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REQUEST FOR INFORMATION NOTICE

The Iowa Department of Human Services (DHS),
will be receiving responses to a
Request For Information (RFI)
Until 3:00 p.m. (Central Time) September 28, 2018 for:

RFI: MED-19-005

Electronic Visit Verification (EVV)

For additional information contact:

Joanne Bush
100 Army Post Road
Des Moines, IA 50315
Phone: 515-256-4887
EVVRFI@dhs.state.ia.us

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Section 1.0 Request For Information

1.1 Purpose

The State of Iowa Department of Human Services ("Department"), Iowa Medicaid Enterprise (IME) is seeking information and feedback from vendors, stakeholders, managed care organizations, members, and constituents on the electronic visit verification (EVV) program. Specifically the IME wishes to receive comments and suggestions on the "Scope of Service" in Attachment A and answers to questions in Section 3.

1.1.1 Background

The Department is responsible for operation of the state Medicaid program under Title XIX of the Social Security Act. The Department operates this program through its business unit, the IME. Currently, approximately 10,000 members are estimated to require EVV for personal care services beginning January 1, 2020. Detailed information on the project and the Agency can be found in the "Project Overview" in Attachment A.

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1.2 Timeline

Below is the tentative timeline for releasing the RFI. The Department reserves the rights to alter, modify, or delete any and all segments and deadlines as it chooses.

a.	Department releases Request For Information	**9/5/2018**
b.	Questions regarding the RFI are due by **3:00 p.m. CST**	**9/14/2018**
c.	IME responses to procedural questions about RFI	**9/21/2018**
d.	Respondents' final written comments due by **3:00 p.m. CST**	**9/28/2018**

1.2.1 RFI Question and Responses Process

The Department requests that any clarifying or procedural questions related to answering this RFI be submitted via email and received by **September 14, 2018 at 3:00 p.m**. All questions must be made in MS Word format and email to the issuing officer at:

Joanne Bush
EVVRFI@dhs.state.ia.us

Responses to the questions will be posted at the State of Iowa's website for bid opportunities: http://bidopportunities.iowa.gov/ on **September 21, 2018**. For clarity and consistency, all questions should reference RFI MED-19-005

Section 2.0 Scope of Service to Consider:

Attached to this RFI, as **ATTACHMENT A,** is a proposed draft of the "scope of services" to be provided by the EVV Vendor selected through the procurement of these services. The Department requests that responders to this RFI review the proposed draft and provide feedback to the Department. Please see Section 4 of the RFI on how to respond and comment on the proposed scope of service and answer questions in Section 3.

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Section 3.0 QUESTIONS

The Department requests that responders to this RFI consider the following general questions. Responders are certainly free to raise other concerns or issue comments on the proposed EVV system in general, but the Department is most interested in perfecting the scope of services as much as possible through this RFI process.

3.1 EVV Services

a. What assurances would members like to see in the EVV Scope of Services from the Department, EVV vendor, and providers?

b. What would members like to see different in the EVV Scope of Services?

c. Potential Bidders, what processes, tools, requirements, and/or elements do you think we are missing, that would assure that Medicaid members in Iowa receive a quality EVV program?

3.2 EVV Implementation and Training

a. What assurances would members and providers like to see regarding training in the EVV Scope of Services?

3.3 General Questions

a. Potential Bidders, what are the pricing methodologies, for capitated rates, that work best for EVV vendors in this industry?

b. Potential Bidders, what are the "cost drivers" that adversely affect State Agencies from managing their EVV programs?

c. Potential Bidders, what technology is utilized for your solution, for example does your solution use .NET or Java? If a cloud-based solution is used, please provide which cloud-based providers your system is compatible with.

d. Potential Bidders, please indicate if customized development is required for the solution that is described in the scope of service. If customized development is required, what percentage of the system needs to be customized?

e. Potential Bidders, is your product available through a state or federal master agreement? If so, please specify.

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Section 4.0 RFI Final Written Responses

4.1 Content of Responses.

Parties interested in submitting final written responses to this RFI (for both answers to the questions in Section 3 and comments related to Attachment A) must submit them by **September 28, 2018, at 3:00 p.m.** to the issuing officer at:

Joanne Bush

EVVRFI@dhs.state.ia.us

Please submit responses with enough detail for the IME to comprehend the information and incorporate suggestions into the proposed RFP.

All responses must be made in MS Word format. Final comments and responses may include:

- Items within the proposed scope that need to be clarified.
- Comments and/or concerns regarding the proposed scope. Please be specific.
- Suggested alternative approaches for IME consideration

All responses are required to have your name, address, e-mail address, and telephone number. If you are a vender, the name, address, e-mail address, and telephone number of your representative to contact regarding all matters concerning this RFI;

- For clarity and consistency, all materials should reference RFI MED-19-005

Section 5.0 GENERAL TERMS AND CONDITIONS

5.1 General Information and conditions

5.1.1 Information is being requested solely to ascertain possible methods, approaches, and solutions associated with this type of expected outcome.

5.1.2 The State of Iowa and the DHS will not enter into a contract with any respondent based solely on the responses provided through this RFI. Should a decision be made to pursue a contract for services related to this RFI, a fair, equitable and competitive process will be done in accordance with State and Departmental procedures.

5.1.3 A respondent's participation in the completion of this response will not be a factor or consideration as part of any subsequent competitive selection process.

5.1.4 Respondents who submitted a response to this RFI will also be notified of any subsequent bidding opportunity. Public notice requirements associated with the respective competitive process will also be completed.

5.1.5 The DHS will not pay for any information herein requested, nor will it be liable for any other costs incurred by the respondent.

5.1.6 The DHS reserves the right to modify this RFI at any time.

5.2 Clarification of Responses.

DHS reserves the right to contact a respondent after the submission of responses for the purpose of clarifying a response to ensure mutual understanding.

5.3 Responses.

All RFI responses become the property of DHS. This is not a competitive process and the contents of all responses will be public information.

5.4 Copyrights.

By submitting a response the respondent agrees that the DHS may copy the response for purposes of facilitating the review or to respond to requests for public records. The respondent consents to such copying by submitting a response and warrants that such copying will not violate the rights of any third party. The DHS will have the right to use the ideas or adaptations of ideas that are presented in the responses.

5.5 Release of Claims.

With the submission of a response, each respondent agrees that it will not bring any claim or have any cause of action against the DHS or the State of Iowa based on any misunderstanding concerning the information provided herein or concerning the DHS' failure, negligent, or otherwise, to provide the respondent with pertinent information as intended by this RFI.

Responses to this Request for Information MED-19-005 must be received on or before **3:00 p.m. CDT** on **September 28, 2018**.

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ATTACHMENT A

DRAFT SCOPE OF SERVICES

Table of Contents

Project Overview
The EVV vendor selected for this project will provide, implement, and support an electronic visit verification system, which verifies that home and community-based services were delivered according to established policies and procedures. The system must utilize multiple technologies to track the time, location, and task performance of direct service and/or in-home workers during service delivery for the purpose of safeguarding against fraud and improving service delivery and program oversight. The system shall interface with the State's Prior Authorization system(s) and Medicaid Management Information System (MMIS) to authorize payment of claims based on verified service delivery and compliance with the policies and procedures associated with the service. CMS certification standards are expected to be released in the coming months. It is the Agency's expectation that EVV vendors meet whatever certifications are released by CMS.

Agency Overview

The Iowa Department of Human Services (the Agency) 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 members under the authority of Title XIX of the Social Security 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 a third MCO will begin operations.

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.

Table 1: Current Iowa Medicaid Population Structure

Eligibility Group	June 2018 Enrollment	Average Monthly Claims Processed *	Delivery System
IA Health Link (including ***hawk-i***)	Medicaid 570,160	2,054,752**	MCOs
	hawk-i 49,478	56,344**	
FFS Medicaid	59,292	219,064	Agency
FFS Dental	300,689	33,829	Agency
Dental Wellness	308,302	27,666	PAHPs
hawk-i Dental (including dental-only)	52,897	5,280 (dental claims only)	PAHP

*Based on claims processed from July 2017 through June 2018.
**claims processed by line, which can include multiple services.

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).

Home and Community-based Services (HCBS) Programs

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

Table 2: Current Iowa Medicaid HCBS Program Enrollment

HCBS Program	August 2018 Managed Care Enrollment	August 2018 FFS Enrollment
AIDS-HIV Waiver	30	0
Brain Injury Waiver	1,279	162
Children's Mental Health Waiver	955	69
Elderly Waiver	7,615	161
Habilitation Program	6,701	66
Health and Disability Waiver	1,895	395
Hospice Program	574	18
Intellectual Disability Waiver	11,257	844
MFP Program	75	7
PACE Program	0	491
Physical Disability Waiver	1,001	18

Personal Care Services in Iowa

Personal care services are provided to members receiving Home- and Community-Based Services (HCBS) through the Consumer- Directed Attendant Care (CDAC) service, Attendant Care service, Homemaker service, Home Health Aide Service or any of the aforementioned services provided through the Consumer Choices Option. The Consumer Choices Option (CCO) is an option that is available under most HCBS waiver programs that gives members control over a targeted amount of Medicaid dollars so that the

member can develop a plan to meet their needs by directly hiring employees and/or purchasing other goods and services. Under the Consumer Choices Option, a contracted Financial Management Services (FMS) provider performs the payroll functions on behalf of the member and pays the direct service workers directly. It is required by CMS that the EVV system will also be utilized for members who have chosen the Consumer Choices Option service delivery option.

CDAC, or attendant care services, are authorized under procedure code S5125 or T1019, Homemaker services are authorized under procedure code S5130, and Home Health Aide services are authorized under procedure codes T1021 and S9122 for members on HCBS waivers. Most months, there are approximately 10,000 members utilizing personal care services.

Home Health Services

Home health services are provided under the state plan, HCBS waivers, and through the consumer choices option. The Agency is still in the process of identifying service codes deemed as home health.

Background of Electronic Visit Verification in Iowa

In Iowa, EVV is being designed to comply with the 21st Century Cures Act and used to monitor the delivery and utilization of personal care and home health services in non-traditional settings by providing verification of the visit with location information and a time stamp. EVV is used to ensure quality and program integrity (PI). In addition to the PI characteristics associated with EVV, the Agency also considers this to be a valuable mechanism to ensure that members are receiving the care they need that is outlined in their service plan. This system can help provide real time alerts when a provider is late or misses a medically necessary service included in a member's service plan.

The following timeline outlines key events in the development of Iowa's electronic visit verification system(s). Additional information on Iowa's implementation status can be found at the state's dedicated EVV webpage: https://dhs.iowa.gov/ime/providers/EVV.

May 19, 2015	House Resolution 2446 is introduced by Representative Brett Guthrie of Kentucky. The bill proposed amends title XIX of the Social Security Act to require use of EVV for personal care services furnished under the Medicaid program.
October 9, 2015	Iowa Medicaid managed care contracts including EVV implementation requirements are signed. Contracts require EVV systems to be developed by MCOs within 180 days from the contract effective date for home and community based services, home health services, hospice, and early and periodic screening diagnosis and

	treatment (EPSDT) services.
September 14, 2016	The Agency issues Informational Letter 1718-MC advising providers of MCO contractual requirements, and proposed implementation in calendar year 2017.
November 1, 2016	The Agency issues Informational Letter 1739-MC advising providers of stakeholder engagement activities, Agency goals, and clarifying that participation in the EVV pilot programs is voluntary. The Agency also extends the project implementation to the Fall of 2017.
December 13, 2016	The 21st Century Cures Act was signed into law by President Obama. The law requires EVV for personal care and home health services. Reductions to the federal medical assistance percentage (FMAP) Medicaid funding will begin in 2019 for states without EVV for personal care services, and in 2023 for states without EVV for home health services.
June 19, 2017	The Agency issues Informational Letter 1805-MC advising Iowa Medicaid Hospice, Home Health Services and Waiver providers of the 21st Century Cures Act passage. The letter also announces the beginning of stakeholder engagement activities, and the launch of the IME EVV provider survey.
September 12, 2017	The first EVV stakeholder workgroup is convened. The workgroup serves to inform decisions on key aspects of the Iowa Medicaid EVV program, and to connect stakeholders with needed information and resources.
November 2017	The Agency releases a Request for Information focused on concerns and proposed solutions emerging from the EVV Stakeholder workgroup.
May 2018	The Centers for Medicare and Medicaid Services releases an EVV FAQ and Informational Bulletin.
August 2018	Legislation is signed delaying EVV penalties until January 1, 2020 for personal care services.

Agency Implementation Strategy

The state will implement EVV using a State Mandated External Vendor Model. In the state mandated external vendor model, states contract with a single EVV vendor to

implement a single EVV solution. The state requires that all MCOs utilize and/ or interface with that system to document services. Providers, individuals and their families may use systems already in place by the provider as long as that system interfaces with the single EVV solution. This model guarantees standardization and access to all data for the state since it uses one vendor. The state has direct involvement in the management and oversight of the EVV program, which should promote compliance with EVV requirements. In addition, this may be less costly for the state than building an EVV system.

There is an administrative burden for states in choosing and contracting with an EVV vendor as well as costs associated with management of the system. Providers and MCOs already operating an EVV system might express concerns with adopting and/or interfacing with a new system. The state and/or its EVV vendor and/or any outsourced EVV vendor must also provide all education and training on the EVV operations, including technical training on use of the system, to individuals, their families, and providers. The state is ultimately responsible for ensuring this occurs. Twelve states report using or have plans to adopt this model: Arizona, Connecticut, Florida, Illinois, Kansas, Mississippi, Montana, Ohio, South Carolina, Washington, West Virginia, and the District of Columbia.

It is anticipated the EVV system will be used for Personal Care Services as described above, during the first year of the contract.

The Consumer Choices Option is a self-directed service delivery option, whereby members may hire and manage their own direct service workers as opposed to receiving personal care services through traditional Medicaid enrolled providers.

Additional services provided through the Medicaid State Plan or waiver programs will be phased-in at the Agency's discretion. The EVV system must be scalable and configurable to add new functional features and support more users in the future without affecting the underlying architecture or performance. The system architecture must be flexible enough to add future desired populations, programs, and services, which have different policies and procedures. The system must be configurable to support the different business rules of multiple programs.

Scope of Service

Scheduling, Billing, and Compliance Capabilities

The EVV system must include the following capabilities:

1) In compliance with the Cures Act, EVV Systems must verify:
    a) The type of service performed;
    b) The individual receiving the service;
    c) The date of the service;
    d) The location of service delivery;

e) The individual providing the service; and
f) The time the service begins and ends.

2) Offer multiple technology options to address recipients receiving services in the home and community including:
   a) Telephony;
   b) Integrated GPS enabled devices to provide visit verification for recipients without a land line but who have cellular service;
   c) Direct service worker timesheets generated for the provider agency;
   d) System to submit billing within 24 hours of service delivery;
   e) Digital Documentation Management System.
3) Provide visit verification that prevents provider abuse or inappropriate billing/payment by collecting recipient and direct service worker information electronically at the beginning and end of services provided in the home. The EVV system must maintain an audit trail that electronically and accurately documents and tracks login and logout times of visits by direct service workers. In addition, the system must allow for multiple in/out activities per day.
4) Provide verification of:
   a) Whether services were provided by providers in accordance with the recipient's service plan and established policies and procedures.
   b) Service tasks performed by the direct service worker.
5) Maintain a response time (to call-in transactions) that shall be less than three (3) seconds for user submitted data for ninety-eight percent (98%) of the transactions.
6) Use biometric voice verification or another proposed method approved by the Agency that provides at least ninety-nine percent (99%) accuracy to assure the correct direct service worker is identified. System must include method(s) for acquiring direct service worker baseline verification information and indicate whether capability is present within the system to determine whether the correct direct service worker is identified with ninety-nine percent (99%) accuracy.
7) Provide multi-level escalating alerts within 10 minutes of late and missed visits to the provider, support coordination agency, and other entities as determined by the Agency (e.g., managed care organization). For instance, the provider is made aware if the worker does not show up so that the provider can schedule an alternate worker or make contact with the recipient.
8) Track and report modifications to the EVV system data input elements after the direct service worker has called in their time or services, including the name of the provider staff making the changes and the reason for changes. The system must have the capability to limit providers' authority to modify service entries or input manual service entries based on program rules which may vary between programs. This may include limiting the number or percentage of manual service entries a provider is allowed to enter.

9) Provide for role-based access controls in a multi-tiered environment that allow the Agency, support coordinators, providers, and managed care organizations to create user roles and assign access to user roles for viewing of appropriate levels of data.
10) Provide real-time visibility, at all levels of authorized users, into the services being provided.
11) Provide for real-time capabilities to record service delivery and task details in home settings and develop an electronic record.
12) Provide an integrated system that includes scheduling, authorization monitoring, visit verification and billing.
13) Receive and store daily updates of member, provider, and plan of care data sent from provider agencies, support coordinators, data-management contractors, and managed care organizations.
14) Provide system architecture that is configurable to support multiple programs or services which have different policies and procedures, reimbursement rates, and business rules, all of which are subject to change during the contract period in response to state and federal regulations, budget appropriations, court proceedings, and other factors. The EVV system should be capable of supporting the following business rules/procedures:
    a) Allow for only certain providers authorized to enter service tasks, based on program needs and rules. Certain programs may require service tasks to be entered in the EVV system for only certain provider types, whereas others may require providers to document service tasks through the current paper process or other alternative process.
    b) Allow for multiple groups or lists of acceptable service task activities to be billed and/or recorded, based on program needs and rules.
    c) Provide for direct service/in-home workers to denote the recipient's status or need for other assistance in the EVV system and to require such notation where necessary based on program needs and rules.
15) Permit the FMS provider to bypass entering a worker schedule in the system.
16) Permit the FMS provider to load various rates of pay for individual direct service workers.
17) Permit certain other providers to bypass entering a worker schedule, based on program-specific rules. Certain programs/services may require providers to enter workers' schedule, whereas other program/services may not require such.
18) Permit recipients to be linked to more than one provider and/or program. Recipients are often eligible for and enrolled in more than one program, each with its own rules, and may have multiple providers within any single program.
19) Enforce the following edit checks:
    a) The same direct service worker is not providing services to multiple recipients at the same time.

b) The same recipient is not receiving the same services from multiple direct service workers at the same time.
c) The service does not overlap with certain other services, which may require interface with the prior authorization system.

20) Handle multiple procedure codes, modifiers, and rates.
21) Allow and enforce multiple service limits for different service ranges (i.e., day, week, month, and year).
22) Permit retroactive prior authorizations and changes to prior authorizations based on revisions to recipients' service plans in accordance with Agency permission levels.
23) Limit providers' authority to modify service information. Program rules as to how many modifications can be made by providers may differ based on the population or service/program.
24) Permit authorizing agency to modify provider/worker schedules, cancel schedules, and receive alerts for monitoring purposes.
25) Permit provider agencies to receive alerts for monitoring purposes.
26) Allow for electronic communication between the Agency and FMS providers.
27) Handle automatic loading of provider and recipient files.
28) Have an architecture model which supports a Business Rules Engine which is easy to maintain and configure. The Business Rules Engine shall allow flexibility supporting Program Policy and Rule changes as they occur and limiting the amount of customization needed in adapting to changes.
29) Have a reliable backup and recovery processes in the event of a system malfunction or disaster situation, as well as provide an alternative for timekeeping due to a provider's failure or inability to use the system for a start or end shift. Provide an emergency back-up system.
30) Securely handle and store sensitive member and provider information in accordance with HIPAA requirements, including the Health Information Technology for Economic and Clinical Health (HITECH) Act amendments.
31) Provide for user support, including support to providers and providing at least a phone-based support for users.

Claims Filing Related Services

The EVV system has the capability of providing the following claims filing services:

1) Ability to round service delivery time in accordance with program requirements.
2) Creating of HIPAA compliant electronic 837 claim file submission in compliance with all Agency filing requirements (i.e., procedure codes, modifiers, Medicaid provider number, etc.)
3) Prior to claims submission, the provider and FMS provider must be able to review claims ready for submission and attest through submission that these are verified provided services.
4) Provide the Agency, providers, and FMS providers with reports of unbilled

encounters through front end edits (i.e., no authorization, expired authorization etc.), reasons that prevented claims from filing, and edits made to claims.

Reports

The EVV system must be able to provide a standard suite of reports to the Agency, CDAC agencies, provider agencies, and managed care organizations. In addition, the system must permit the Agency to use data elements to query and generate ad-hoc reports. The EVV vendor must describe the methodology for generating Ad-Hoc reports and include a sample listing of reports as evidence of the capability of the function. Samples shall include but not be limited to:

1) Direct service worker reporting, including but not limited to service delivery, timesheets, etc.
2) Scheduling reports.
3) Claims filed and unbilled encounters including activity by recipient, agency, CDAC agency, managed care organization, and direct service worker.
4) Claims/Authorizations/Services reconciliation reports.
5) Verified hour reports for payroll.
6) Daily system activity reports including, but not limited to all calls received, calls by recipient, calls by direct service workers, late or missed visits, and unscheduled visits.

Data Retention

The Contractor must agree to retain direct service worker and recipient service data for at least seven (7) years, and the EVV system must have sufficient capacity to allow for recording and storing of all data for at least seven (7) years. In addition, sufficient capacity must be present to allow for future expansion of additional populations or services in the future. The EVV vendor must transmit all raw data elements to the Agency in the format and frequency approved by the Agency.

Training

The EVV vendor must provide initial, refresher, and ongoing system training at least annually to the Agency, providers, support coordinators, and others as deemed necessary by the Agency. The EVV vendor must provide a detailed plan for initial and ongoing role-based training, including a training manual, in-person and Self-Paced Web Based Training Modules. In addition, the EVV vendor must address how questions will be received and answered once the system is up and running.

The EVV vendor must provide providers and agency users with a description of the minimum hardware and software requirements, installation, maintenance and enhancement of software.

Project Work Plan

The EVV vendor must provide a detailed project work plan that clearly identifies all tasks required to implement an EVV system and all timeframes in which each task will be accomplished. The work plan shall include the information described in the Content Work Plan/Project Execution. The EVV vendor shall submit the work plan within 5 days from the start date of the approved contract.

Optional System Features –

The EVV vendor is invited to submit additional optional features, if any, not discussed herein, that may be pertinent to the Agency's needs.

Warranty and Maintenance

The EVV vendor shall submit its warranty and maintenance policy for the system.

Software System Updates

The EVV vendor shall submit its plan, including its communication strategy, for potential software and/or system updates.

System Testing

The EVV vendor shall submit its plan for systems testing including development and operations.

Specific Features for the Agency

The Agency, at its option, may require the successful EVV vendor to tailor the system to specific Medicaid waivers/services. There shall be no additional costs associated with configurations of delivered functionality for those additional features.

Policy and Procedure Manual

Within 30 days after the start date of the operations, the EVV vendor must submit a policy and procedure manual and technical documentation related to the software to the Agency for approval. The policy and procedure manual must be updated as changes occur.

Fraud and Abuse

1) The EVV vendor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. Internal controls must meet current industry standards for known best practices with a progressive view for the future.
2) Such policies and procedures must be in accordance with state and federal regulations. EVV vendor shall have adequate staffing and resources to investigate unusual incidents.

3) Develop and implement corrective action plans to prevent and detect potential fraud and abuse activities.

Technical Requirements
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.

The EVV vendor will be required to transmit all non-proprietary data which is relevant for analytical purposes to the Agency on a regular schedule in XML format. Final determination of relevant data will be made by the Agency based on collaboration between both parties. The schedule for transmission of the data will be established by the Agency and dependent on the needs of the Agency related to the data being transmitted. XML files for this purpose will be transmitted via SFTP to the Agency. Any other data or method of transmission used for this purpose must be approved via written agreement by both parties.

- The EVV vendor is responsible for communicating hardware and software resource requirements which are sufficient to successfully perform the services detailed except expenses designated by the Agency to be the responsibility of the

provider agencies.

- The EVV vendor shall adhere to state and federal regulations and guidelines as well as industry standards and best practices for systems or functions required to support the scope of service.
- The EVV vendor shall clearly identify any systems or portions of systems outlined in the response which are considered to be proprietary in nature.
- Unless explicitly stated to the contrary, the EVV vendor is responsible for all expenses required to obtain access to the Agency systems or resources which are relevant to successful completion of the requirements. The EVV vendor is also responsible for expenses required for the Agency to obtain access to the EVV vendor's systems or resources which are relevant to the successful completion of the scope of service. Such expenses are inclusive of hardware, software, network infrastructure and any licensing costs.
- Any confidential information must be encrypted to FIPS 140-2 standards when at rest or in transit.
- EVV vendor-owned resources must be compliant with industry standard physical and procedural safeguards (NIST SP 800-114, NIST SP 800-66, NIST 800-53A, ISO 17788, etc.) for confidential information (HITECH, HIPAA part 164)
- Any EVV vendor use of flash drives or external hard drives for storage of Agency data must first receive written approval from the Agency and upon such approval shall adhere to FIPS 140-2 hardware level encryption standards.
- The EVV vendor shall comply with the following security requirements:
    - Complete the Agency vendor questionnaire;
    - Provide evidence of SOC 2 certification or at time of contract and annually thereafter, attestation of passed information security risk assessment, passed network penetration scans and web application scans (if applicable);
    - Include Agency Business Associate Agreement (BAA) and Qualified Service Organization (QSO) language;
    - And the FedRamp certification level will be Moderate at the very minimum, with a final determination made at a later date.
- All EVV vendor-utilized computers and devices must:
    - Be protected by industry standard virus protection software which is automatically updated on a regular schedule.
    - Have installed all security patches which are relevant to the applicable operating system and any other system software.
    - Have encryption protection enabled at the Operating System level.
- The EVV vendor shall clearly define how they will adapt to the Agency's architectural conceptual model including:
    - What additional value-add their solution offers.

  - The method through which they will partner with the Agency in the governance of this model.
- The EVV vendor shall engage in robust planning discussions which will drive the technical compatibility of the solution within the Agency infrastructure that will be in place.
- The EVV system shall be MITA 3.0 compliant upon implementation.
- EVV vendor must clearly outline the solution's technical approach as it relates to service-oriented architecture. Descriptions of service-oriented architecture must align with the NIST Definition of Cloud Computing. The NIST Definition of Cloud Computing can be found in NIST Special Publication 800-145. Details should include a description of capability and potential strategy for integration with future Agency-wide enterprise components as they are established, specifically making use of an enterprise service bus for managing touch points with other systems, integration with a master data management solution and flexibility to utilize a single identity and access management solution.

Glossary
The Agency (Agency/the Agency). The Iowa Department of Human Services.

Claim. A formal request for payment for benefits received or services rendered.

CCO. Consumer Choices Option.

CDAC. Consumer Directed Attendant Care.

Centers for Medicare and Medicaid Services (CMS). The agency within the U.S. Department of Health and Human Services that provides administration and funding for Medicare under Title XVIII, Medicaid under Title XIX, and the Children's Health Insurance Program under Title XXI of the Social Security Act. This agency was formerly known as the Health Care Financing Administration (HCFA).

Corrective Action Plan (CAP). A plan designed to ameliorate an identified Deficiency and prevent recurrence of that Deficiency. The CAP outlines all steps, actions and timeframes necessary to address and resolve the Deficiency.

DIA. The Iowa Department of Inspections and Appeals.

Dual Eligible. A member enrolled in both Medicaid and Medicare.

Electronic Visit Verification (EVV) System. An electronic system into which providers can check-in at the beginning and check-out at the end of each period of service delivery to monitor member receipt of HBCS and which may also be utilized for submission of claims.

ETL. Extraction, Transformation, and Load.

FFS. Fee-for-Service.

FMS. Financial Management Services.

Fraud. An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or State law. Fraud may include deliberate misrepresentation of need or eligibility, providing false information concerning costs or conditions to obtain reimbursement or certification, or claiming payment for services which were never delivered or received (see 42 C.F.R. § 455.2).

Home and Community-Based Services (HCBS). Services that are provided as an alternative to long-term care institutional services in a nursing facility or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) or to delay or prevent placement in a nursing facility.

IAC. Iowa Administrative Code.

Long Term Care (LTC) or Long Term Services and Supports (LTSS). The services of a nursing facility (NF), an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/ID), State Resource Centers or services funded through 1915(c) home and community based services waivers.

MCO. Managed Care Organization.

Medicaid. A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving eligible individuals.

Medicaid Management Information System (MMIS). Mechanized claims processing and information retrieval system that all Medicaid programs are required to have and must be approved by the Secretary of DHHS. This system pays claims for Medicaid services and includes information on all Medicaid providers and enrollees.

Member. A Medicaid recipient or a recipient of services provided under the State Children's Health Insurance Program operated by the Agency or an MCO.

MFCU. Medicaid Fraud Control Unit.

OIG. Office of Inspector General.

Performance Measures. Performance measures are specific, operationally defined performance indicators that utilize data to track performance, quality of care, and to identify opportunities for improvement in care and services.

Provider. A health care provider who has entered into a contract with the Agency to provide covered services to members.

Service Authorization. As outlined at 42 C.F.R. § 438.210, the review and consistent authorization or denial of a request by the member, or the member's authorized representative, for a service covered under this Contract to be provided.

Service Plan. Or "care plan." The plan which authorizes services for recipients of HCBS services.

UAT. User Acceptance Testing.

1915(c) HCBS Waiver. Refers to the seven (7) 1915(c) HCBS waivers operated by the Agency as of the release date of this Contract. Includes: (i) AIDS/HIV; (ii) Brain Injury; (iii) Child Mental Health; (iv) Elderly; (v) Health and Disability; (vi) Intellectual Disabilities; and (vii) Physical Disabilities. For purposes of clarification, this definition remains in effect even in the event of a change in waiver authority affecting these covered populations.