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State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

February 1, 2016

Dear Interested Parties:

CALIFORNIA DENTAL ADMINISTRATIVE SERVICES ORGANIZATION REQUEST FOR PROPOSAL 13-90271

ADMINISTRATIVE BULLETIN 7, ADDENDUM 2

Administrative Bulletin 7, Addendum 2, issued by the California Department of Health Care Services (DHCS), Office of Medi-Cal Procurement (OMCP), announces release of information pertaining to Request for Proposal (RFP) #13-90271 for the California Dental Administrative Services Organization (ASO) procurement. DHCS provides notification to interested parties of the following:

- 1) Enclosed with this Administrative Bulletin is the third release of DHCS' official responses to questions submitted by prospective Proposers. Prospective Proposers are reminded that no additional questions will be accepted, with the exception of questions or inquiries as described in RFP Section G, Proposer Questions.
- 2) Addendum 1 incorporates changes to the following RFP sections:
 - Exhibit A, Attachment II (Operations)

These changes are being made to modify or clarify sections in the RFP. Within the text of the documents, changes are indicated as red text strikethroughs (deletions) and/or underlined blue text (additions) to denote revisions. For Americans with Disabilities Act purposes, text deletions will be preceded and ended with an asterisk (*), while text additions will be preceded and ended with a double asterisk (**). The locations of revisions will be indicated by a vertical line in the right margin of the page where applicable. Language modifications supersede prior published language. It is the responsibility of the Proposer to assure they are working from the latest version of all sections and subsections of the RFP.

In order to configure the internet version of the RFP to accurately reflect the current requirements and considerations, remove the existing pages and insert the appropriate replacement pages as shown in the chart below.

REMOVE EXISTING PAGES	INSERT REPLACEMENT PAGES
Exhibit A, Attachment II (Operations) pages 89-91, 98, 105-108, 110-111, and 138-142	Exhibit A, Attachment II (Operations) pages 89-91, 98, 105-108, 110-111, and 138-142

Prospective Proposers can view and download the CD-MMIS ASO Services RFP and other material relative to this procurement from the following internet site:

http://www.dhcs.ca.gov/provgovpart/rfa_rfp/Pages/OMCPDentalAsoDNLD.aspx

If unable to obtain the RFP, Administrative Bulletins, Addenda, etc., via the internet, prospective Proposers are encouraged to contact OMCP at (916) 552-8006 or omcprfp2@dhcs.ca.gov to request disk or hard copy versions of the document(s).

Thank you for your continued interest in the CD-MMIS FI Services procurement.

Sincerely,

Original Signed by *Kevin Morrill*

Kevin Morrill, Chief
Office of Medi-Cal Procurement

Enclosure

Q #	RFP Reference	Section	Question-Issue	Remedy Sought	DHCS Response
1	RFP Main, Attachment 1	P.4.a, Page 25	<p>The RFP states, "a. Proposal Cover Page, RFP Attachment 1 A person authorized to bind the Proposer must sign RFP Attachment 1, Proposal Cover Page. If the Proposer is a corporation, a person authorized by the Board of Directors to sign on behalf of the Board must sign the Proposal Cover Page." There are three blank areas on the form to be filled out. Please identify what information goes in each of these fields.</p>	Identify how the form is to be filled out.	Attachment 1 was replaced as part of Addendum 1. The replacement form displays the proper headings in each field that were improperly masked in the original release.
2	Attachment 17	Question 47	<p>Question 47 asks: "To what extent does the Proposer demonstrate procedures, methods, and processes to ensure the administration and operation of the Medi-Cal Dental program is or will be in compliance with ISO 9001:2008 standards upon Contract implementation and certified to ISO 9001:2008 within one year of the start of the Operation's period?"</p> <p>This question is longer applicable based on Bulletin 6 - Addendum 1, Question 3</p>	<p>Please clarify how scoring for Quality Management and/or the Narrative section is impacted by this change.</p> <p>To maintain weighting of the section will the question be removed and section weighting be changed to 6/7ths (~.875); will another question be substituted; will all respondents be given 4 points automatically; or will the total points for the section and for the Narrative be altered?</p>	<p>No RFP change required.</p> <p>Question 47 will remain in the RFP and all vendors will receive the maximum points.</p>

Q #	RFP Reference	Section	Question-Issue	Remedy Sought	DHCS Response
3	Exhibit I, Staffing Qualifications	A.6., page 5 of 9	<p>The Department released Administrative Bulletin 3 for the California Dental Medicaid Management Information System Fiscal Intermediary Services Request for Proposal 13-90270 on November 20, 2015.</p> <p>Question #86 for RFP Reference Exhibit I, Section Senior Management Team, page 1 of 14 stated " Can the vendor provide the Information Security Officer and Privacy Officer roles through a single resource who meets all qualifications of both and would perform all responsibilities of both roles? "</p> <p>DHCS's Response stated "No RFP change required. Clarification: Yes, as long as the single resource meets all the qualifications and requirements. The Department may at any time require the Contractor to provide another resource at the Contractor's expense if the Department's needs are not met in a timely manner."</p> <p>Please verify the vendor can provide the Information Security and Privacy Officer roles through a single resource who meets all qualifications of both and will perform all responsibilities of both roles is also acceptable to the Department for the ASO Contractor.</p>	Please confirm the Information Security Officer and the Privacy Officer roles can be met through a single resource who meets all qualifications of both and would perform all responsibilities of both positions.	<p>No RFP change required.</p> <p>The Information Security Officer and the Privacy Officer roles can be fulfilled with a single resource provided they meet the qualifications of both positions. The individual must not only hold the qualifications, but must also be able to perform the contractually required tasks.</p>

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and other claims as required by the Contract or those added at a later date by the Department.

In this subsystem, TARs are either approved as submitted, approved as modified, or denied. The only exception is a Notice of Authorization (NOA) that has been returned by the provider requesting reconsideration of previously denied or modified lines. These requests may be referred to as TAR re-evaluations. The TAR re-evaluations may have been preceded by a Resubmission Turnaround Document (RTD) resulting in a NOA being issued.

Claims/NOAs for payment are either approved as submitted and prepared for payment, approved as modified and prepared for payment, or denied.

Throughout this Contract the term "claim" is used to refer to claims as well as to NOAs returned for processing as claims resulting from a previously approved TAR. The NOA is generated by CD-MMIS when a TAR is fully adjudicated. The NOA notifies the provider of the actions taken by the Contractor which is either to approve, modify, or deny. Once the authorized services have been rendered, the provider completes the NOA by adding service dates, provider signature or initials and returns to the Contractor as a claim for processing.

The provider may submit a claim for services as a request for payment to the Fiscal Intermediary (FI) Contractor by two methods:

- a. Submission of a standard paper claim form or return of a NOA. When the service is performed, the NOA is completed and returned back to the FI Contractor.
- b. Submission of a claim or NOA via Electronic Data Interchange (EDI).

The Claims Processing Subsystem is central to all functions of the California Dental Medicaid Management Information System (CD-MMIS) and interfaces with all other subsystems.

- 1) The five major functions of claims processing to be carried out by the respective Contractor are as follows:
 - a) Document Control – FI Contractor
 - b) Data Entry – FI Contractor.
 - c) File Maintenance – Administrative Service Organization (ASO) Contractor.
 - d) Adjudication – ASO Contractor.
 - e) Payment Processing – FI Contractor

2. Objectives

The Claims Processing Subsystem has specific objectives designed to reflect the intent of the subsystem and to meet the most current federal and State requirements. The Contractor shall:

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- a. Ensure all input is accurate and positive control is maintained throughout processing;
- b. Ensure the provider is an enrolled Medi-Cal dental provider and the beneficiary is eligible for services billed and/or authorized;
- c. Ensure accurate and timely adjudication of all claims/NOAs to final resolution for payment or denial in accordance with the most current program policy and procedures, established reimbursement rates, and federal and State statutes and regulations;
- d. Process TARs for approval, modification, or denial in accordance with the most current program policy and procedures, federal and State statutes, and regulations;
- e. Assist the Surveillance and Utilization Reports unit to detect overutilization, underutilization, and potential abusers of the Medi-Cal Dental Program; and
- f. Comply with the most current Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other legal requirements; and maintain required audit trails.

3. Assumptions and Constraints

- a. The Medi-Cal Dental Fee-For-Service program consists of two separate Contracts - one pertaining to the ASO Contractor and one pertaining to the FI Contractor. These two Contractors are expected to work in concert with each other to perform all activities associated with the requirements of claims processing during the term of the Contracts.
- b. Claims that successfully pass all edits and audits are forwarded to the payment module for final adjudication.
- c. Application of the whole document concept is applied in the processing and payment of claims/NOAs/TARs. Each document is processed as a whole; however, each service line is reviewed and adjudicated separately.
- d. Provider and recipient data in the Provider Master File (PMF), Fiscal Intermediary Access of Medi-Cal Eligibility file (FAME), and all supporting files accessed by the Claims Processing Subsystem will be utilized in an accurate and timely manner.
- e. Eligibility verification for claims processing shall reference against the Department's FAME file and information associated with the Eligibility Verification Confirmation (EVC) file.
- f. In instances where the EVC record is in conflict with the Department's FAME file, the claim/NOA/Claim Inquiry Form (CIF) shall be adjudicated based on the record which is most favorable toward paying the document for the provider. In other words, if the FAME file indicates no eligibility but the EVC number provided on the claim/NOA/CIF indicates eligibility, the document will be adjudicated based on the EVC.
- g. The FI Contractor shall:

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- 1) Execute the weekly check run cycle and create payment files;

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- ~~4)2)~~ Create and submit a check write invoice along with supporting documentation to the DHCS Accounting Division and State Controllers Office;
- ~~2)3)~~ Print and mail the checks and corresponding Explanation of Benefits (EOBs) to providers;
- ~~3)4)~~ Perform the functions associated with Document Management. Refer to the FI Contract, Exhibit A, Attachment II, Claims processing for additional information and FI Contract, Exhibit A, Attachment II, Document Management System;
- ~~4)5)~~ Maintain all electronic media documents and comply with the EDI standards adopted pursuant to HIPAA and in accordance with Department approved formats and specifications;
- ~~5)6)~~ Track, record, and report all activity for each claim/NOA/TAR from receipt through final adjudication to include the update to the adjudicated claim history files. This tracking shall include the identification of all appeals, CIFs, or any adjustments related to each claim/NOA/TAR. This shall include the documentation of each Data Control Center (DCC) location and date as the document moves through the system. This tracking system that shall be maintained by the FI Contractor will also provide a history of all edits and audits where the document has failed;
- ~~6)7)~~ Reflect all activities on appropriate CD-MMIS reports with each Document Control Number (DCN), Most Recent Document Control Number (MRDCN), Correspondence Reference Number (CRN) or other identifying number and each DCC location with date of DCC entry to ensure a complete audit trail and to meet all reporting requirements;
- ~~7)8)~~ Purge the approved and denied TARs from the database to an appropriate storage media to be retained for a period of no less than three years; and
- ~~8)9)~~ Generate all Claims Processing Subsystem reports produced by CD-MMIS. Refer to FI Contract, Exhibit A, Attachment II, Claims Processing and FI Contract, Exhibit A, Attachment II, General Reporting for additional information.

h. The Department intends to transfer responsibility for issuing provider payments to the State Controllers Office (SCO). When the transfer of responsibilities is complete, the Contractor will be responsible for adjusting any claims processing procedures and/or processes impacted by the electronic transfer to the SCO of all files and documentation necessary for the SCO to produce and issue provider payment. **

4. General Responsibilities

The ASO Contractor shall:

- a. Adjudicate all claims documents through to final resolution pursuant to Department policy and contractual requirements.

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be selected. This processing requirement applies to un-adjudicated claims/TARs/CIFs. Department directed priority-processing requests will not exceed thirty (30) requests per month for individuals or groups of providers, or a total of one thousand (1,000) claims/TARs/CIFs per month. Priority process claims/*~~TARs~~*/CIFs within five business days of receipt of request as directed by the Contracting Officer. ** Priority process TARs within three working days of receipt of request as directed by the Contracting Officer; **

- c. Upon Department approval, suspend selected claims in the unique priority processing DCC. If the Contractor caused the error/problem, the time in the unique DCC is included in cycle time calculations. If the error/problem is Department caused, the time in the unique DCC is excluded from cycle time calculations;
- d. The Contractor shall return priority processing request forms to the Department within two business days of completion of the priority-processing request documenting date of completion; and
- e. After correction of the identified problem(s), all documents suspended for those reasons shall be released into the claims processing system to complete processing. Report such information to the Department as specified in Exhibit A, Attachment II, Quality Management Process section.

12. Exceptional Processing Instructions

If the Contractor prepares and distributes Exceptional Processing Instructions (EPIs) for use by staff in the processing of documents, each EPI shall include a start/end date and shall be submitted to the Department for review and approval prior to distribution and implementation. EPIs shall only be used to communicate time-critical processing instructions to adjudication staff in which immediate implementation is deemed necessary by the Department. An EPI shall expire no later than thirty (30) calendar days from the date of issuance.

13. Clinical Screening of TARs

Some TARs prior to approval, modification, or denial may require a screening or second opinion by a Clinical Screening dentist. A Clinical Screening dentist is a California licensed dentist utilized by the Contractor to review dental treatment proposed or performed by a Medi-Cal dental provider.

- a. When the findings of the Clinical Screening dentist conflict with the observations/diagnosis of the beneficiary's treating dentist, such screening reports shall be reevaluated/adjudicated by a Contractor-designated dental consultant.
- b. Second opinion Clinical Screenings may also be utilized to evaluate appropriateness of:
 - 1) Beneficiary complaints;
 - 2) Previously denied services that subsequently result in the filing of State Hearing requests;

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- f. Offset payment when notified by a provider that an overpayment has occurred.

19. Provider Grievances Requirements

The Contractor shall process provider grievances, e.g., appeals, in the manner and time frames prescribed in Title 22, CCR, Section 51015. For additional information beyond the following items, reference Exhibit A, Attachment II, Provider Services.

The Contractor shall:

- a. Adjudicate claim appeals by analyzing documents and telephoning providers for clarification to obtain missing information;
- b. Based upon information provided in the appeal, CD-MMIS files, or CD-MMIS reports, resolve the problems with the claim being appealed that are related to the processing of the claim (e.g., beneficiary, provider, TAR, reference file, or policy issues and considerations);
- c. Respond to providers' requests and inquiries regarding claim appeal status and denial reason. Requests for reconsideration of denials shall be adjudicated under the same guidelines as appeals submitted for the first time;
- d. Process claims requiring manual processing that are received more than one year from date of service; and
- e. Provide instructional information and/or materials requested by the provider to help them in their future efforts to submit complete and accurate claims.

20. Payment Responsibilities

The FI Contractor shall produce and process electronic payment files on a weekly basis for claims/NOAs processed to full adjudication. The FI Contractor shall print and mail the checks and EOB documents to the appropriate providers.

The ASO Contractor duties shall include, but are not limited to, the following:

- a. Checkwrite Process
 - 1) **Ensure payment files are accurate prior to generation of the of the check write invoice and provider checks by the FI Contractor.**
 - 2) **Review and approve the check write invoice and supporting reports for payment process is accurate according to the approved check write schedule.**
 - 3) Notify the Department and the FI Contractor of any errors prior to the release of checks. For claims found to be in error, identify the error in a PS, work with the FI Contractor to reprocess the claims, and make adjustments as necessary.
 - 4) Resolve restrictions prior to payment, such as overpayments, improper payments, liens, and levies, and process all accounts receivable activity;
 - 5) Convert any negative balance(s) to an accounts receivable (A/R) prior to the next checkwrite. A negative balance occurs when a provider's obligation to the Department as a result of adjustments, overpayment collections, etc.,

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exceeds the total payment due to the provider for a given checkwrite. Upon establishment of the A/R, the Contractor shall initiate a 100 percent (100%) withhold against payment for claims, or the percentage of the payment that will clear the A/R. The Department may, at its discretion, alter the percentage of withhold against the provider's claims payment; and

- 6) Process retroactive rate changes in accordance with Department-approved policies and procedures and as directed in DOILs.
- b. Interim Payment Process
- 1) Process and maintain records for interim payments. Interim payments are normally those payments made to providers for unpaid claims that have been in the system for thirty (30) calendar days or more due to Contractor or Department errors, or for paid claims affected by retroactive changes.
 - 2) Providers may request interim payments in writing or by telephone subsequently followed up in writing. Upon receipt of the provider request, the Contractor shall log all requests by provider name, provider number, dollar amount of the request, and the date received (and the time if the request is by phone);
 - 3) If the Contractor determines a provider does qualify for an interim payment, the Contractor shall forward to the Department the findings that the interim payment requirements have been met. The Contractor shall deliver these findings to the Department within two business days of its determination. The Department will review the Contractor's findings and make the final decision to approve or deny the interim payment request;
 - 4) If the Contractor is unable to make a determination, the provider shall be notified by telephone within twenty-four (24) hours of this finding. If no additional information is obtained, a follow-up letter shall be mailed within two business days;
 - 5) If the Contractor determines that a provider does not qualify for an interim payment based on Department established criteria, the Contractor shall forward to the Department such requests within seven business days from the date the Contractor receives the provider's written request. The Department will review the Contractor's findings and make the final decision to approve or deny the interim payment request;
 - 6) When the Department approves an interim payment, the Department shall verbally notify the Contractor and confirm the notice in writing. The Contractor shall then verbally notify the provider within twenty-four (24) hours of the Department's verbal notification, follow-up with written notice, and issue the interim payment within two business days;
 - 7) When the Department denies an interim payment request, the Department shall verbally notify the Contractor and confirm this notice in writing. The Contractor shall verbally notify the provider within twenty-four (24) hours of the verbal notification by the Department and follow with written notice within two business days; and

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- 8) Upon request, and within one business day of the request, the Contractor shall provide the Department with all records of provider request and subsequent correspondence, including related accounts receivable records and status of the affected provider.

c. Adjustment Process

The Contractor shall be responsible for the receipt, processing and adjustment to history of all repayments submitted by providers, (e.g., offset for overpayment received from an outside source). In addition, the Contractor shall process provider-initiated adjustments. Responsibilities shall include, but are not limited to, the following;

- 1) Accept providers' returned payments in several forms:
 - a) Personal check – the provider cashes the warrant but returns a personal check with a copy of the warrant's supporting documentation.
 - b) CIF – the provider cashes the warrant but completes a CIF requesting that his/her next payment(s) be adjusted accordingly.
 - c) Returned warrant – the provider returns the actual warrant to **** [the FI Contractor](#).****
 - d) Personal check with no supporting documentation. The Contractor shall attempt to contact the provider to identify the claims to be adjusted if not previously identified.
- 2) Within five business days of receipt of a returned provider payment check or personal check, the Contractor shall notify the provider in writing that the payment has been received. The written acknowledgment shall also inform the provider that a follow-up letter shall be sent within forty-five (45) calendar days of receipt of provider's returned payment/check. The follow-up letter shall include what specific action(s) were taken regarding the provider's returned check;
- 3) Forward all returned checks to the Department within twenty-four (24) hours or receipt;
- 4) Accept, process, and make adjustments to claims history, including TAR records, when the claimed service(s) was authorized on a TAR, for all repayments submitted by providers (e.g., offset for overpayment received from an outside source.);
- 5) If resolution to the problem is so complex that additional time is required, the Contractor shall submit a written request to the Department for additional time. Whenever the Department grants an extension in writing, the affected provider shall in turn be notified in writing by the Contractor of the extension of time;
- 6) Research and process all other adjustments to adjudicated claims and provider payments as directed by the Department. Prior to initiating adjustment transactions, either on an individual claim basis or as part of a mass adjustment and/or recovery action, the Contractor shall first determine if the provider has already initiated the adjustment(s). If a provider has

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submitted a personal check to adjust an identified overpayment, the Contractor shall not initiate an adjustment, and/or recovery action for the same overpayment;

- 7) All adjustments, including record corrections, shall be completed within thirty (30) calendar days of the date of the Department notice. The thirty (30) calendar-day limit may be extended if the Contractor requests an extension in writing and is approved by the Department. Upon completion of the adjustment, the Contractor shall provide written notification, which includes dates of completion and rescheduled payments, to the Department; and
- 8) The requirement of prior authorization may be waived where medical conditions or a time factor relating to treatment makes it inappropriate. Approval for payment of services provided in such circumstances rests with the Department based on submitted documentation justifying failure to obtain prior authorization.

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d. The Department intends to transfer responsibility for issuing provider payments to the State Controllers Office (SCO). When the transfer of responsibilities is complete, the Contractor will be responsible for adjusting any claims processing procedures and/or processes impacted by the electronic transfer to the SCO of all files and documentation necessary for the SCO to produce and issue provider payment. **

21. Cycle Time Requirements

- a. The Contractor shall comply with all of the most current federal and State statutes and regulations as specified in Exhibit A, Scope of Work, Exhibit D(F), Special Terms and Conditions, and Exhibit E, Additional Provisions.

Timely processing of documents by the Contractor is of critical importance. This section addresses the Contractor's responsibilities for timely processing and lists the performance requirements for Operation payment. The Contractor shall be evaluated on a monthly basis for payment of cycle time performance standards.

- 1) Claims, as referenced in the following section, refers to:
 - a) Whole claim/NOA document;
 - b) Claims/NOAs with or without professional review; and
 - c) CIFs adjudicated as claims (for reevaluation and adjustments only). For CIFs adjudicated as claims, the Contractor shall calculate cycle time using the CRN Julian date as the calculation start date.
- 2) TARs, as referenced in the following section, refer to:
 - a) Whole document;
 - b) TARs with or without professional review; and
 - c) Reevaluations of denied TARs (TAR reconsiderations).
- 3) RTD processing requirements are also addressed in this section;

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- 7) The time claims/NOAs/TARs are in the following document control locations are excluded from the RTD processing calculation: State review, SOC recycle, FAME recycle, and claims affected by a processing problem/error as defined in Claim/TAR Adjudication Responsibilities;
 - 8) Ensure that the number of claims/NOAs held for processing over thirty (30) calendar days shall not exceed nine percent of total claim/NOA inventory. Also ensure one hundred percent (100%) shall be processed within ninety (90) calendar days. Inventory is defined as non-adjudicated claims/NOAs in suspense and in "in process" DCCs, including daily receipts and daily cycle approved claims/NOAs. All claims/NOAs are considered in the inventory until the check write/EOB date; and
 - 9) Priority process claims as described in this Contract within seven calendar days of receipt of the Department's request.
- c. TAR Processing Cycle Time Requirements

This subsection addresses the Contractor's responsibilities for the timely processing of TARs and TAR reevaluations within CD-MMIS. The requirements listed below exclude Clinical Screening dentist screening time but includes professional review time.

The Contractor shall:

- 1) Utilize the following calculation methodology for determining compliance of TARs and TAR reevaluations:
 - a) Exclude the following DCCs from the TAR processing cycle time calculations:
 - i. State review (DCC 3W, 4W, 5W, 6W, 7W);
 - ii. FAME cycle wait (DCC 3E);
 - iii. SOC cycle wait (DCC 3S);
 - iv. RTD sent (DCC 6R);
 - v. Clinical Screening (DCC 5G and 5P);
 - vi. TARs and TAR reevaluations affected by a processing problem/error as defined within this Contract; and
 - vii. PA/SCR (DCC 5S).
 - b) Include professional review of TARs and TAR reevaluations within the overall processing time requirements;
- 2) Process and final adjudicate all TARs and TAR reevaluations within an average of **** five (5) working **** days of receipt in the system;

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- 3) Process and final adjudicate ninety percent (90%) of all TARs and TAR reevaluations within **five (5) working** days and ninety-nine percent (99%) within thirty (30) calendar days;
 - 4) Ensure that the number of TARs and TAR reevaluations held for final adjudication over twenty (20) calendar days shall not exceed nine percent of total inventory. No TAR or TAR reevaluation shall be over sixty (60) calendar days old. Inventory is defined as non-adjudicated TARs in suspense and in "in process" DCCs, including daily receipts and daily cycle approved TARs. TARs are considered in the inventory until the NOA is processed; and
 - 5) Priority process TARs and TAR reevaluations, as described in this Contract, within **three (3) working days** of receipt of the Department's request.
- d. Clinical Screening Dentist Review Cycle Time Requirements

This section addresses the Contractor's responsibilities for the timely processing of documents that require Clinical Screening dentist review. The time it takes to reschedule an appointment when a beneficiary fails to show for a screening appointment shall be excluded from cycle time calculations. Clinical Screening dentist review cycle time shall only pertain to the following document control locations:

- 1) Clinical Screening pre-schedule (DCC 5P); and
 - 2) Out for screening (DCC 5G).
 - a) The Contractor shall:
 - i. Within thirty-five (35) calendar days process and enter back into the system ninety percent (90%) of all documents sent to Clinical Screening;
 - ii. Within forty (40) calendar days process and enter back into the system ninety-nine percent (99%) of all documents sent to Clinical Screening;
 - iii. Meet the following aging inventory standards:
 - A. The number of documents held for Clinical Screening shall not exceed nine percent over thirty (30) calendar days; and
 - B. The number of documents held for Clinical Screening shall not exceed zero percent over sixty (60) calendar day;
 - iv. Through the use of the MRDCN, calculate Clinical Screening time as described above.
- e. Provider Cycle Time Requirements

The Contractor shall ensure Provider Cycle Time Requirements consist of the following categories:

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appropriate, least restrictive, and most cost-effective treatment to meet their identified oral health needs. UM includes practices such as notification, prior authorization, and medical necessity review. All authorization decisions must conform to the Department's definitions of medical necessity, appropriateness, and overall Medi-Cal Dental Program policy.

- c. All performance improvement projects and their work plans shall be subject to Department review and written approval.
- d. Sufficiently separate QM and QA activities from UM activities to ensure QM/QA activities can be distinctly identified as such.

The Contractor shall for each committee:

- 1) Implement a quality assessment and performance improvement program to monitor and strive to continuously improve the quality of care provided to beneficiaries;
- 2) Provide descriptive information on the operation, performance, and success of the QMI Program/UM Program;
- 3) Consist of staff from the ASO Contractor, FI Contractor, and the Department;
- 4) Conduct committee meetings at a minimum of four times per year;
- 5) For each meeting, record meeting minutes, delegate and follow-up on all action items;
- 6) Review the prior quarter's performance and the trends over, at a minimum, the past twelve (12) months in each operational area deemed appropriate for review;
- 7) Participate in communication and collaboration with Stakeholders including, but not limited to, California county agencies, providers, and beneficiaries;
- 8) Develop written procedures for following up on the results of the QMI Program/UM Program activities to determine success of implementation;
- 9) Provide written results on the activities of the QMI Program/UM Program regarding the operation and performance to determine success of implementation;
- 10) Document actions taken and follow-up efforts on the results of the QMI Program/UM Program activities to determine success of implementation; and
- 11) Modify the plans in the areas that fail to meet the Department's desired goals/outcomes. The Department may provide the Contractor with a model plan and/or the Contractor shall modify the plan based on the discussions with the Department.

12. Payment Responsibilities

The Contractor shall: **

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a. Ensure the payment process is accurate prior to the FI Contractor issuing checks to the providers. This may include submitting the payment file through a series of edits/audits to detect errors;

a.b. Perform a QM review of each payment file to detect errors in payments not detected in routine processing, including the pre-checkwrite function; **

- 1) Include the use of computerized reports to detect potential errors, including payments in excess or under allowable amounts and payments in excess of established amounts as defined by the Department, and manual review of all exceptions to determine if they are in error;
- 2) Notify the Department and the FI Contractor of any errors prior to the release of checks. For claims found to be in error, identify the error in a Problem Statement (PS), work with the FI Contractor to reprocess the claims, and make adjustments as necessary.
 - a) Weekly Checkwrite Reviews
 - i. To minimize the delay in issuing payment to a provider when the Contractor retains a provider check for review and/or lists claims, the Contractor shall reschedule for payment those claims within the retained check or list of claims that do not contain errors. The rescheduled payment shall be made either within seven business days or by the next checkwrite following the date the Contractor notifies the Contracting Officer, whichever period is shorter;
 - ii. All corrections and rescheduling of corrected provider payments shall be completed within thirty (30) calendar days of notification to the Contracting Officer, unless additional time is granted by the Contracting Officer. When the Contracting Officer grants additional time, and within three business days of the approval notice, the affected provider(s) shall be notified in writing of the claims in question; and
 - iii. Upon completion of the corrections and rescheduling within thirty (30) calendar days, the Contractor shall notify the Contracting Officer in writing of the completed transaction(s). Where extended time has been authorized, the Contractor shall again notify the Contracting Officer in writing of the completed transactions by the end of the extension period or completion of corrections and rescheduling of provider payments, whichever occurs first. All notices shall include date(s) of completion and rescheduled payment(s).
- 3) Refer to Exhibit A, Attachment II, Claims Processing for additional information on processing provider-initiated adjustments. Within five business days of receipt of a returned provider payment check or personal check, the Contractor shall notify the provider in writing that the payment has been received. The written acknowledgment shall also inform the provider that a follow-up letter shall be sent within forty-five (45) calendar days of receipt of the provider's returned payment/check. The follow-up letter shall include what specific action(s) were taken regarding the provider's returned check.

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- b. Validate all erroneous payments to providers and ensure all records have been adjusted regardless of the cause or the source of the erroneous payment. Other adjustment requirements are described in the Exhibit A, Attachment II, Claims Processing.

PSs related to erroneous payment corrections shall be submitted to the FI Enterprise Project Management Office (EPMO) by Department and/or Contractor staff. The QM Operations of both the FI and ASO Contractors shall have responsibility to coordinate and validate all PSs related to erroneous payment corrections.

- c. Liability for Overpayment

The Contractor is liable to the Department for unrecoverable overpayments and any associated administrative expenses. Unrecoverable overpayments are erroneous payments caused by the Contractor where the Department and the Contractor are unable to collect. Below are examples of what the Department considers unrecoverable overpayments:

- 1) Erroneous payment whereby the overpayment cannot be collected from the provider due to the Contractor's negligence or inaction;
- 2) Erroneous payment for claims paid to a provider who was inappropriately enrolled in the Medi-Cal Dental Program;
- 3) Erroneous payment for claims paid to a provider who was suspended from the Medi-Cal Dental Program; and
- 4) Those erroneous payments for claims processed when a beneficiary's eligibility would preclude reimbursement for services through CD-MMIS, e.g., the beneficiary is enrolled in a dental managed care plan.

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d. The Department intends to transfer responsibility for issuing provider payments to the State Controllers Office (SCO). When the transfer of responsibilities is complete, the Contractor will be responsible for adjusting all quality management processes and/or procedures impacted by the electronic transfer to the SCO of all files and documentation necessary for the SCO to produce and issue provider payment. Refer to the FI Contract, Exhibit A, Attachment II, Claims Processing for additional information regarding payment processing. **

13. Trend Analysis Reports

The Monthly Quality Management Performance Reports shall include analysis reports identifying process-oriented error trends and proposed process improvement recommendations. The reports shall be based upon data collected from Problem Statement correction notices and/or additional information provided by the FI Contractor, Monthly Quality Management Performance reviews, federal and State audit reports and internal audits.

The reports shall contain:

- a. Ongoing trend analysis graphs identifying frequency of errors for the previous month's reporting period plus a cumulative analysis of errors from the beginning of Operations;

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- b. Follow-up information from the prior month's PS correction notices and implemented resolutions to the recommendations;
- c. Identification of the specific process within the Contractor's Operation that prominently contributed to the error's occurrence;
- d. Identification of all the adverse impacts resulting from the defective process, and the extent of the adverse impacts (as quantified by number of errors, number of erroneously paid claims, and amount of over verses underpayments);
- e. Recommendation of process and policy changes that would reduce recurrence of errors, and a detail of what would be involved to complete the change; and
- f. Ongoing status reports of all process error recommendations.

The Contractor shall utilize all available resources and not solely depend on the FI Contractor to support the development of the QM Performance reporting.

14. Individual Professional Performance Review

The Contractor shall employ a QMDC, reporting to the Director of QM, whose responsibility is to monitor the training and professional competency of the Contractor's Dental Consultants and Clinical Screening Dentists. The QMDC is a dedicated position to be used solely for this function and cannot be used in the processing of documents to meet cycle time requirements.

The QMDC shall:

- a. Monitor all Dental Consultants and Clinical Screening Dentists' training;
- b. Ensure that each individual Dental Consultant has at all times in his/her immediate work area, at a minimum, a Medi-Cal Dental Program Provider Handbook (with bulletins), a Professional & Paraprofessional Adjudication Manual, a Code Manual, a Suspense & Error/File Maintenance Processing Manual, and a Clinical Screening Dentist Manual. In addition, each Dental Consultant's manual shall contain the most current update/revision pages;
- c. Monitor the quality performance of all Dental Consultants and Clinical Screening Dentists and record findings on a monthly Professional Review Performance Report commencing ninety (90) calendar days after the AOO. All Dental Consultants shall be reviewed monthly and Clinical Screening Dentists shall be reviewed on a semi-annual basis and reported on an individual basis. The Contractor shall provide the information necessary to identify each Dental Consultant and Clinical Screening Dentist by the name appearing on his or her State of California dental license;
- d. Utilize the system to ensure that all Dental Consultants and Clinical Screening Dentists hold current, active, and unrestricted licenses to practice dentistry within the State of California;
- e. Establish policies and procedures for measuring the quality of professional review and adjudication for each Dental Consultant and the quality of professional review for each Clinical Screening Dentist. In performing professional reviews, the QMDC shall:

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- 1) Ensure individual Dental Consultants maintain a minimum of a ninety-eight percent (98%) accuracy level in the professional adjudication of claims/TARs, and for every Professional Review Data Control Center except the State Wait Data Control Center, in accordance with Medi-Cal Dental policy and procedures;
- 2) Review a statistically valid sample of all Clinical Screening Dentists' reports and determine compliance with Medi-Cal Dental policy and procedures. Errors shall be compiled in semi-annual reports, and included in the Clinical Screening Dentist database; and
- 3) Be responsible for the creation and execution of a CAP for each Dental Consultant and Clinical Screening Dentist whose performance fails to meet Contract requirements or QM standards.

15. Integrated Test Facility

The Contractor shall aid the Department in monitoring the system's accuracy. The Department will utilize live test transactions to aid and enhance monitoring of the Contractor's performance. This will include the establishment by the Department of test providers and beneficiaries on production files, as well as the submission of test data, including claims, TARs, CIFs, and other documents, without limitation and as necessary, into the production system. The Department will utilize this process without notice to the Contractor to assure that the test replicates outcomes to be expected in a live environment. This facility may be made available to the Contractor with written approval of the Contracting Officer.

16. Acceptance Test System

The acceptance test system is an environment used to test system changes before promoting those changes into the production system. The environment shall include a test (mirror) version of on-line and batch programs and system files identical to the production environment. It shall replicate the production environment, which allows testing of system changes against realistic data values and against a realistic volume of data.

The Contractor shall:

- a. Ensure the CD-MMIS operates according to federal and State statutes and regulations. Work with the FI Contractor who shall support and maintain an acceptance test environment to allow the ASO Contractor to fully test system changes prior to implementation into the production environment for mainframe and non-mainframe systems, including related applications;
- b. Continue to perform comprehensive Acceptance Testing to ensure that system changes to CD-MMIS, Electronic Data Interchange (EDI) and non-mainframe systems initiated by any change instruments (e.g. PSs, SDNs, MCDs, DOILs, or previous implemented PSs) will be correctly installed into the production environment;
- c. Execute all Acceptance Testing as part of the Department's ongoing monitoring of System Group (SG) testing. This is necessary to ensure that federal and State goals for accuracy, efficiency, and policy conformance are met;