CONTRACT DECLARATIONS AND EXECUTION

Procurement Type/Number	Contract #
RFP #MED-22-003	MED-22-003

Title of Contract
External Quality Review Services

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

Agency of the State (hereafter "Agency")

Name/Principal Address of Agency: Iowa Department of Human Services 1305 E. Walnut Des Moines, IA 50319-0114	**Agency Billing Contact Name / Address:** Lisa Burk 1305 East Walnut Des Moines, IA 50319 **Phone:** 515-371-4703
Agency Contract Manager (hereafter "Contract Manager") /Address ("Notice Address"): Lisa Burk 1305 East Walnut Des Moines, IA 50319 **Phone:** 515-371-4703 **E-Mail:** lburk@dhs.state.ia.us	**Agency Contract Owner (hereafter "Contract Owner") / Address:** Elizabeth Matney 1305 East Walnut Des Moines, IA 50319 **E-Mail:** ematney@dhs.state.ia.us

Contractor: (hereafter "Contractor")

Legal Name: Health Services Advisory Group, Inc.	**Contractor's Principal Address:** Health Services Advisory Group 3133 East Camelback Road, Suite 140 Phoenix, AZ 85016-4545
Tax ID #: 860440007	**Organized under the laws of:** Arizona
Contractor's Contract Manager Name/Address ("Notice Address"): Mary Ellen Dalton Health Services Advisory Group 3133 East Camelback Road, Suite 140 Phoenix, AZ 85016-4545 **Phone:** (602) 801-6701 **E-Mail:** mdalton@hsag.com	**Contractor's Billing Contact Name/Address:** Joellen Tenison Health Services Advisory Group 3133 East Camelback Road, Suite 140 Phoenix, AZ 85016-4545 **Phone:** (602) 801-6700

Contract Information

Start Date: 01/01/22	**End Date of Base Term of Contract:** 12/31/24
Possible Extension(s): The Agency shall have the option to extend this Contract up to 3 additional 1-year extensions.	
Contract Contingent on Approval of Another Agency: No	**ISPO Number:** ISPO-20-25
Contract Include Sharing SSA Data? No	**DoIT Number:** N/A

Contract Execution

This Contract consists of this Contract Declarations and Execution Section, the Special Terms, any Special Contract Attachments, the General Terms for Services Contracts, and the Contingent Terms for Service Contracts.

In consideration of the mutual covenants in this Contract and for other good and valuable consideration, the receipt, adequacy and legal sufficiency of which are hereby acknowledged, the parties have entered into this Contract and have caused their duly authorized representatives to execute this Contract.

Contractor, Health Services Advisory Group, Inc.	**Agency, Iowa Department of Human Services**
Signature of Authorized Representative: Mary Ellen Dalton	Signature of Authorized Representative: Kelly Garcia Kelly Garcia (Dec 21, 2021 09:10 CST)
Printed Name: Mary Ellen Dalton, PhD, MBA, RN	Printed Name: Kelly Garcia
Title: Chief Executive Officer	Title: Director
Date: 11/22/2021	Date: Dec 21, 2021

SECTION 1: SPECIAL TERMS

1.1 Special Terms Definitions.
Definitions Specific to this RFP.
When appearing as capitalized terms in this RFP, including attachments, the following quoted terms (and the plural thereof, when appropriate) have the meanings set forth in this section.

"**CAHPS**®" Consumer Assessment of Healthcare Providers and Systems.

"**CDPS**" Chronic Illness and Disability Payment System.

"**CSHCN**" Children with Special Health Care Needs.

"**ECHO**®" Experience of Care and Health Outcomes

"**FSI**" The Family Strain Index.

"**HOS**" Medicare Health Outcomes Survey.

"**Managed care plan**" or "**MCP**". Encompasses managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), and primary care case management (PCCM) entities described in 42 C.F.R. § 438.310(c)(2).

"**NS-CSHCN**" National Survey of CSHCN

"**EPSDT**" Early and Periodic Screening, Diagnostic, and Treatment.

"**External Quality Review**" or "**EQR**" EQR is the analysis and evaluation of aggregated information on quality, timeliness, and access to the health services that an MCP or its contractors furnish to Medicaid beneficiaries [see 42 C.F.R. § 438.320]. EQR can only be conducted by a qualified EQRO

"**External Quality Review Organization**" or "**EQRO**" An EQRO is an organization that meets the competence and independence requirements set forth in 42 C.F.R. § 438.354, and performs EQR, EQR-related activities, or both

"**EQR-related activities**". The activities addressed in these protocols. EQR-related activities produce the data used by an EQRO to complete the annual EQR. EQR related activities may be conducted by the state, its agent that is not an MCP, or an EQRO [see 42 C.F.R. § 438.358]

"Financial Relationship" means—

(1) A direct or indirect ownership or investment interest (including an option or nonvested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest; or

(2) A compensation arrangement with an entity.

"**Hawki**" means Healthy And Well Kids in Iowa, the Iowa program to provide health care coverage for uninsured children of eligible families as authorized by Title XXI of the federal Social Security Act.

"**HEDIS**" Healthcare Effectiveness Data and Information Set

"**Managed Care Organization**" or "**MCO**" means an entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is—
(1) A Federally qualified HMO that meets the advance directives requirements of 42 C.F.R 489 subpart I; or
(2) Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:
(i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.
(ii) Meets the solvency standards of 42 C.F.R 438.116.

"**Potentially Preventable Events or "PPEs**" identify and classify 5 types of health care encounters or events that are potentially preventable and lead to unnecessary services and contribute to poor outcomes quality:
- Potentially Preventable Admissions or "PPAs" mean hospital admissions or long-term care facility stays that might have been reasonably prevented with adequate access to ambulatory care or health care coordination.
- Potentially Preventable Readmissions or "PPRs" mean clinically related return hospitalizations within a set time period that might have resulted from problems in the care during a previous hospital stay or from deficiencies in a post-hospital discharge follow-up.
- Potentially Preventable Emergency Room Visits or "PPVs" mean emergency room visits not resulting in hospital stays, for conditions that could have been treated or prevented by physicians or other health care providers in nonemergency settings.
- Potentially Preventable Complications or "PPCs" mean harmful events or negative outcomes, such as infections or surgical complications, that occur after hospital admissions or long-term care facility stays and might have resulted from the care, lack of care, or treatment provided during the admissions or stays.
- Potentially Preventable Ancillary Services or "PPAs" mean services, including procedures, treatments and other interventions, provided or ordered by physicians or other health care providers to supplement or support the evaluation or treatment of patients that may not provide useful information for diagnosis and treatment (e.g., MRI for back pain).

"**Quality**", as it pertains to External Quality Review, means the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

"**QuICCC- R**" Questionnaire for Identifying Children with Chronic Conditions-Revised

"**SLAs**" Service Level Agreements.

"**Validation**" means the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

1.2 Contract Purpose.
The purpose of this Request for Proposal (RFP) is to solicit proposals that will enable the Department of Human Services (Agency) to select the most qualified contractor, demonstrating competence and independence requirements set forth in 42 C.F.R. § 438.354, to conduct External Quality Reviews (EQR) and other related activities for the Agency's Medicaid Managed Care Plans (MCPs).

The Agency's desired result is to improve the health of Iowans by:
1. Monitoring the quality of care to consumers;
2. Monitoring consumer satisfaction;
3. Monitoring provider satisfaction;

4. Monitoring the accessibility of care for eligible recipients; and
5. Measuring the performance and cost-effectiveness of MCPs administering the Iowa Medicaid and Children's Health Insurance Program (CHIP) programs.

The overall goal of the contract resulting from this RFP is to develop an integrated approach to quality assessment and improvement that leads to measurable quality improvement initiative in all areas of managed care contracting and service delivery.

1.3 Scope of Work.

1.3.1 Deliverables.

The Contractor shall provide Deliverables which include, but may not be limited to, the items described below. The Agency anticipates that many of the meetings required as part of the scope of work will be conducted virtually as a results of the continuing COVID-19 pandemic. The Contractor's approach to achieving the following deliverables shall include the use of an Agency approved virtual meeting platform(s) that provides for video and ensures that contractor staff participate with video enabled. The Agency reserves the right to request face-to-face meetings. When face-to-face meetings are required, CDC guidelines will be followed as appropriate.

1.3.1.1 General Obligations

A. EQRO qualifications

1. *Independence*. The Contractor and its subcontractors must be independent from the Agency and from the MCPs entities (described in 42 C.F.R. § 438.310(c)(2)) that they review. To qualify as "independent" the Contractor must meet all the stated requirements under this section:
    a. If the Contractor is a State agency, department, university or other State entity: the Contractor:
        i. May not have Medicaid purchasing or managed care licensing authority; and
    b. Must be governed by a Board or similar body the majority of whose members are not government employees.
    c. The Contractor **MAY NOT**:
        i. Review a particular MCP or a competitor operating in the State, over which the Contractor exerts control or which exerts control over the Contractor (as used in this paragraph, "control" has the meaning given the term in 48 C.F.R. § 19.101) through:
            1. Stock ownership;
            2. Stock options and convertible debentures;
            3. Voting trusts;
            4. Common management, including interlocking management; and
            5. Contractual relationships.
        ii. Deliver any healthcare services to Medicaid recipients;
        iii. Conduct, on the State's behalf, ongoing Medicaid managed care program operations related to oversight of the quality of MCP services, except for the related activities specified in 42 C.F.R. § 438.358; or
        iv. Have a present or known future, direct or indirect financial relationship with an MCP entity that it will review as a Contractor.
2. *Competence*. The Contractor shall meet the competence requirements of 42 C.F.R. § 438.354 and provide staff to perform all tasks specified in the Contract. The Contractor must have the following:
    a. Staff with demonstrated experience and knowledge of:
        i. Serving Medicaid recipients, handling Medicaid policies, data systems and processes;
        ii. Managed care delivery systems, organizations, and financing;

iii. Quality assessment and improvement methods; and
iv. Research design and methodology, including statistical and financial analysis.

b. Sufficient physical, technological, and financial resources to conduct EQR and EQR-related activities; and
c. Other clinical and non-clinical skills necessary to carry out the duties of the EQRO.

B. Staff Skills and Experience

1. The Contractor shall ensure staff performing services under this Contract have clinical skills in both medicine and dentistry, as well as experience in:
   a. Statistics;
   b. Economics;
   c. Encounter data analysis, including the use of one or more of the following case-mix adjustment systems:
      i. Chronic illness and disability payment system;
      ii. Adjusted clinical groups
      iii. Diagnostic cost groups
      iv. Clinical risk groups; and
      v. Global risk assessment model

   d. Encounter data certification and validation, to ensure that data is complete and accurate to support quality management and rate-setting premium payments analysis and calculations;
   e. Research and writing for publication on healthcare issues;
   f. Clinical evaluation competence or direct contract access to such competence in areas such as:
      i. Pediatrics;
      ii. Long-term services and supports;
      iii. Acute care;
      iv. Behavioral health (substance use disorder and mental health);
      v. Chronic illness and disability;
      vi. Complex special healthcare needs;
      vii. Dental care;
      viii. Women's health; and
      ix. Pharmacy services.
   g. Using or analyzing data and performance in one or more of the following performance measurement systems and software:
      i. Health Employer Data Information Set (HEDIS);
      ii. Children with Special Health Care Needs (CSHCN) Screener;
      iii. Items from the National Survey of CSHCN (NS-CSHCN) addressing issues of transition to adult care;
      iv. Questionnaire for Identifying Children with Chronic Conditions-Revised (QuICCC-R);
      v. Chronic Illness and Disability Payment System (CDPS);
      vi. Consumer Assessment of Healthcare Providers and Systems (CAHPS®);
      vii. CAHPS® Clinician and Group Surveys;
      viii. RAND Quality Care Measurement System;
      ix. The Experience of Care and Health Outcomes (ECHO®) Survey;
      x. The Family Strain Index (FSI);
      xi. Medicare Health Outcomes Survey (HOS);
      xii. Systems developed by the Contractor to collect member and caregiver demographics and household characteristics; and
      xiii. Other systems recommended by the Contractor.

2. The Contractor shall ensure staff performing services under this Contract are skilled in or have access to expertise in medical record review, survey implementation and techniques, statistics and economics to support Agency quality and performance analysis, and rate-setting activities. Staff must have the ability to research and analyze the clinical aspects of healthcare delivery which affect populations of special concern to the Agency, including:
    a. Children under 21 years of age, including children with special healthcare needs and the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services;
    b. Individuals receiving LTSS, including those participating in home and community-based services; and
    c. Persons with behavioral health (substance use disorder and mental health) diagnoses.

C. Project Management

1. The Contractor shall designate one Project Manager, who will be dedicated to the Contract full time.
2. The Agency reserves the right to interview any and all candidates for the Project Manager position prior to approving the candidate.
3. The requirements for the Project Manager are as follows:
    a. Be available to meet with the Agency's management, policy staff and contract manager to respond to questions and concerns related to the Contract during normal Agency Business Hours. The Project manager shall be available to attend meetings in person as determined by the Agency.
    b. Project Manager positions are required to communicate absences with the Agency contract manager and provide suitable coverage during extended absences;
    c. Provide policy advice and support to the Agency and participate in meetings with the Agency as subject matter expert;
    d. Prepare and present status updates periodically to the Agency and other stakeholders, as requested by the Agency;
    e. Comply with all timelines in the Agency-approved project work plans; and
    f. Represent the Contractor in terms of day-to-day negotiations and resource allocations, and be the primary liaison with the Agency; and
    g. Develop and maintain a plan for job rotation and knowledge transfer to ensure that all functions can be adequately performed during the absence of the project manager for vacation and other reasons.
4. The Contractor shall ensure staff are trained and able to perform the functions of sensitive positions when the Project Manager is absent.
5. The Contractor shall develop and maintain, subject to Agency approval, standardized reports that may be necessary to implement the project.
6. The Agency reserves the right of prior approval for any replacement of the Project Manager.
7. The Contractor must commit the project manager to the project on or before the conclusion of the transition period of the Contract and for at least six months, and must not replace the project manager during this period except in cases of termination, death, or the key person's resignation;
8. The Contractor shall provide the Agency with a minimum of 15 days' notice prior to any proposed transfer or replacement of the project manager. At the time of providing notice, the Contractor shall also provide the Agency with the resumes and references of the proposed replacement of named key personnel;
9. Replacement personnel must be in place performing their new functions before the departure of the personnel they are replacing;
10. Replacement personnel shall have knowledge transfer, experience, and ability comparable to the person originally in the position; and
11. The Agency may waive requirements (a) through (d) and 8 through 9 upon presentation of good cause by the Contractor. In those instances when good cause is granted, the Contractor commits

to replacing key personnel within thirty days (30) of the departure of a key person and to providing temporary personnel in the interim that are capable of maintaining operational performance at acceptable levels.

D. System Requirements

1. The Contractor shall maintain a system, as necessary, to support all EQR functions, including the ability to interface with data sources as determined by the Agency.
    a. System shall be compatible with any legacy and current patient-level Medicaid and CHIP encounter and claims data, member eligibility, provider, and other applicable data required to perform all activities required in the Scope of Work;
    b. Contractor shall perform system quality assurance and testing in accordance with Agency-approved work plan; and
2. The Contractor shall perform ongoing data collection, data analysis, and data transfer in accordance with Agency-approved work plan;
3. The Contractor shall meet Agency and the State of Iowa's Enterprise security standards for data collection, storage, and secured electronic transmissions. This includes, but is not limited to use of at minimum 256-bit encryption for both authentication and data transmission. See Attachment G, Section 1.8.1 – General Terms for Service Contracts (Section 2.8.6).
4. The Contractor shall develop and maintain an Agency approved interface control document describing the data exchange and processing necessary to implement and operate the EQR service functions, interfaces necessary for electronic transmissions of data files, processing rules, and required sequence of data to manage the services. Contractor shall consult with the Agency data management staff in developing this document.
5. The Contractor shall develop and maintain an Agency approved disaster recovery plan and data backup plan that addresses recovery of business functions, business units, business processes, human resources, and the technology infrastructure. The Contractor shall protect against hardware and software failures, human error, natural disasters, and other emergencies that could interrupt services and operations.
6. The Agency will support this activity by providing the Contractor with the following information:
    a. Provider files in the specified format;
    b. Enrollment files in the HIPAA 834 format;
    c. Encounter data files in the HIPAA 837 format;
    d. State requirements for collection and submission of encounter data by the MCPs;
    e. Encounter data format specifications;
    f. The Agency data dictionary;
    g. Flow chart of data from the MCP to the Agency;
    h. Agency standards for MCP encounter data completeness and accuracy;
    i. Timeframes for encounter data submission; and
    j. Thresholds for acceptable rates of accuracy and completeness for each data field of MCP encounter data.

1.3.1.2 Transition Phase

A. Planning The Contractor shall develop, maintain and comply at all times with the following:

1. Project work plans.
    a. Project work plans shall include:
        i. A transition plan detailing Contractor’s strategy to implement the staff, systems, applications, software and services contemplated by this Contract;
        ii. An operations plan detailing the daily performance of all required activities by the Contractor, including required coordination and safeguards;
        iii. A communications plan specifying expectations for all parties involved. This plan shall be developed in consultation with the Agency;
        iv. Defined deliverables and outcomes;

v. Timeframe in which each activity will be completed;
b. The work plan shall be updated at a minimum monthly.

2. Reporting plan. A reporting plan detailing requirements for submitting report to the Agency. This plan shall be developed in consultation with the Agency.
   a. Reporting plan requirements include, but are not limited to:
      i. Use of standard naming conventions;
      ii. Templates for standardized reports that may be necessary to implement the project. The Contractor shall revise report contact as needed and upon Agency request;
      iii. Use of the Agency-designated SharePoint site to upload reports, with link sent to relevant Agency staff via email;
      iv. Detail of whom the reports should be delivered to for review and approval, as necessary;
      v. Frequency and due dates for reports;
3. Standard operating procedures (SOPs). SOPs shall be maintained in the Agency-prescribed format using standard naming conventions in the documentation.
   a. SOPs shall document the processes and procedures used by the Contractor in the performance of its obligations under this Contract, including but not limited to:
      i. Notification and issue escalation procedures and timelines; and
      ii. Policy manuals required for all EQR functions.
   b. SOPs shall be updated with any changes to the methods and procedures used by the Contractor in the performance of its duties under this Contract.
      i. The Contractor shall document all changes within 30 business days of the change.
      ii. The Contractor shall use version control to identify the most current documentation and any previous versions, including their effective dates.
      iii. The Contractor shall provide all documentation in electronic form and store all documentation within the Agency-designated repository.
   c. SOPs shall be reviewed with the Agency no less than annually and shall be made available to the Agency upon request.

B. Meetings. The Contractor shall participate in the following related to the scope of work performed by the Contractor:

1. Meetings with the Agency:
   a. Regular contract and status meetings or discussions with the Agency;
   b. Meetings to develop final annual work plan and timeline for all EQRO activities and deliverables for the contract year;
   c. Meetings to review and discuss contract milestones agreed upon in the work plan;
   d. Meetings to discuss contract audits and audit findings;
   e. Meetings to develop Agency, MCP, or stakeholder training and special forums; and
   f. Meetings to develop annual performance improvement projects with the Agency and MCPs.
2. Conducting specific meetings with an MCP:
   a. Prior to initiating any meeting with an MCP, the Contractor shall develop an agenda for review and approval by the Agency;
   b. If the meeting is a result of an analysis conducted by the Contractor of the MCP, the Contractor shall provide a preliminary report/finding to the Agency for review and discussion, prior to providing the preliminary findings to the MCP;
   c. The Contractor shall provide the Agency with an annual onsite MCP visit calendar; and
   d. The Contractor shall lead or participate in other meetings as needed, with advocates, members, or other stakeholders as requested by the Agency.
3. The Contractor shall have subject appropriate staff members attend meetings or conference calls as requested and required by the Agency to no additional cost.

C. Reporting

1. For Section 1.3.1.3 Protocols 1-5 combined, and including each of Protocols 6-8 that are requested by the Agency as part of an External Quality Review of the MCP the Contractor shall:
    a. For each MCP, provide preliminary results to the managed care organizations;
    b. For each MCP, develop and submit a draft report to the Agency within a timeframe designated by the Agency;
    c. For each MCP, develop and submit a final report to the Agency within a timeframe designated by the Agency; and
    d. For each MCP, review and submit an updated MCP score card to the Agency within a timeframe designated by the Agency; and
    e. Submit a comprehensive, aggregated summary report to the Agency of all MCP findings.
2. Ad Hoc Reports.
    a. The Agency may request up to three (3) additional ad hoc reports that may utilize the data from the Agency's data sources. The Contractor shall analyze the data and produce the report as requested by the Agency. The Agency shall work with the Contractor to establish the analysis and reporting requirements.
3. At the completion of any studies or analyses of MCP quality or performance, the Contractor shall work collaboratively with the Agency to present the final report to the MCP and may assist in development and monitoring of any resulting performance improvement plan.

1.3.1.3 EQR Key Deliverables

A. Mandatory EQR-related activities. The Contractor shall perform the following activities:

1. Protocol 1: Validation of Performance Improvement Projects (PIPs)
    a. Annual Process for PIPs required by the Agency that were underway in year one and during the preceding twelve (12) months on an ongoing basis:
        i. Contractor shall assess the study methodology;
        ii. Contractor shall verify PIP study findings and, if feasible:
            1. The Agency may elect to have the Contractor verify PIP findings on an ad hoc basis when the Agency has special concerns about data integrity; and
            2. Contractor shall validate the processes through which data needed to produce quality measures were obtained, converted to information, and analyzed;
                a. If the PIP uses HEDIS® measures that have been certified by a third party, this step is not needed.
        iii. Contractor shall evaluate overall validity and reliability of PIP study results.
    b. The number of PIPs to be submitted per MCP is to be determined by the Agency, There will be a minimum of two (2) per MCO and two (2) per PAHP but more than two (2) PIPS may be required by the Agency.
    c. Contractor shall solicit input from MCPs in the identification of PIP topics and methodologies and propose MCP performance improvement projects, subject to Agency approval.
    d. Contractor shall include PIP outcome and trending information in the annual EQR technical report for submission to CMS.
    e. Contractor shall submit the validation report to the Agency. If a measure applies to children, the validation report shall break measures out by Medicaid and CHIP.

2. Protocol 2: Validation of Performance Measures
    a. The Contractor shall use national standards to validate and report findings on MCP performance measures and outcomes. The validation shall include the whole process from the initial source point through the final reporting.

b. The Contractor shall develop an annual process to determine the accuracy of the performance measures reported by the MCP in year one and during the preceding twelve (12) months on an ongoing basis:
    i. The Contractor shall complete the following tasks prior to individual MCP review or analysis:
        1. Define the scope of the validation by confirming Agency-required technical specifications for each of the performance measures and Agency requirements for performance measure reporting;
        2. Assess the integrity of the MCP's Information System;
        3. Select measures for detailed review;
        4. Initiate review of medical record data collection; and
        5. Prepare for the MCP onsite visit.
    ii. The Contractor shall conduct individual MCP onsite visits to include follow up on findings from the pre-onsite information system assessment and validation of the production and reporting of performance measures through document review or direct observation, including:
        1. Review information system underlying performance measurement;
        2. Assess data integration and control for performance measure calculation;
        3. Review performance measurement production;
        4. Conduct detailed review of selected measures;
        5. Assess the sampling process; and
        6. Review preliminary findings and outstanding items
    iii. The Contractor shall complete the following tasks after individual MCP onsite visits:
        1. Determine preliminary validation findings for each measure;
        2. Assess accuracy of MCP's performance measure reports to the agency; and
        3. Submit validation report to the Agency. If a measure applies to children, the validation report shall break measures out by Medicaid and CHIP.

3. Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations:
    a. The Contractor shall contact each participating MCP at least six (6) months in advance of the onsite review and work with the Agency and each MCP to select a date (or dates if necessary) for the onsite review.
    b. The Contractor shall conduct a review that follows the standards contained in 42 C.F.R 438, Subparts D and E. The scope of the standards are:
        i. Availability of services §438.206;
        ii. Assurances of adequate capacity and services §438.207;
        iii. Coordination and continuity of care §438.208;
        iv. Coverage and authorization of services §438.210;
        v. Provider selection §438.214;
        vi. Confidentiality §438.224;
        vii. Practice guidelines §438.236;
        viii. Grievance and appeal process §438.228;
        ix. Health information systems §438.242;
        x. Quality assessment and performance improvement program §438.330;
        xi. Sub contractual relationships and delegation $438.230;
        xii. Mechanisms to detect under- and over-utilization of services;
        xiii. Credentialing for long-term services and supports (LTSS) providers.

c. The Contractor shall conduct annual interviews and onsite visits to determine MCP compliance with federal and state standards for access to care, structure and operations, and quality measurement and improvement (i.e., Administrative Interviews).
d. Contractor shall perform an exit interview at the conclusion of the site visit with MCP staff to clarify the EQRO's understanding of the information collected throughout the compliance review process.

4. Protocol 4: Validation of Network Adequacy
    a. In accordance with the access standards set out in the MCP contract, the Contractor shall collaborate with the Agency to review and define the Network Adequacy Validation activities for each contract year. The Contractor will perform one of the following activities in a given year:
        i. Conduct an analysis that includes reviewing and determining the usefulness of the provider network files for each MCP provided by the Agency, determining the specific data submission requirements and parameters that MCPs must follow to submit data to the Contractor, determining the parameters of the study based on the data available, and determining the timeline for the completion of the study. Analyze the provider network files submitted by each of the MCPs. The analysis shall track the geographic distribution of providers and hospitals in comparison to the number of Medicaid and Hawki enrollees served in a particular coverage area by the MCPs as well as the distance and time needed to get to the provider. Any MCP that does not have adequate access to providers, including hospitals, in coverage area shall be identified.

        ii. The Contractor shall conduct phone calls to a sample of primary care providers for each MCP to ascertain whether the providers are accepting new patients who are enrolled in the Medicaid and Hawki programs. The responses obtained from the phone survey calls shall be compared to the data provided by the MCPs on their provider file to validate the information. The Contractor shall work with the Agency to develop the appropriate statistically valid sample size for the survey and the timeframe for conducting the survey.

    b. The Contractor shall also:
        i. Submit to the Agency a report using maps and written descriptions of the results of the analysis. The report shall contain a separate map of each provider group. The report shall contain the results of the phone survey.
        ii. The provider network analysis activities to be performed will be done in accordance with appropriate federal requirements, including but not limited to 42 C.F.R Section §438.206.
    c. Contractor shall report the EQR results to the Agency. The provider network analysis shall be submitted separately as a stand-alone report.

5. Protocol 5: Validation of Encounter Data Reported by the Medicaid and CHIP MCP
    a. The Contractor shall conduct an annual validation of encounter data submitted by each MCP, and any other capitated Medicaid programs implemented during the contract period. This validation shall occur concurrently with activities listed in Section 1.3.1.3 A. The Contractor shall utilize the CMS protocol for determination of the accuracy and completeness of MCP encounter data and prepare an annual encounter data validation report for all programs that includes medical record reviews to validate performance and compliance

b. The Contractor shall complete on an annual basis the following tasks prior to examining data produced by the MCP's information system:
    i. Review the state requirements for collection and submission of encounter data by the MCPs;
    ii. Review the MCP's capability for collecting accurate and complete encounter data
    iii. Review the MCP's Information Systems Capabilities Assessment (ISCA); and
    iv. Interview MCP personnel
c. The Contractor shall review or conduct an ISCA to determine where the MCP's information systems may be vulnerable to incomplete or inaccurate data capture, integration, storage, or reporting:
    i. The Contractor shall determine if the MCP has already undergone such a review and if the review findings are current.
    ii. If a recent ISCA has been conducted, the Contractor shall obtain a copy of the findings.
    iii. If the MCP has not recently undergone an ISCA, the Contractor shall conduct one consistent with the EQR Protocols:
        1. The Contractor shall provide the MCP a copy of the ISCA to complete. The MCP will complete the ISCA and provide supporting documentation to the Contractor within thirty (30) days
    iv. The Contractor shall review the completed ISCA and supporting documentation to assess the adequacy of the MCP's policies and procedures. The MCP's answers shall be evaluated against state standards for:
        1. MCP information systems;
        2. Calculation and reporting of specific MCP performance measures; and
        3. Collection and submission of encounter data to the Agency.
    v. If a MCP answer does not sufficiently answer the question or does not appear to sufficiently meet process requirements, the Contractor shall note for follow-up and review further during the onsite review.
    vi. The Contractor shall conduct an onsite review of the MCP information system and interview MCP information technology staff. The review shall include, but is not limited to, processing of all HIPAA 837 Professional and 837 Institutional sample of cases.
    vii. The Contractor shall conduct follow-up interviews with MCP staff responsible for completing the ISCA and additional staff responsible for the MCP's information system functions. Contractor-facilitated interviews shall focus on topics outlined in the ISCA interview guide with additional topics covered as necessary.
    viii. The Contractor shall analyze information obtained through ISCA and follow-up interviews and submit a written report of findings to the Agency about the MCP's information system and implications of the information systems review. Analysis, in a format approved by the Agency, shall include:
        1. Completeness and accuracy of encounter data collected and submitted to the Agency;
        2. Calculation and validation of performance measures;
        3. Ability of the MCP to conduct quality assessment and improvement initiatives; and
        4. Ability of the MCP to oversee and manage the delivery of health care to plan enrollees.

ix. The Contractor shall analyze encounter data and perform a series of checks to assess whether the encounter data can be used for analysis. The review shall include:
    1. Encounter and enrollment data;
    2. A focus on finding missing and erroneous data;
    3. Comparison of the findings to state standards and comparison error rates;
    4. Analysis of the completeness of encounter data over time; and
    5. Calculation of utilization rates.

x. The Contractor shall develop and implement a plan, subject to Agency approval, for assessing data quality and standard processes for analyzing electronic encounter data.

xi. The Contractor shall review medical records:
    1. If the Contractor is unsure of the quality of the encounter data at the completion of the previous activity, it should not proceed to the medical record review activity. Rather, the Contractor shall repeat the previous activity or seek additional information until the Contractor is able to determine quality and usefulness of the submitted encounter data.
    2. Consistent with the federal EQR Protocols previously cited, the Contractor must undertake annual medical record reviews as part of encounter data validation and for those HEDIS® measures that require medical record review to calculate performance and compliance rates.
    3. These reviews must be conducted in accordance with state and federal HIPAA privacy and confidentiality statutes and regulations. The Agency will utilize the expertise of the Contractor in determining the number of records (sample size) that must be reviewed with consideration to appropriate statistical models and the topic under review or study.

xii. The Contractor shall use data available, including the Medicaid provider master file for address and other information to generate correspondence and mail-outs for purposes of data validation.

xiii. The Contractor shall track compliance with requests and accuracy of address information to improve the validation process.

xiv. The Contractor shall submit findings of encounter data validation review including, but not limited to, the following elements:
    1. A narrative report of findings;
    2. Data tables illustrating findings;
    3. Summary of statistics for each activity of the review; and
    4. Highlighted issues related to the accuracy and completeness of the encounter data reviewed.

B. Optional EQR-related activities. At the Agency's request the Contractor shall perform the following activities:

1. Protocol 6: Validation of MCP Enrollee and Provider Surveys.
    a. The Contractor shall validate and report on MCP enrollee and provider surveys of quality of care, including surveys that focus on satisfaction and experience with healthcare services, and particular aspects of clinical or non-clinical services, as determined by the Agency. The Contractor shall:
    b. Conduct validation of MCP survey results shall include, but is not limited to:
        i. Evaluation of the MCP sampling methodology;
        ii. Evaluation of the MCP survey administration methodology;
        iii. Evaluation of the MCP data collection process;

iv. Evaluation of the soundness of the specified survey results by verifying whether the data for the survey results are accurately produced, calculated, and reported; and
v. Assessment of whether the MCPs have addressed quality improvement recommendations from previous reviews.

c. Submit the survey validation report to the Agency.

2. Protocol 7: Calculation of Additional Performance Measures
   a. The Contractor shall, in consultation with Agency staff, review and periodically propose new performance measures to improve MCP performance or meet new state mandates and objectives. These performance measures shall be included on the MCP scorecards each year. The Contractor shall:
      i. Review state performance measure requirements;
      ii. Outline its performance measure calculation activities and provide to the MCP:
         1. A list and description of the State-required performance measures it plans to calculate;
         2. A list of documents that the Contractor will need to review; and
         3. A list of information the Contractor may need about the MCP's structure and capacity to supply the data needed to calculate the performance measures.
      iii. Review the MCP's Information System Capability Assessment (ISCA);
      iv. Calculate measures of MCP performance in accordance with State technical specifications and EQR Protocols:
         1. Consistent with federal guidelines, the measures and objectives must be clear and verifiable;
         2. For each performance measure, the Contractor shall construct a companion performance measurement worksheet that contains the technical specifications for the measure, benchmarks, performance standards, or any other information needed to analyze the performance measure according to the Agency's requirements; and
         3. The Agency has a particular interest in the Medicaid and CHIP core set of pediatric and adult measures identified by CMS in the Children's Health Insurance Program Reauthorization Act of 2009, (CHIPRA) and the Affordable Care Act of 2010. Also of interest are measures and objectives relating to long-term services and supports, behavioral health, and PPEs.
      v. Submit a report to the Agency on the MCP's performance compared to Agency-established benchmarks or performance standards.

3. Protocol 8: Implementation of Additional Performance Improvement Projects (PIPs)
   a. In consultation with Agency staff, the Contractor shall evaluate and periodically propose new PIP to improve MCP performance or meet new state mandates and objectives. The Contractor shall:
      i. Select the study topic(s), the Agency has a particular interest in PIPs that address some of the national health priorities CMS has identified (e.g., Partnership for Patients, Million Hearts Campaign, pediatric oral health, and childhood obesity).
      ii. Define the study question(s);
      iii. Use a representative and generalizable sample;
      iv. Select the study variables(s);
      v. Use sound sampling methods (if sampling is used);
      vi. Reliably collect data;

vii. Analyze data and interpret study results;
viii. Implement intervention and improvement strategies;
ix. Plan for "real" improvement;
x. Achieve sustained improvement; and
xi. Submit a report to the Agency on performance improvement results.

4. Protocol 9: Conducting Focus Studies of Health Care Quality
    a. The Contractor shall conduct focused; one-time studies on a particular aspect of clinical and/or non-clinical services at a point in time, for quality improvement (QI), administrative, legislative, or other purposes. The Contractor shall:
        i. Select the study topic(s);
        ii. Define the study question(s);
        iii. Select the study variable(s);
        iv. Study the whole population or use a representative sample;
        v. Use sound sampling methods;
        vi. Reliably collect data;
        vii. Analyze data and interpret study results; and
        viii. Report results to the Agency.
5. Other Optional EQR-related Activities
    a. The Contractor shall conduct a comparative analysis utilizing the reports issued in compliance with the Scope of Work (i.e. Protocols 1-8). The Contractor shall:
        i. Identify utilization trends, access issues, or other issues that may have an impact on Medicaid and CHIP enrollees. For example, if the provider analysis report indicates a shortage of providers in a certain area of the state, the comparative analysis should analyze whether or not the EQR also shows an access issue and whether this is reflected in encounter data.
        ii. Report results to the Agency identifying any finding from the analysis and make recommendations to the Agency for actions that may be needed.
    b. The Contractor shall conduct a Validation of MCP quality management/quality improvement (QM/QI) plans. Each contracted Medicaid/ CHIP MCP must have a comprehensive ongoing QM/QI program in place. As part of this QM/QI program, each MCP is required to develop and maintain an annual and prospective five (5) year QM/QI work plan that sets measurable goals, establishes specific objectives, identifies the strategies and activities to be undertaken, monitors results and assesses progress toward the goals. The Contractor shall:
        i. Review and evaluate these plans consistent with the federal EQRO Protocols previously cited; and
        ii. Report results to the Agency and make recommendations to the Agency for design improvements to current MCP QM/QI plans.
    c. The Contractor shall work in conjunction with the Agency and MCPs to develop a global quality strategy plan. The Contractor shall:
        i. Submit the quality strategy plan to the Agency for approval;
        ii. Review the quality strategy plan consistent with the federal EQRO Protocols previously cited, and update as needed. The quality strategy plan shall include, but is not limited to:
            1. Identification of quality indicators;
            2. Establishment of benchmarks, goals and validation of outcome measurements;
            3. Identification of PIP topics and methodologies so that relevant clinical, administrative, and population-based improvement efforts are addressed

as part of the Agency's overall strategy to improve health care delivery and outcomes.

4. Conducting studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time; and

d. Coordination of the Centers for Medicare and Medicaid Services (CMS) outcome measures with MCPs.

e. The Contractor shall invoice for this activity under Protocol 9.

C. Conducting the Annual EQR. The Contractor shall perform the following activity:

a. Contractor shall perform an annual EQR of each contracted MCP and any other capitated Medicaid and CHIP programs implemented during the contract period, pursuant to the requirements of 42 C.F.R 438 Subpart E. The EQR shall include the following:

i. A detailed report that, at minimum meets the requirements of 42 C.F.R. §438.364(a)(1);

ii. An assessment of each MCP's strengths and weaknesses with respect to the quality, timeliness, and access to healthcare services furnished to Medicaid and Hawki recipients;

iii. Recommendations for improving the quality of healthcare services furnished by each MCP;

iv. Methodologically appropriate, comparative information about all MCPs; and

v. An assessment of the degree to which each MCP has addressed effectively the recommendations for quality improvement made by an EQRO during the previous year's EQR.

b. The Contractor shall conduct the annual EQR using the most current CMS protocols within timeframes established in the Agency-approved work plan. The Agency preference is for EQRs to be conducted no earlier than August of each year.

c. The Contractor shall invoice for this activity under Protocol 3.

D. Conducting Other EQR-Related Activities. The Contractor shall perform the following activities:

a. The Contractor shall calculate and report Potentially Preventable Events (PPEs), to include admissions (PPAs), readmissions (PPRs), emergency room visits (PPVs), complications (PPCs), and ancillary services (PPSs).

i. The Contractor shall invoice for this activity under Protocol 4.

b. The Contractor shall annually review and update MCP score cards, as defined by the Agency.

i. In collaboration with the Agency, the Contractor shall develop a MCP score card and report to the Agency the MCP's performance compared to State-established benchmarks or performance standards. The purpose of the scorecard is to allow new members to easily compare health plans across quality domains when selecting a health plan during the enrollment process.

ii. The Contractor shall invoice for this activity under Protocol 3.

1.3.1.4 Readiness Review Key Deliverables and Content

A. Readiness Review Tool(s)

1. The Contractor shall provide, subject to Agency approval, a readiness review tool(s) to assess the MCP's level of compliance with State and Federal requirements, as well as their ability to provide the requested services to the State as set forth in the Contracts with the MCPs. The current Contracts can be found at this link: https://dhs.iowa.gov/MED-16-009_Bidders-Library
2. The Contractor shall ensure that the readiness review tool meets all current regulatory obligations as such regulations may be modified from time to time.

B. MCP Desk Audits

1. The Contractor shall perform a desk audit of the one identified contracted Medicaid MCP during the term of this contract. The desk audit should include, but no be limited to, a review of the following:
    a. relevant policies and procedures;
    b. program descriptions;
    c. training materials;
    d. educational materials;
    e. incentive programs;
    f. provider agreement templates;
    g. provider access standards;
    h. manuals and handbooks;
    i. quality data; and
    j. any other documents to demonstrate readiness to implement, such as:
        i. MCP project implementation plan;
        ii. staffing plan;
        iii. geo access plan
        iv. financial statements; and
        v. self-assessments from network providers
2. The Contractor shall report to the Agency potential areas of concerns that will be addressed during the on-site review of the MCP. The readiness review is an interactive process, and the Contractor shall provide the Agency with regular updates on the information identified in the review findings report prior to submission of the final report or the MCP reviewed.

C. MCP On-Site Reviews

1. The Contractor shall perform an on-site review of the identified Medicaid MCP during the term of the Contract. The on-site review should include, but not be limited to, a review of the following:
    a. Credentialing files;
    b. Critical processes and operating functions, such as:
        i. Service authorization validation;
        ii. Training; and
        iii. Care coordination.
    c. Demonstration of IT systems and testing, such as:
        i. Critical MCP Systems;
        ii. Interface for eligibility, enrollment and encounter data; and
        iii. Claims processing.
    d. Staff reviews.
2. The Contractor shall submit to the Agency a draft readiness review findings report after the MCP on-site review, identifying MCP deficiencies.
    a. The draft readiness review report shall include:
        i. A corrective action plan (CAP) template for the MCP to complete and submit as part of its CAP submission to the Agency and Contractor.
        ii. The CAP template will detail all issues and deficiencies identified in the readiness review process.
    b. The readiness review is an iterative process, and the Contractor shall provide the Agency with regular updates on the information identified in the review findings report prior to the submission of the final report for the MCP reviewed.

D. Follow-Up on Identified Issues

1. The Contractor shall review the MCP's CAP and timeline to remedy all deficiencies noted on the draft readiness review report and identify any issues or deficiencies that are the result of State activity
2. Once submitted by the MCP, the CAP template will serve as the weekly status report and activity log for follow up on identified issues.
3. The Contractor shall document the status of review for each deficiency and associated resolution by the MCP in the CAP template.

E. Reporting

1. Contractor shall submit the following:
    a. Draft MCP readiness review report that includes the findings generated from the desk audit on-site review. The report shall include the CAP template for the MCP to complete and submit as part of its CAP submission to the Agency and Contractor;
    b. CAP status review that documents the Contractor's review of the MCP's CAP and timeline to remedy all deficiencies noted in the draft readiness review report;
    c. Meeting agendas and activity work plan documenting the Readiness Review process, which shall include updates on information identified in the MCP readiness review finding report; and
    d. Final report for the MCP reviewed as part of the Readiness Review process.
2. If any protected health information (PHI) is contained in any of the reports submitted, the format and transmittal of reports shall comply with HIPAA standards.

F. Contents of Readiness Review

a. Compliance with the MCP Contracts: The Contractor shall evaluate the MCP's compliance with the requirements found in the MCP Contract. The MCP Contract(s) is (are) between the Agency and the MCPs to deliver high quality healthcare services for the Iowa Medicaid, Iowa Health and Wellness Plan and Hawki programs. The Contractor's review includes existing MCP contracts with the possibility that additional MCPs may be added to deliver Medicaid and dental benefits the review shall include, but not limited to, the following areas:
b. General and Administrative Requirements, including, but not limited to, requirements for:
    i. Licensure and accreditation;
    ii. Subcontractor requirements;
    iii. Maintenance of records;
    iv. Disclosures;
    v. Organizational structures;
    vi. Written policies and procedures;
    vii. Implementation plan; and
    viii. Confidentiality of member medical records and other information, including HIPAA compliance.
c. Scope and Covered Benefits, including, but not limited to, requirements for:
    i. Covered benefits;
    ii. Continuity of care; and
    iii. Coordination with Medicare.
d. Long Term Services and Support, including, but not limited to, requirements for:
    i. Level of care and support assessments;
    ii. Community-Based case management; and
    iii. 1915(c) and 1915(i) Waivers
e. Billing and Collections, including, but not limited to, requirements for:

i. Healthy Behaviors Programming;
ii. Copayments;
iii. Patient liability and;
iv. IDPH Sliding Scale.

f. Provider Network requirements, including, but not limited to, requirements for:
i. Network development and adequacy; and
ii. Requirement by provider type.

g. Enrollment, including, but not limited to, requirements for:
i. Enrollment discrimination; and
ii. Member disenrollment.

h. Member Services, including, but not limited to, requirements for:
i. Marketing;
ii. Member communications;
iii. Member services helpline;
iv. Nurse call line;
v. Electronic communications;
vi. Member website;
vii. Health education and initiatives;
viii. Cost and quality information;
ix. Advance directive information;
x. Member rights;
xi. Redetermination assistance;
xii. Member stakeholder engagement;
xiii. Stakeholder education;
xiv. Implementation support; and
xv. Grievance appeals and state fair hearings.

i. Care Coordination

j. Quality Management and Improvement, including, but not limited to, requirements for:
i. Contractor Quality Management/Quality Improvement (QM/QI) Program;
ii. Critical incidents; and
iii. Provider preventable conditions.

k. Utilization Management, including, but not limited to, requirements for:
i. Utilization Management Program; and
ii. Prior authorization.

l. Program Integrity, including, but not limited to, requirements for:
i. General expectation;
ii. Program integrity plan;
iii. Required fraud and abuse activities;
iv. Reporting fraud and abuse;
v. Coordination and program integrity efforts;
vi. Verification of services provided;
vii. Obligation to suspend payments to providers;
viii. Required provider ownership and control disclosures
ix. Contractor reporting obligations for adverse actions taken on provider.
x. Applications for program integrity reasons; and
xi. Enforcement of Iowa Medicaid program rules.

m. Information Technology, including, but not limited to, requirements for:
i. Information system services
ii. Contingency and continuity planning;
iii. Data exchange;
iv. Claims processing;

v. Encounter claims submission;
vi. Third party liability processing; and
vii. Health information technology.

n. Performance Targets and Reporting Requirements, including, but not limited to, requirements for:
i. Provider network reports and performance targets;
ii. Quality management reports and performance targets;
iii. LTSS Reports and Performance Targets;
iv. Quality of life reports and performance targets;
v. Utilization reports and performance targets; and
vi. Claims reports and performance targets.

1. Compliance with Federal Requirements (42 C.F.R. §438.66). The Contractor's review shall focus on the requirements that are necessary for quality operations with a priority on the core services of member enrollment/disenrollment, processing of grievances and appeals, violations subject to intermediate sanctions, and violations of the conditions for federal financial participation. The review shall include, but not be limited to, the following areas:
a. Operations and Administration, including but not limited to:
i. Administrative staffing and resources;
ii. Delegation and oversight of MCP responsibilities
iii. Enrollee and provider communications;
iv. Grievances and appeals;
v. Member services and outreach;
vi. Provider network management; and
vii. Program integrity and compliance.
b. Service Delivery, including but not limited to:
i. Case management/care coordination;
ii. Service planning;
iii. Quality improvement; and
iv. Utilization review.
c. Systems Management
i. Claims management; and
ii. Encounter data and enrollment information management.
2. Information Technology Review
a. In addition to the requirements listed in Section 1.3.1.3.A.5.a the Contractor shall ensure that the readiness review assesses the MCP's IT systems to ensure they are prepared to provide all functions required for meeting the State's needs. The Contractor shall ensure that the review shall include, but not be limited to, the following areas:
i. Technical and Functional System Designs and Scalability;
ii. Architectural Review including SaaS, Cloud Based Services, On-Premise and Off-Premise, and Data and Security Compliance Standards and HIPAA, Integration of Services Utilization of Service Oriented Architecture;
iii. Claims Processing and Adjudication;
iv. Encounter Data Management;
v. Provider Network Management, with focus on:
1) Eligibility
2) Enrollment/disenrollment
3) Prior authorization;
4) Referrals;
5) Credentialing and re-credentialing
6) SLAs/pricing agreements;
7) Appeals and grievances; and

8) Service and supports.

vi. Member Network Management, with a focus on;

1) Eligibility
2) Enrollment/disenrollment
3) Credentialing
4) Appeals and grievances; and
5) Services and supports.

b. Information Systems Capability Assessment. The Contractor shall conduct an Information Systems Capability assessment (ISCA) for each of the MCPs. The purpose of the ISCA is to examine the MCP's information systems, data processing, and reporting procedures to determine the extent to which they support the production of valid and reliable state performance measures and the capacity to manage the health care of the MCP's enrollees. The ISCA shall include the following components:

i. Information systems;
ii. Hardware;
iii. Security;
iv. Administrative data;
v. Enrollment systems;
vi. Ancillary systems;
vii. Provider compensation and monitoring; and
viii. Electronic health records.

1.3.2 Performance Measures.

1. The Contractor shall submit the work plan, communications plan, and standardized reports templates to the Agency for approval no later than fifteen (15) days after the effective date of the Contract. The Contractor must receive final approval of these documents within fifteen (15) days of the first submission.
2. The Contractor shall submit the final interface control document and disaster recovery plan to the Agency no later than thirty (30) days after the effective date of the Contract.
3. Unless otherwise identified, the Contractor shall provide all identified deliverables in an Agency-approved format and in accordance with timeframes established in the Agency-approved work plan.
4. For Protocols 1-5, the Contractor shall meet the following reporting timeframes:
    a. Submit a draft of the EQR report to the Agency and the MCP reviewed within thirty (30) days from the date of the EQR.
    b. Allow the Agency and the MCP reviewed forty-five (45) days to provide comments on the draft report.
    c. Within fifteen (15) days from the date the comments are due (or ninety [90] days from the date of the EQR), submit a final report to the Agency and the MCP reviewed.
5. For Protocols 6-9, the Contractor shall meet the following reporting timeframes for any Protocols required or requested by the Agency:
    a. Submit a draft of the report to the Agency and the MCP reviewed within thirty (30) days of Protocol completion.
    b. Allow the Agency and the MCP reviewed forty-five (45) days to provide comments on the draft report.
    c. Within fifteen (15) days from the date the comments are due (or ninety (90) days from the date of Protocol completion), submit a final report to the Agency and the MCP reviewed.
6. The Contractor shall validate each year at least ten (10) performance measures submitted by each MCP.

7. The Contractor shall submit a draft report on the focused study to the Agency within thirty (30) days of the conclusion of the study. Contractor must receive final approval of the report within fifteen (15) days of the first submission.
8. All submitted reports shall be concise, free from typographical and grammatical errors, and come to logical conclusions, and
9. The Contractor shall notify the Agency within two (2) business days of any problems associated with data contained in any files submitted by the Agency.
10. Unless otherwise identified, the Contractor shall provide all identified deliverables for the Readiness Review in an Agency approved format and in accordance with timeframes established in the Agency approved work plan.

1.3.3 Monitoring, Review, and Problem Reporting.

1.3.3.1 Agency Monitoring Clause. The Contract Manager or designee will:

- Verify Invoices and supporting documentation itemizing work performed prior to payment;
- Determine compliance with general contract terms, conditions, and requirements; and
- Assess compliance with Deliverables, performance measures, or other associated requirements based on the following:

The Contract Manager or designee will:

- Verify Invoices and supporting documentation itemizing work performed prior to payment;
- Determine compliance with general contract terms, conditions, and requirements; and
- Assess compliance with Deliverables, performance measures, or other associated requirements

based on the following:

The Agency's representative will perform at minimum monthly desk monitoring of deliverables, reports, corrective action plans, and results to determine the success of the Contractor.

-The Agency's representative will meet at minimum monthly with the Contractor's project manager to discuss status, timelines, and issue resolution related to the project.

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

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

1.3.3.2 Problem Reporting. As stipulated by the Agency, the Contractor and/or Agency shall provide a report listing any problem or concern encountered. Records of such reports and other related communications issued in writing during the course of Contract performance shall be maintained by the parties. At the next scheduled meeting after a problem has been identified in writing, the party responsible for resolving the problem shall provide a report setting forth activities taken or to be taken to resolve the problem together with the anticipated completion dates of such activities. Any party may recommend alternative courses of action or changes that will facilitate problem resolution. The Contract Owner has final authority to approve problem-resolution activities.

The Agency's acceptance of a problem report shall not relieve the Contractor of any obligation under this Contract or waive any other remedy. The Agency's inability to identify the extent of a problem or the extent of damages incurred because of a problem shall not act as a waiver of performance or damages under this Contract.

1.3.3.3 Addressing Deficiencies. To the extent that Deficiencies are identified in the Contractor's performance and notwithstanding other remedies available under this Contract, the Agency may require the Contractor to develop and comply with a plan acceptable to the Agency to resolve the Deficiencies.

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

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

The Agency's acceptance of a problem report shall not relieve the Contractor of any obligation under this Contract or waive any other remedy. The Agency's inability to identify the extent of a problem or the extent of damages incurred because of a problem shall not act as a waiver of performance or damages under this Contract.

1.3.4 Contract Payment Clause.

1.3.4.1 Pricing. In accordance with the payment terms outlined in this section and the Contractor's completion of the Scope of Work as set forth in this Contract, the Contractor will be compensated as follows:
The Contractor will be paid a fixed amount for services rendered, in accordance with the pricing set forth in Special Contract Attachment A (i.e. the Cost Proposal).

1.3.4.2 Payment Methodology. For Protocols 1-5, the Contractor may invoice 80% of the amount for each Protocol in equal monthly installments. The remaining 20% withhold may be invoiced on December 31st of each year, and will be paid upon Agency confirmation that Deliverables have been met according to performance measures and the Agency-approved work plan.

For Protocols 6-9, the Contractor may invoice 80% of the amount for each Protocol requested in the month that the draft report or deliverable is submitted to the Agency. The remaining 20% withhold may be invoiced at the upon Agency acceptance of final deliverables at the conclusion of the requested Protocol, and will be paid upon Agency confirmation that Deliverables have been met according to performance measures and the Agency-approved work plan.

For the Readiness Review, the Contractor may invoice 80% of the amount for each milestone requested in the month that the milestone is acknowledged in writing by the Agency as completed. The remaining 20% withhold may be invoiced upon the Agency acknowledgement in writing that the transition of monitoring of outstanding readiness review items to the Agency has been completed, and will be paid upon Agency confirmation that this milestones has been met according to performance measures and the Agency approved work plan.

Determination of whether Deliverables have been met is strictly and solely at the discretion of the Agency. Each invoice will include documentation itemizing all work completed.

1.3.4.3 Timeframes for Regular Submission of Initial and Adjusted Invoices. The Contractor shall submit an Invoice for services rendered in accordance with this Contract. Invoice(s) shall be submitted monthly. Unless a longer timeframe is provided by federal law, and in the absence of the express written consent of the Agency, all Invoices shall be submitted within six months from the last day of the month in which the services

were rendered. All adjustments made to Invoices shall be submitted to the Agency within ninety (90) days from the date of the Invoice being adjusted. Invoices shall comply with all applicable rules concerning payment of such claims.

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

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

The Agency shall pay all approved Invoices in arrears and in conformance with Iowa Code 8A.514. The Agency may pay in less than sixty (60) days, but an election to pay in less than sixty (60) days shall not act as an implied waiver of Iowa law.

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

1.4 Insurance Coverage.

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

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

1.5 Data and Security. If this Contract involves Confidential Information, the following terms apply:

1.5.1 Data and Security System Framework. The Contractor shall comply with either of the following:

- Provide certification of compliance with a minimum of one of the following security frameworks, if the Contractor is storing Confidential Information electronically: NIST SP 800-53, HITRUST version 9, SOC 2, COBIT 5, CSA STAR Level 2 or greater, ISO 27001 or PCI-DSS version 3.2 prior to implementation of the system and again when the certification(s) expire, or
- Provide attestation of a passed information security risk assessment, passed network penetration scans, and passed web application scans (when applicable) prior to implementation of the system and again annually thereafter. For purposes of this section, "passed" means no unresolved high or critical findings.

1.5.2 Vendor Security Questionnaire. If not previously provided to the Agency through a procurement process specifically related to this Contract, the Contractor shall provide a fully completed copy of the Agency's Vendor Security Questionnaire (VSQ).

1.5.3 Cloud Services. If using cloud services to store Agency Information, the Contractor shall comply with either of the following:

- Provide written designation of FedRAMP authorization with impact level moderate prior to implementation of the system, or
- Provide certification of compliance with a minimum of one of the following security frameworks: HITRUST version 9, SOC 2, COBIT 5, CSA STAR Level 2 or greater or PCI-DSS version 3.2 prior to implementation of the system and again when the certification(s) expire.

1.5.4 Addressing Concerns. The Contractor shall timely resolve any outstanding concerns identified by the Agency regarding the Contractor's submissions required in this section.

1.6 **Reserved.** ***(Labor Standards Provisions.)***

1.7 **Reserved.** ***(Performance Security.)***

1.8 Incorporation of General and Contingent Terms.

1.8.1 General Terms for Service Contracts ("Section 2"). The version of the General Terms for Services Contracts Section posted to the Agency's website at https://dhs.iowa.gov/contract-terms that is in effect as of the date of last signature in the Contract Declarations and Execution section, or a more current version if agreed to by amendment, is incorporated into the Contract by reference. The General Terms for Service Contracts may be referred to as Section 2.

The contract warranty period (hereafter "Warranty Period") referenced within the General Terms for Services Contracts is as follows: The term of this Contract, including any extensions.

1.8.2 Contingent Terms for Service Contracts ("Section 3"). The version of the Contingent Terms for Services Contracts posted to the Agency's website at https://dhs.iowa.gov/contract-terms that is in effect as of the date of last signature in the Contract Declarations and Execution section, or a more current version if agreed to by amendment, is incorporated into the Contract by reference. The Contingent Terms for Service Contracts may be referred to as Section 3.

All of the terms set forth in the Contingent Terms for Service Contracts apply to this Contract unless indicated otherwise in the table below:

Contractor a Business Associate? Yes	**Contractor a Qualified Service Organization?** Yes
Contractor subject to Iowa Code Chapter 8F? No	**Contract Includes Software (modification, design, development, installation, or operation of software on behalf of the Agency)?** No
Contract Payments include Federal Funds? Yes **The Contractor for federal reporting purposes under this Contract is a:** Vendor **Federal Funds Include Food and Nutrition Service (FNS) funds?** No **DUNS #:** 114443260 **The Name of the Pass-Through Entity:** Iowa Department of Human Services	
CFDA #: 93.778 **Grant Name:** Medicaid Assistance Program	**Federal Awarding Agency Name:** Department of Health and Human Services/Centers for Medicare and Medicaid Services

1.9 **Reserved.** ***(Additional Terms.)***

SPECIAL CONTRACT ATTACHMENTS

The Special Contract Attachments in this section are a part of the Contract.

Attachment F – Pricing Schedule

MCO Pricing	Year 1 1/1/22 - 12/31/22	Year 2 1/1/23 - 12/31/23	Year 3 1/1/24 - 12/31/24	Option Year 4 1/1/25 - 12/31/25	Option Year 5 1/1/26 - 12/31/26	Option Year 6 1/1/27 - 12/31/27	
Key Deliverables	**Cost For One**						**Totals**
Protocol 1: Validation of Performance Improvement Projects (PIPs)	$ 17,989.00	$ 18,529.00	$ 19,085.00	$ 19,658.00	$ 20,248.00	$ 20,855.00	$ 116,364.00
Protocol 2: Validation of Performance Measures	$ 28,102.00	$ 28,945.00	$ 29,813.00	$ 30,707.00	$ 31,628.00	$ 32,577.00	$ 181,772.00
Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations • For invoicing purposes, Protocol 3 includes Review of Compliance, Annual EQR and Technical Report, and Score Card activities.	$ 62,037.00	$ 63,898.00	$ 65,815.00	$ 67,789.00	$ 69,823.00	$ 71,918.00	$ 401,280.00
Protocol 4: Validation of Network Adequacy • For invoicing purposes, Protocol 4 includes Validation of Network Adequacy and PPE activities.	$ 50,075.00	$ 51,577.00	$ 53,124.00	$ 54,718.00	$56,360.00	$ 58,051.00	$ 323,905.00
Protocol 5: Validation of Encounter Data Reported by the Medicaid and CHIP MCP	$ 61,712.00	$ 63,563.00	$ 65,470.00	$ 67,434.00	$ 69,457.00	$ 71,541.00	$ 399,177.00
Protocol 6: Validation of MCP Enrollee and Provider Surveys.	$ 6,247.00	$ 6,434.00	$ 6,627.00	$ 6,826.00	$ 7,031.00	$ 7,242.00	$ 40,407.00

Protocol 7: Calculation of Additional Performance Measures	$ 25,061.00	$ 25,813.00	$ 26,587.00	$ 27,385.00	$ 28,207.00	$ 29,053.00	$ 162,106.00
Protocol 8: Implementation of Additional Performance Improvement Projects (PIPs)	$ 3,477.00	$ 3,581.00	$ 3,688.00	$ 3,799.00	$ 3,913.00	$ 4,030.00	$ 22,488.00
Protocol 9: Conducting Focus Studies of Health Care Quality • For invoicing purposes, Protocol 9 includes Focus Studies of Health Care Quality and tasks a - c delineated under Other Optional EQR-related Activities	$ 17,024.00	$ 17,536.00	$ 18,062.00	$ 18,604.00	$ 19,162.00	$ 19,737.00	$ 110,125.00
						Subtotal	$ 1,757,624.00

PAHP/PIHP/PCCM Percentage Reduction	**75%**

PIHP/PAHP/PCCM Pricing	**Year 1 1/1/22 - 12/31/22**	**Year 2 1/1/23 - 12/31/23**	**Year 3 1/1/24 - 12/31/24**	**Option Year 4 1/1/25 - 12/31/25**	**Option Year 5 1/1/26 - 12/31/26**	**Option Year 6 1/1/27 - 12/31/27**	
Key Deliverables	**Cost For One**						**Totals**
Protocol 1: Validation of Performance Improvement Projects (PIPs)	$ 4,497.25	$ 4,632.25	$ 4,771.25	$ 4,914.50	$ 5,062.00	$ 5,213.75	$ 29,091.00
Protocol 2: Validation of Performance Measures	$ 7,025.50	$ 7,236.25	$ 7,453.25	$ 7,676.75	$ 7,907.00	$ 8,144.25	$ 45,443.00
Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations • For invoicing purposes, Protocol 3 includes Review of Compliance, Annual EQR and Technical Report, and Score Card activities.	$ 15,509.25	$ 15,974.50	$ 16,453.75	$ 16,947.25	$ 17,455.75	$ 17,979.50	$ 100,320.00

Protocol 4: Validation of Network Adequacy • For invoicing purposes, Protocol 4 includes Validation of Network Adequacy and PPE activities.	$ 12,518.75	$ 12,894.25	$ 13,281.00	$ 13,679.50	$ 14,090.00	$ 14,512.75	$ 80,976.25
Protocol 5: Validation of Encounter Data Reported by the Medicaid and CHIP MCP	$ 15,428.00	$ 15,890.75	$ 16,367.50	$ 16,858.50	$ 17,364.25	$ 17,885.25	$ 99,794.25
Protocol 6: Validation of MCP Enrollee and Provider Surveys.	$ 1,561.75	$ 1,608.50	$ 1,656.75	$ 1,706.50	$ 1,757.75	$ 1,810.50	$ 10,101.75
Protocol 7: Calculation of Additional Performance Measures	$ 6,265.25	$ 6,453.25	$ 6,646.75	$ 6,846.25	$ 7,051.75	$ 7,263.25	$ 40,526.50
Protocol 8: Implementation of Additional Performance Improvement Projects (PIPs)	$ 869.25	$ 895.25	$ 922.00	$ 949.75	$ 978.25	$ 1,007.50	$ 5,622.00
Protocol 9: Conducting Focus Studies of Health Care Quality • For invoicing purposes, Protocol 9 includes Focus Studies of Health Care Quality and tasks a - c delineated under Other Optional EQR-related Activities	$ 4,256.00	$ 4,384.00	$ 4,515.50	$ 4,651.00	$ 4,790.50	$ 4,934.25	$ 27,531.25
						Subtotal	$ 439,406.00

Grand Total	$ 2,197,030.00