needy spenddown account for approved Medically Needy clients.

### **Contract Management**

Meet ninety-five percent (95%) of the corrective action commitments within the agreed upon timeframe

Provide the monthly contract management reports within three (3) business days of the end of the reporting period.

Provide monthly performance monitoring report card within ten (10) business days of the end of the reporting period.

Provide an acknowledgment of the receipt of a user support request by response to the requestor within twenty-four (24) hours and indicate the time frame for a resolution to the issue or question.

Provide a response/resolution to State Project Management staff within forty-eight (48) hours of receipt to requests made in any form (e.g., e-mail, phone) on routine issues or questions.

Provide a response within 24 hours to State Project Management staff on emergency requests, as defined by the State.

Provide new user training for State staff and other component contractor staff a minimum of one time per quarter.

Provide refresher training to State users and other component contractor staff a minimum of twice a year.

Provide training on system changes as a result of upgrades or other enhancements within two (2) weeks of the upgrade.

Identify deficiencies and provide the State with a corrective action plan within ten (10) business days of discovery of a problem found through the internal quality control reviews.

### **Systems**

## Core Unit

Ninety percent (90%) of schedule and cost estimates for system enhancements must be submitted within ten (10) business days after receiving request, and one hundred percent (100%) must be submitted within thirty (30) business days

Ninety-eight percent (98%) of client claim histories shall be provided within three- (3) business days of DHS request.

Notify DHS of system problems identified by the contractor within twenty-four (24) hours of identification of the problem.

Maintain a ninety-nine percent (99%) accuracy rate for electronic claims receipt and transmission.

Meet a ninety-eight percent (98%) accuracy rate on appropriate payment, or denial, of fee for service claims for HMO members.

Assure a response time of less than ten (10) seconds on the AVRS/REVS. Response time is determined by measuring the elapsed time from speaking or entering the requested provider and member information to receipt of a response

The AVRS/REVS must be available ninety-eight percent (98%) of the time, twenty-four (24) hours a day, and seven (7) days a week

Identify and correct errors within one (1) business day of error detection (Reference Function)

Meet a ninety-eight percent (98%) accuracy rate for all capitation rate assignments

Accept and update EPSDT screening data from claims no less frequently than weekly

Respond to system maintenance requests within five (5) business days except for emergency requests for which a response is due within twenty-four (24) hours of receipt of the request.

Report findings from audits of HMO and Iowa Plan encounters to DHS within five (5) business days from the end of the reporting quarter.

### System Reports

Provide monthly reports of programmer hours by the fifth (5th) calendar day of the month for activity completed in the previous month.

Ninety-eight percent (98%) accuracy is required on all MMIS reports. The contractor will propose a means for calculating the 98% accuracy rate.

Report claim count and payment amount per rate cell

## Core Unit

When an error in a MAR report is identified either by the Core MMIS contractor or by DHS, provide an explanation as to the reason for the error

All required reports must be available for review by DHS staff.

Provide monthly reports of enhancement project progress and to-date cost report and time expended on each open project by the fifth (5th) calendar day of the month for activity in the previous month.

### **Systems Updates**

Update and notify the State of provider data received electronically within one (1) business day of receipt of file.

Resolve eligibility transactions that fail the update process within two (2) business days of error detection

Complete all PA interface updates within one (1) business day of receipt of a file if there are no critical errors

Resolve licensing transactions that fail the update process within two (2) business days of error detection.

Maintain a ninety-nine percent (99%) accuracy rate on electronic eligibility file updates.

### **Operational Procedures**

Produce and make provider mailing labels available for printing in the State data center within one (1) business day of request.

Produce facsimiles of electronic claims within one (1) business day of receipt

Process and report disposition of encounter file edit review to the submitting managed care organization within three (3) business days of receipt.

\*\*Produce and mail REOMBs by the 15th calendar day of the month.

Once a month, within 5 calendar days of month end, produce and mail letters to members for claims with services exceeding \$100 related to trauma resulting from an accident requesting additional information concerning the accident and whether any other thi

Produce and mail provider 1099s by January 31st of each calendar year.

For claims submitted via modem-to-modem transmission or via the Internet, return an electronic receipt and/or notification within four (4) business hours of receipt

All EMC claims, including Medicare crossover claims, must be processed in the next daily cycle after receipt

## Core Unit

\*\*Issue Notices of Decision to members within twenty-four (24) hours of the determination of the denial of ambulance claims and rehabilitation therapy services claims for occupational therapy, physical therapy and speech therapy.

Provide encounter data files, in acceptable format, to DHS-recognized contractors within five (5) business days of end of designated reporting period.

Produce and submit to the State, balancing and control reports that reconcile all claims input to the processing cycle to the output of the cycle by the next business day following the cycle.

Provide a weekly report to DHS of all "Notices of Decision to Recipients" that were sent to members based on adverse actions for denied ambulance and rehabilitation claims, and denied and modified prior authorizations within five (5) business days

Provide update error reports and audit trails to the State within 24 hours of completion of the update.

Hard copy reports, when requested, must be delivered to DHS staff within two (2) business days of availability of online report. (MARS)

Data files for all reports must be made available on the State data center servers and accessible online within 24 hours of completion. (MARS)

Hard copy reports, when requested, must be delivered to DHS staff within two (2) business days of availability of online report. (EPSDT)

Update month-end replacement files and provide DHS with update and error reports before the first day of the replacement month

Process capitation payments before the 15th of the month and report claim count and payment amount per rate cell to DHS within two (2) business days of processing the payment.

Balancing reports are to be provided to DHS within two (2) business days after completion of the MARS production run.

When an error in a MAR report is identified either by the Core MMIS contractor or by DHS, provide an explanation as to the reason for the error within three (3) business days and correct the report within ten (10) business days following the date the error

Provide a monthly report to DHS identifying all payments avoided due to TPL in a format approved by the Department by the 10th calendar day of the following month.

## Core Unit

Generate a weekly report from the data provided by the TPL Resource File, HIPP and Child Support Recovery unit so that the information can be keyed into the system by the end of the week in which the report is generated.

Produce the check-write accounting reports by 8:00AM after completion of payment cycle.

Update the Provider database with Occupational Licensing updates at least twice per month

Validate the licensing update process within two (2) business days of application of the update transmission.

Update the member eligibility database with electronically received data and provide DHS with update and error reports within twenty-four (24) hours of receipt of daily updates. For a batch-processing environment, updates must be done prior to daily claim

Update the CLIA laboratory designations within one (1) business day of receipt of file

Perform online updates to reference data within twenty-four (24) hours of receipt.

Process procedure, diagnosis, and other electronic file updates to the reference databases within five (5) business days of receipt or upon a schedule approved by the State.

Update edit adjudication documentation within three (3) business days of the request from DHS.

Update error text file documentation within three (3) business days of DHS approval of the requested change.

Ninety-five percent (95%) of prior authorization file updates received from outside entities/agencies will be applied no later than the next business day.

Refer to the State all licensing transactions that fail the update process and cannot be resolved by contractor staff pursuant to edit update rules or State-approved procedures

### **TOTALS**

\*\*SFY06 is based on 2 quarters data

# Pharmacy POS

**Key Performance Indicators**

	SFY 2006	SFY 2007
Total number of claims paid	5,640,324	3,627,679
Total cost for claims paid	\$341,719,046	\$231,191,931
Average cost per claim	\$60.91	\$63.65
Number of Calls Received	53,206	39,691
Number of Calls Answered	52,211	38,918
Percentage of Calls Answered	98.13%	98.05%
Percent of Calls Answered within 30 Seconds or Less	76.04%	85.24%
Average Queue Time for Providers	8 seconds	5 seconds

**Other Performance Measures**

**Claims Processing**

The contractor shall provide sufficient staff, facilities & technology such that 95% of all call line inquiry attempts are answered. The total number of abandoned calls shall not exceed 5% in any calendar month.

Calls must be answered within thirty (30) seconds. If an automated voice response system is used as an initial response to inquiries, an option must exist that allows the caller to speak directly with an operator. The Contractor shall provide sufficient

All call line inquiries that require a call back, including general inquiries, shall be returned within 1 business day of receipt one hundred percent (100%) of the time.

Provide POS claims function availability 23 hours a day, 7 days a week.

Provide adjudicated claims and payment data to the Core MMIS contractor by 10:00 pm on the day prior to the payment cycle.

Update provider, provider, member, TPL, and Medicare Part D data within one business day of receipt of the data from the Core MMIS Operator.

## Pharmacy POS

### **Drug Rebates**

Update the manufacturer rebate data within five (5) business days of receipt of the update from CMS.

Generate and mail invoices to manufacturers within five (5) business days of the receipt of the CMS drug rebate tape & IME Pharmacy Medical Services contractor supplemental drug rebate data.

Generate initial collection letters or make phone calls to non-responding manufacturers within thirty-eight (38) calendar days from the mailing date of the invoice.

Collect at least ninety percent (90%) of the total of accounts receivables outstanding at the beginning of the quarter plus invoices issued during the current quarter by the end of the current quarter.

Deposit all payments from drug manufacturers into designated State accounts within one (1) business day of receipt.

Generate and mail invoice letters for the J-Code rebate within 5 business days of receipt from Core.

### **IT Services**

Notify POS Unit Manager of system problems identified by the contractor within twenty-four (24) hours of identification of the problem.

Respond to system maintenance requests within five (5) business days except for emergency requests for which a response is due within twenty-four (24) hours of receipt of the request.

Ninety percent (90%) of schedule and cost estimates for system enhancements must be submitted within ten (10) business days after receiving request, and one hundred percent (100%) must be submitted within thirty (30) business days

Ninety-five percent (95%) of system changes must be completed on the date agreed to by the POS Unit Manager and the contractor. Completion dates may be extended with concurrence of the State.

## Pharmacy POS

Provide monthly reports as requested by DHS of programmer hours by the fifth (5th) calendar day of the month for activity completed in the previous month.

Provide monthly reports as requested by DHS of enhancement project progress and to-date cost report and time expended on each open project by the fifth (5th) calendar day of the month for activity in the previous month.

## Provider Services

### Key Performance Indicators

	SFY 2006	SFY 2007
Provider Applications Approved	7,118	7,608
Number of Calls Received	340,741	350,645
Number of Calls Answered	268,984	340,006
Percentage of Calls Answered	78.94%	96.97%
Percent of Calls Answered within 30 Seconds or Less	39.00%	76.80%
Average Queue Time for Providers	6:08 minutes	0:40 minutes
Service Level	40%	77.40%

### Other Performance Measures

#### Enrollment

Send 95% of provider enrollment packets to the provider no later than one business day following receipt of the request.

95% of the Provider enrollment applications must be approved, assigned a provider number, entered in the provider file, denied or returned to the provider within 5 business days following receipt of the application.

## Provider Services

100% of online provider data will be updated within one business day of receipt.

Maintain 98% of online update transactions.

100% of identified errors will be corrected within one business day of detection.

100% of the Provider enrollment applications will be verified against the appropriate licensing entity and against the additional specialty credentials.

100% of the Providers will have valid licensing criteria and specialty credentials at the time of approval of the provider enrollment application.

### **Inquiry and Relations**

Maintain a service level of 80% for incoming calls.

Respond to 90% of telephone inquiries during the initial call from the provider.

Completely respond to 100% of written, faxed or emailed inquiries within 5 business days of receipt. If the response cannot be completed, then an interim response must be provided.

## Provider Services

### Outreach

Print 100% of new or updated provider manuals and make them available for distribution within 10 business days of written approval by the state. If no activity, award full points

Print and distribute 100% of newsletters, bulletins, inserts or other special mailings within 5 business days of written approval by the state. If no activity, award full points

Incorporate 100% of all provider manual revisions and updates into current and future stock within 22 business days of issuance of the revision. If no activity, award full points

Distribute 100% of supplies of claim forms and other provider forms to providers within 2 business days after request.

\*\*Distribute 100% of provider manuals to newly enrolled **waiver** providers within 3 business days of receipt of request and fully enrolled.

100% of the website will be updated within 2 business days of approval of information by DHS. If no activity, award full points

In an emergency situation, print and distribute 100% of any manuals, updates and letters or bulletins within 3 business days following approval by DHS. If no activity, award full points

Maintain 100% of informational letters, bulletins, manual updates on the provider website until replaced or directive has expired. If no activity, award full points

100% of the time, for each training session or individual provider visit, present a report to DHS within 10 business days of the session or provider visit. If no activity, award full points

## Provider Services

### Professional Services

Provide a 100% response/resolution to DHS Project Management Team within 2 business days of receipt to requests made in any form (e.g., e-mail, phone) on routine issues or questions. If no activity, award full points

Provide a 100% response within 1 business day to DHS Project Management Team on emergency requests, as defined by the State. If no activity, award full points

Identify 100% of deficiencies and provide DHS with a corrective action plan within 10 business days of discovery of a problem found through the internal quality control reviews. If no activity, award full points

Meet 95% of corrective action commitments within the agreed upon time frame. If no activity, award full points

Provide 100% training on operational procedure changes as a result of upgrades or other changes within 10 business days of the upgrade. If no activity, award full points

Update 100% operational procedure manuals within 10 business days of the implementation of a change. If no activity, award full points

\* FY2006 based on 3 quarters of data

## Member Services

### Key Performance Indicators

	SFY 2006	SFY 2007
Number of Calls Received	148,334	117,062
Number of Calls Answered	100,802	113,993
Percentage of Calls Answered	67.96%	97.38%
Average Queue Time for Members	4:03 minutes	0:22 minutes
Service Level	27%	86%

### Other Performance Measures

#### Customer Mailings

Mail IowaCare Disenrollment Letters to Members by the 15th working day of each month

Mail IowaCare FAQ to Members by the 15th working day of each month

## Member Services

Mail Healthy Start to Members by the 15th working day of each month

### **DHS Inquiries**

Respond to Appeals as requested within required timeframe

### **Managed Care Enrollment**

Distribute enrollment packets to eligible managed health care participants within two (2) business days from receipt of eligibility alert from MMIS.

Meet a ninety-eight percent (98%) accuracy rate for all enrollment assignment for both HMO and MediPASS participation.

### **Member Relations**

For calls in which a member has a person-to-person conversation, ninety-five percent (95%) of the inquiries (with the exception of bill inquiries) whose answer is not immediately available to the Customer Service attendant will be researched and forwarded

For each Member Call Center bill inquiry, one hundred percent (100%) of bill inquiries will be responded to in writing within thirty (30) days of the initial inquiry

Maintain a service level of eighty percent (80%) for incoming calls, using service level formula.

Respond to ninety percent (90%) of written, faxed, or e-mailed inquiries within five (5) business days of receipt excluding bill inquiries.

### **Professional Services**

Mail 100% of publications within five working days.

### **Member Quality Assurance**

Provide training on operational procedure changes as a result of upgrades or other changes within two (2) weeks of the upgrade.

Update operational procedure manuals within two (2) weeks of the implementation of a change (10 business days).

## Member Services

### Internal Business Processes

Identify deficiencies and provide DHS with a corrective action plan within ten (10) business days of discovery of a problem found through the internal quality control reviews.

Meet ninety-five percent (95%) of the corrective action commitments within the agreed upon time frame.

\*\*SFY06 is based on 2 quarters data

## Medical Services

### Key Performance Indicators

	SFY 2006	SFY 2007
Percentage of Prior Authorizations processed timely	95%	95%
Percentage of Exception to Policy medical reviews processed timely	86%	96%
Number of members enrolled in MHEP/LI	5,204	5,998
Percentage of Long Term Care programs level of care reviews completed timely	n/a	97%
Percentage of Provider Inquiries response timely	98%	99.70%

### Other Performance Measures

#### Prior Authorizations

95% of alerts will be provided to Case Managers for home health authorizations due for children.

95% of PA requests will be processed timely.

#### Exceptions to Policy

95% of Exception to Policy reviews will be completed within ten (10) business days or within a granted extension.

#### Lock-in Program

Members identified appropriate for an educational (MHEP) intervention, the member will receive notification within ten (10) business days of the date of the identification

Assign a member to a primary care provider if the provider requests the re-assignment or can no longer serve as the provider. This re-assignment should occur within 30 days of the request from provider or member.

Maintain a combined monthly average of 415 Lock-in enrollees and MEHP interventions.

## Medical Services

## Medical Services

### Care Management

Increase the member enrollment for Care Management by 10 percent annually.

Upon referral, initial contact for care management services shall be completed for ninety five percent within five business day. If the member is hospitalized at the time of the referral, the initial contact shall be within five days of notification of

Based on evidence-based guidelines (for pre-determined interventions), show an overall compliance rate for 90 %members enrolled in the diabetes program.

Establish a medical home for ninety percent of members enrolled.

## Medical Services

### **Long Term Care Services Review**

MDS validation/QA outcome reports will be completed and mailed to the provider within 30 days of receipt of information.

95 % of initial assessments shall be completed within two (2) business days, and the annual assessment completed within five (5) days five

95 % of quality reviews for all IME certified NF, ICF/MR and HCBS waiver programs shall be completed within 30 days of receipt of requested information.

## Medical Services

### **Retro Review**

95% of Retrospective reviews for inpatient sample will be completed with 40 days of receipt of all requested information.

95% of outpatient reviews will be completed within 60 days of receipt of all requested information.

## Medical Services

### **Claims Prepay Review**

As measured on the last working day of the month, 95% of claims will have been suspended less than 30 days.

Notify provider within five (5) business days of receipt of a claims inquiry with missing or incomplete information.

Send the final determination letter on claims inquiries to the provider within ten (10) business days of receipt of complete documentation

## Medical Services

### **Remedial Services**

95% of initial reviews will be completed within two (2) days.

95% of continued reviews will be completed within five (5) days.

Provide feedback to remedial providers within 30 days of review of progress notes.

## Medical Services

### **Habilitation Service**

95% of initial level of care will be completed within two (2) days.

95% of continuing level of care review will be completed within five (5) days.

95% of service plans will be approved within 2 days of notification in ISIS

## Medical Services

### CMH

95% of initial level of care will be completed within two (2) days.

95% of continuing level of care review will be completed within five (5) days.

Quality improvement feedback to providers on services & documentation will be given within 30 of receipt of required information.

## Pharmacy Medical Services

<b>Key Performance Indicators</b>	<b>SFY 2006</b>	<b>SFY 2007</b>
Prior Authorization Requests Received	65,052	59,374
Prior Authorization Requests Approved	36,860	33,270
Prior Authorization Requests Denied	17,465	15,684
Prior Authorization Requests Incomplete	7,783	6,923
Prior Authorization Requests Not Required	2,791	2,701
Prior Authorization Requests Part D	153	796
Average Determination Time	1.06 hours	1.17 hours
Number of Calls Received	21,902	17,021
Number of Calls Answered	21,099	16,419
Percentage of Calls Answered	96.33%	96.46%
Percent of Calls Answered within 30 Seconds or Less	78.30%	80.41%
Average Queue Time for Providers	8 seconds	6 seconds

### Other Performance Measures

#### Performance Measurement

##### **Prior Authorization**

The contractor shall provide sufficient staff, facilities & technology such that 95% of all call line inquiry attempts are answered. The total number of abandoned calls shall not exceed 5% in any calendar month.

Calls must be answered within thirty (30) seconds. If an automated voice response system is used as an initial response to inquiries, an option must exist that allows the caller to speak directly with an operator. The Contractor shall provide sufficient

All call line inquiries that require a call back, including general inquiries, shall be returned within 1 business day of receipt one hundred percent (100%) of the time.

## Pharmacy Medical Services

Respond to one hundred percent (100%) of pharmacy prior authorization requests within twenty-four (24) hours of receipt.

### **PDL & Supplemental**

Provide DHS with access to all supplemental rebate agreements and related documentation within twenty-four (24) hours of request.

Provide the P&T Committee with required information a minimum of thirty (30) days prior to the meeting.

Provide DHS with a written report of the P&T Committees recommendations within three (3) business days of the conclusion of the meeting.

## Revenue Collections

### Key Performance Indicators

	<u>SFY 2006*</u>	<u>SFY 2007</u>
State revenue collected is 115% or more of the costs of revenue collection in the immediately preceding SFY		
Amount collected for Estate Recovery:	\$9,423,028	\$14,571,056
Amount collected for TPL, Lien and Provider Overpayment:	\$27,597,119	\$34,420,321
Cost Avoidance:	\$96,964,527	\$115,364,857
Percent of previous SFY, including cost avoidance:	132%**	119%***
Deposit all TPL recoveries in the state bank account within two banking days of receipt.	100%	100%
Initiate follow-up activities on unpaid post-payment carrier billings within forty-five (45) days from submission.	100%	100%
Complete the verification or validation of TPL and update MMIS with the data within ten (10) business days of receiving the TPL leads from the DHS IMW's.	93%	93%
Open lien recovery cases within ten (10) business days after correspondence indicating potential subrogation is received.	100%	100%
Prepare and process adjustments/voids against refunds and returned warrants within ten (10) business days of receipt of the refund or returned warrant.	98%	98%
1.C.6. Report to the Department all third party health insurance coverage information for IowaCare Members and post this information to the Third Party Resource file in the MMIS within ten (10) business days of receipt.	93%	93%

\*SFY 2006 data is an average of scorecard data from March 2006 through June 2006

\*\*SFY 2006 data compared against SFY 2004 data

\*\*\*SFY 2007 data compared against SFY 2006 data

### Other Performance Measures

#### TPL

Deposit all TPL recoveries in the designated state bank account within two (2) banking days of receipt.  
Initiate follow-up activities on unpaid post-payment carrier billings within forty-five (45) days from submission if no response has been received.

## Revenue Collections

Initiate follow-up activities on denied post-payment billings within two (2) business days of receipt of the denial notice.

## Revenue Collections

Complete the verification or validation of TPL and update MMIS with the data within ten (10) business days of receiving the TPL leads from the DHS Income Maintenance Workers.

Ensure ninety-five percent (95%) accuracy of TPL data in MMIS files based on the monthly quality assurance audit of the data.

Maintain a ten percent (10%) benefit to cost ratio for the TPL function. (The revenue collected is at least ten percent (10%) greater than the cost to staff and maintain the contractor's TPL unit).

### **Estate Recovery**

Initiate recoveries within one (1) month of determining that a Medicaid member is deceased and that the member's assets are subject to recovery. The Revenue Collection contractor must wait at least four (4) months after the death of the member before est

Within thirty- (30) days of receiving the report of death, notify the representative of the deceased that there is an amount due DHS as a result of estate recovery.

Provide monthly reports to DHS by the 10th of each month for the preceding month.

## Revenue Collections

Provide the annual report to DHS no later than August 15th of each Contract year

### **Lien Recovery**

Deposit all lien recoveries in the designated state bank account within two (2) banking days of receipt.

Open lien recovery cases within ten (10) business days after correspondence indicating potential subrogation is received

Associate paid Medicaid claims with the trauma case within ten (10) business days of receipt of monthly paid claims files.

File liens within ten (10) business days of associating the Medicaid paid claims with the case.

### **Provider Overpayments**

Deposit refund checks to the designated State bank account within two (2) banking days of receipt.

Provide deposit receipt and check log to DHS within twenty-four (24) hours of depositing the refund checks.

Prepare and process adjustments/voids against refunds and returned warrants within ten (10) business days of receipt of the refund or returned warrant.

For refunds requiring additional information from the provider, enter claim adjustments within five (5) business days of receipt of additional information from the provider.

### **Tax Offset**

Process the Department of Administrative Services Offset Program file within 1 business day of receipt.

## Revenue Collections

Validate the processing of liens within one (1) business day after each payment cycle.

### **Amendment One (eff. 9/29/05)**

1.C.2. Post all information not done so electronically, within one business day of receipt from the state bank, to the system designated to record IowaCare premium information (MIPS).

1.C.6. Report to the Department all third party health insurance coverage information for IowaCare Members and post this information to the Third Party Resource file in the MMIS within ten (10) business days of receipt.

**\*SFY 2006 data is an average of scorecard data from March 2006 through June 2006**

**\*\*Reporting of third party health insurance to the DHS was established in SFY 2008.**

## Provider Cost Audits and Ratesetting

### Key Performance Indicators

	<u>SFY 2006</u>	<u>SFY 2007</u>
State Savings through collection of overpayments or avoidance of overpayments.	\$5,427,557	\$5,725,703
Cost settlements - completed in three months if Medicare institutional provider, twelve months if not	91.25%	90.90%
Quarterly NF rate sheets & budget projections sent timely	98.53%	99.45%

### Other Performance Measures

#### Ratesetting

RFP 6.7.2.2.1 - Settle cost reports for all institutional providers within three (3) months after receipt of the final Title XVIII Medicare cost report or if no Title XVIII Medicare cost report is submitted, within twelve (12) months after receipt of the

RFP 6.7.2.2.3 - For NF, ICFs/MR, RCF and HCBS providers, notify the provider and the Department of the new payment rate by sending a "rate sheet" within two (2) months of the end of the month after receipt of the financial and statistical report.

RFP 6.7.2.2.4 - For NF's a "rate sheet" shall be sent to each NF on a quarterly basis based on the case mix index by the 15th day of the first month of the quarter, including NF budget projections.

## Provider Cost Audits and Ratesetting

RFP 6.7.2.2.6 - The Acuity Analysis Report for Accountability Measures shall be provided to the Department semiannually by February 1 and August 1 of each Contract year. Even though this report is due semiannually, the report is provided to the Department

### **SMAC**

RFP 6.7.2.3.1 and 2 - Complete required reports accurately and timely. Complete all duties in an accurate, complete, timely and professional manner.

A. Provide quarterly report on the savings associated with the SMAC by the 20th day of the month

RFP 6.7.2.3.1 AND 2 - Complete required reports accurately and timely. Complete all duties in an accurate, complete, timely and professional manner.

B. Provide an annual acquisition cost study summary by February 1.

RFP 6.7.2.3.1 and 2 - Complete required reports accurately and timely. Complete all duties in an accurate, complete, timely and professional manner.

RFP 6.7.2.3.5 and 6 - Provide notification to pharmacy providers a minimum of thirty (30) days prior to the effective date of any new drug(s) being added to the SMAC fee schedule and notify providers of any changes in reimbursement rates and any deletion(

## Provider Cost Audits and Ratesetting

### Hospital Rebasing

RFP 6.7.2.4.1 - Ensure a ninety-five percent (95%) accuracy rate in calculations to apportion costs to Medicaid for each hospital submitting Form CMS 2552, Hospital and Healthcare Complex Cost Report, for use in calculating the base, capital cost, direct

RFP 6.7.2.4.2 - Ensure a ninety-five percent (95%) accuracy rate in calculating hospital case-mix indices, inpatient base, capital cost, direct and indirect medical education, and disproportionate share rates and outpatient base and direct medical educati

RFP 6.7.2.4.3 - Ensure a ninety-five percent (95%) accuracy rate in calculating DRG and APG weights when determined using Medicaid paid claims data or when determined based on other negotiated or manually calculated means.

### Revenue Maximization

RFP 6.7.2.5.1 - Provide annual reports of upper payment limit test results and final fiscal analyses for hospital and nursing facility services within 30 days after the beginning of each state fiscal year, applicable (prospectively) for that state fiscal

RFP 6.7.2.5.5 - Respond to requests and inquiries from the Department regarding all Federal Medicaid maximization work within 24 hours of the request.

RFP 6.7.2.5.6 - Draft all policy changes to the Medicaid State Plan, state administrative rules, and provider or employee manuals according to the timeframe required by the Department.

### Professional/Contractual

RFP 6.2.1.5.2 - Produce a fee schedule for Home Health Services as required.

RFP 6.2.1.5.3 - Produce an annual analysis and report of the relationship between Iowa Medicaid payment rates and those of other 3rd party payers each State Fiscal year.

## Provider Cost Audits and Ratesetting

### Amendment Three (eff. 9/25/07)

4.6.1 The performance standards for annual desk reviews and cost settlements for remedial service providers, habilitation waiver service providers and community mental health centers are: a. Settle cost reports within six months after receipt of the submi

4.7.1 The performance standards for the desk review of all providers under the purview of the Iowa Departments of Education (LEA's and AEA's) and Public Health (Infant & Toddler), including cost settlements and calculation of interim rates are:

a. Perform desk reviews of all the Area Education Agency providers (who are under the purview of the Iowa Department of Education) and desk reviews of ten (10) of the Local Education Agency providers by January 31, 2008, using fiscal year ending June 30,

b. Beginning July 1, 2008, perform an annual desk review of all providers under the purview of the Iowa Departments of Education (LEA's and AEA's) and Public Health (Infant & Toddler), including cost settlements and calculation of interim rates, within 9

4.8.1 The performance standards for the development and implementation of a new reimbursement system for outpatient hospital services are:

a. Accurately prepare fiscal impact models to ensure implementation of the APC system is budget neutral or at the funding level appropriated by the Iowa General Assembly for outpatient hospital services.

b. Provide updates to the Medicaid State Plan, Iowa Administrative Code, and Medicaid Provider Manual in a timely manner, so their effective dates coincide with the implementation of the revised reimbursement system.

## Provider Cost Audits and Ratesetting

- c. Ensure that system changes are coordinated with the IME Core Unit and that system testing is completed in a timely manner.

### **Amendment Four (eff. 10/25/07)**

The performance standards for assisting the Department in administration of the IowaCare Program are:

- a. Prepare monthly expenditure analysis within 20 days after the last day of the month.
- b. Prepare annual reconciliation of IowaCare funding sources within 30 days after receipt of the annual Medicare cost report, including all Medicaid supplemental schedules and disproportionate share survey data.

## SURS

### Key Performance Indicators

State funds recovered or cost avoided will be no less than 350% of the State cost of SURS activities.\*

	<u>SFY 2006</u>		<u>SFY 2007</u>
Amount Collected/Cost Avoided (State Dollars):	\$ 805,500	\$	1,768,768
Percent of State cost of SURS activities:	116%		247%
Annually review a random sample of .5% of paid claims:	100.00%		100.00%
Review of all provider types annually:	100.00%		100.00%
Number of Cases Reviewed:	388		512
Disposition of Cases Reviewed:			
Overpayment Recovered: # of cases:	237		255
\$ amount of recoveries:	\$ 865,622	\$	1,336,180
Overpayment Appealed: # of cases:	67		87
\$ amount of appeals:	\$ 4,145,417	\$	859,909
No overpayment Identified: # of cases:	72		164
Referral for Fraud & Abuse Investigation: # of Cases:	12		6
\$ amount of F & A Investigations:	\$ 351,370	\$	12,197

### Other Performance Measures

#### Performance Measurement

#### SURS Activities

In SFY 2006 and each year thereafter, total State funds recovered and cost avoidance recommendations developed by the SURS contractor shall be no less than 350% of the total State cost of SURS Activities. (6.2.1.3)

Annually review a random sample of .5% paid claims. The reviews will involve performing both in-house and field audits (Annual and cumulative.) (RFP MED-04-015, Section 6.6.2.2.4, #24)

## SURS

Open a minimum of 60 cases for provider reviews during each quarter. All cases referred from DHS must be opened in the quarter referred. Review cases must include both providers who exceed calculated norms, and a random sample of providers who do not exce

Index all payments received from providers and entered in OnBase within one (1) business day of the OnBase receipt date. (RFP MED-04-015, Section 6.6.2.2.4, #25)

Develop and coordinate the update of the parameters file on the MMIS to classify providers into peer groups using criteria such as category of services, provider type, specialty, type of practice or organization, enrollment status, facility type, geograph

Identify providers who exhibit aberrant practice or utilization patterns, as determined by an exception process, comparing the individuals' profiles to the limits established for their respective peer groups, reviewing each provider type scheduled in that

(Non-contractual) Reviews of provider types and referrals will be processed in a timely manner by the SURS Unit (Level 1 - 5)

(Non-contractual) Requests for appeals by providers will be addressed and processed in a timely manner by the SURS Unit, per the guidelines set out by the Department of Inspections and Appeals.

(Non-contractual) Proposals for Cost Avoidance Measure submitted by SURS staff members or other entities will be analyzed and addressed with a response for proposed action (including the option of closure) within 30 days of the date the proposal was submi

(Non-contractual) Proposals for Cost Avoidance Measures that have been approved for follow-up action to be implemented by the SURS Unit will be addressed with the identified follow-up action within 45 days of the date that the proposal was approved by the

## SURS

Update operational procedure manuals within two (2) weeks of the implementation of a change (10 business days).  
Provide training on operational procedure changes as a result of upgrades or other changes within two (2) weeks of the upgrade.

Identify deficiencies and provide DHS with a corrective action plan within ten (10) business days of discovery of a problem found through the internal quality control reviews.  
Meet ninety-five percent (95%) of the corrective action commitments within the agreed upon time frame.