



**COMMONWEALTH of VIRGINIA**  
**DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**  
600 East Broad Street, Suite 1300  
Richmond, VA 23219

November 24, 2010

Dear Prospective Vendor:

The Department of Medical Assistance Services (DMAS) is soliciting proposals from qualified firms for a Virginia Medicaid/FAMIS Plus/FAMIS Dental Benefits Administrator (DBA). Duties of the DBA will include strengthening the *Smiles For Children* program in terms of enhanced network access to quality dental and specialty providers, monitoring and encouraging appropriate pediatric dental utilization, and effective program integrity activities. The qualified Contractor shall demonstrate exceptional provider relations and network recruitment/retention abilities, including proven strategies to: (1) expand current provider network access (including maintenance of current network providers), (2) maintain high provider satisfaction ratings, (3) target recruitment of providers and specialists based upon program need, (4) effectively credential for participation of quality service providers, and (5) assist with the development of a quality improvement strategy. The qualified Contractor shall also be responsible for monitoring and encouraging appropriate pediatric dental utilization through dental disease prevention, outreach, and education activities. The DBA must demonstrate effective utilization control and program integrity practices through activities including but not limited to: service authorization, prepayment claims review, etc. The selected DBA will promote the *Smiles For Children* dental program; conduct provider and enrollee outreach activities; handle enrollee and provider services issues; interface with the Virginia Medicaid Management Information System (VAMMIS), and submit encounter data per established criteria outlined in this RFP. The selected Contractor will provide the required services for DMAS. Specific details about this procurement are in the enclosed Request for Proposal (RFP) 2011-03.

The Commonwealth will not pay any costs that any Offeror incurs in preparing a proposal and reserves the right to reject any and all proposals received.

Offerors are requested not to call this office. All issues and questions related to this RFP should be submitted in writing to the attention of Daniel Plain, Dental Program Manager, Health Care Services Division, 600 East Broad Street, Suite 1300, Richmond, VA 23219. In order to expedite the process of submitting inquiries, it is requested that vendors submit any questions or issues by email in MS Word format to [RFP2011-03@dmass.virginia.gov](mailto:RFP2011-03@dmass.virginia.gov)

Contractors who wish to submit a proposal are required to submit a Letter of Intent which must be received by the Department no later than **2:00 PM** local time on December 6, **2010**. The prior submission of a Letter of Intent is a prerequisite for submitting a proposal; proposals shall not be accepted from Contractors who have not submitted a Letter of Intent by the deadline specified above. Letters of Intent may be emailed to the address listed above with original hard copy to follow via USPS, overnight delivery or courier service. All Letters of Intent shall be addressed to:

Department of Medical Assistance Services  
Attention: William Sydnor  
600 East Broad Street, Suite 1300  
Richmond, VA 23219

Sincerely,

*William D. Sydnor*

William D. Sydnor  
Contract Management Director

Enclosure

**REQUEST FOR PROPOSALS**  
**RFP 2011-03**

**Issue Date:** November 24, 2010

**Title:** Virginia Medicaid/FAMIS Plus/FAMIS Dental Benefits Administrator for the *Smiles For Children* program

**Period of Contract:** An initial period of four years from award of contract, with provisions for four twelve-month extensions.

All inquiries should be directed in writing via email in MS Word Format to: [RFP2011-03@dmas.virginia.gov](mailto:RFP2011-03@dmas.virginia.gov)

Daniel Plain  
Dental Program Manager  
Department of Medical Assistance Services  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219

**Deadline for submitting inquiries and Letter of Intent: 2:00 pm E.S.T., December 6, 2010**

**Proposal Due Date:** Proposals will be accepted until **2:00 pm E.S.T., January 14, 2010**

**Submission Method:** The proposal(s) must be sealed in an envelope or box and addressed as follows:

“RFP 2011-03 Sealed Proposal”  
Department of Medical Assistance Services  
600 E. Broad Street, Suite 1300  
Richmond, Virginia 23219  
Attention: William D. Sydnor

Facsimile Transmission of the proposal is not acceptable

**Note:** This public body does not discriminate against faith-based organizations in accordance with the *Code of Virginia*, §2.2-4343.1 or against an Offeror because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment.

In compliance with this Request for Proposal and to all conditions imposed therein and hereby incorporated by reference, the undersigned proposes and agrees to furnish the services contained in their proposal.

Firm Name (Print)	F.I. or S.S. Number
Address	Print Name
Address	Title
City, State, Zip Code	Signature (Signed in Ink)
Telephone:	Date Signed
Fax Number:	E-Mail:
eVA Registration Vendor Number <b>(Required):</b>	eVA #:
State Corporation Commission ID Number <b>(Required):</b> (See Special Terms and Conditions)	SCC ID #:
Check Applicable Status: Corporation: _____ Partnership: _____ Proprietorship: _____ Individual: _____ Woman Owned: _____ Minority Owned: _____ Small Business: _____ If Department of Minority Business Enterprises (DMBE) certified, provide certification number: _____	

**COMMONWEALTH OF VIRGINIA**  
**DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**  
**REQUEST FOR PROPOSALS**  
**FOR**  
**VIRGINIA MEDICAID/FAMIS Plus/FAMIS**  
**DENTAL BENEFITS ADMINISTRATOR FOR THE *SMILES FOR CHILDREN* PROGRAM**

**RFP 2011-03**

**November 24, 2010**

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**I. PURPOSE AND DEFINITIONS**

The Department of Medical Assistance Services hereinafter referred to as the Department or DMAS, is the single State agency in the Commonwealth of Virginia that administers the Medicaid program under Title XIX of the Social Security Act and the State Child Health Insurance Program (known as FAMIS) under Title XXI of the Social Security Act for low-income people. These programs are financed by federal and state funds and administered by the state according to federal guidelines. Both programs include coverage of dental services for eligible Medicaid/FAMIS Plus and FAMIS members.

Dental services are a mandatory Medicaid benefit for children. Section 1902(a)(43) of the Social Security Act specifically requires that State Medicaid plans provide or arrange for such services. In addition, the Virginia State Plan for FAMIS, as provided for in the *Code of Virginia* § 32.1-320, as amended, includes provisions for dental benefit coverage for FAMIS children. The Department is hereby soliciting proposals from qualified organizations through a competitive procurement process for a dental benefits administrator (DBA) to include provider recruitment, member outreach, coordination, management, and reimbursement of dental services for Title XIX Medicaid members and Title XXI FAMIS children. The Contract will be provided as an Administrative Services Only (ASO) Contract. This Request for Proposals (RFP) is for the provision of dental services statewide for Title XIX Medicaid members and children enrolled in Virginia's Title XXI program (FAMIS). Dental services also are provided for members enrolled in Medicaid home-based and community-based waiver programs at the same amount, duration, and scope as covered for the Medicaid population.

Number of Awards: An Offeror may submit a proposal for statewide services only. The maximum number of contracts to be awarded under this RFP is one. Based on the proposals, DMAS is planning to select and enter into a contractual agreement with a qualified organization for the provision of dental administration services in the Commonwealth.

Duration of Contract: The duration of the contract resulting from this RFP is four (4) years from award of contract. This contract may be renewed by the Commonwealth upon written agreement of both parties for up to four (4) successive one-year periods, under the terms of the current contract, and at a reasonable time (approximately 90 days) prior to the expiration.

General Scope of Responsibilities: The responsibilities of the DBA, which are more fully described later in the RFP, will include maintaining and expanding the Department's dental provider network, including recruiting, credentialing and contracting with providers; increasing member utilization of dental services; handling service authorization requests; processing claims and submitting encounter data; promoting the dental program; conducting provider and member outreach activities; handling member and provider services issues, and interfacing with the Virginia Medicaid Management Information System (VAMMIS). The Commonwealth's goal is to increase access to and utilization of high quality dental care services through an expanded and comprehensive network of dental providers. The Contractor selected in response to this RFP must be able to perform the services described in the RFP's Section 4 Technical Proposal Requirements, by July 1, 2011.

Dental services are currently covered for Medicaid/FAMIS Plus children under 21 years of age and under age 19 for FAMIS children. Covered services are defined as any medically necessary diagnostic,

preventive, restorative, and surgical procedures, as well as orthodontic procedures, administered by, or under the direct supervision of a dentist. Limited medically necessary oral surgery coverage is available for members 21 years of age and older when performed by a participating dentist and only when the service is one that is either generally covered under Medicaid and/or is medically necessary. Examples of medically related covered services for adults include removal of cysts and tumors not related to the teeth, biopsies for suspected malignancies, repair of traumatic wounds, and extraction of teeth for severe abscesses complicating a medical condition or contributing to poor general health.

Department’s Dental Program Name: “*Smiles For Children*” is the Department’s unified dental administrative arrangement for all Medicaid/FAMIS Plus and FAMIS enrollees.

Volume and Participation: In SFY 09 approximately 686,118 Medicaid/FAMIS Plus and FAMIS children ages 0 – 20yrs were eligible for the *Smiles For Children* program. Approximately 276,143 of these children received care through the Department’s *Smile For Children* dental program. During this time period limited coverage for medically necessary oral surgery was available for approximately 253,375 Medicaid adults.

Table 1 below reflects the combined dental expenditures for the Medicaid/FAMIS Plus/FAMIS and FAMIS program’s children and adult participants for state fiscal years 2008 and 2009.

**Table 1: Virginia Dental Expenditures**

Program	Fiscal Year 2008	Fiscal Year 2009
<i>Smiles For Children</i>	\$116,282,862.45	\$134,144,257.65

**Impact of Federal Health Reform on Enrollment and Eligibility of Children**

Under the federal health reform effort (The Patient Protection and Affordable Care Act (PPACA)), starting January 1, 2014, the Medicaid program will be expanded greatly and many if not most individuals with family incomes at or below 133 percent of the federal poverty level will be eligible for Medicaid. While Virginia Medicaid currently covers children up to this income level, it is possible that more children will enroll because of the additional publicity surrounding this expansion, or because newly eligible parents will enroll their children because of the federal mandate that all individuals obtain coverage. DMAS’ initial estimate is that the monthly enrollment may increase by an additional 270,000 to 425,000, including 50,000 new children. The contractor may receive per member per month/administrative cost increases as defined in the contract.

**1.2 Definitions**

Throughout this RFP, the following definitions shall be applicable:

The following terms when used in this RFP shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation.

1. Administrative Cost - All costs to the Contractor related to the administration of the activities required through this RFP. Costs of subcontractors engaged solely to perform a non-medical administrative function for the Contractor specifically related to securing or fulfilling the Contractor’s obligations to the Department under the terms of this RFP (including, but not limited to, claims processing, postage, personnel, rent) are considered to be an “administrative cost.”

2. Administrative Services Fee – The per member per month amount the Contractor shall charge for provision of the services outlined in this RFP.
3. Adverse Action – An action taken by the Contractor to deny, terminate, suspend, reduce services and/or date range(s) for services, or partially approve a covered service. The Contractor’s failure to take action on a request for services within established timeframes is also an adverse action. “Adverse Action” and “Action” are used interchangeably.
4. Annually – For the purposes of contract reporting requirements, annually shall be defined as within 90 calendar days of the effective contract date and effective contract renewal date.
5. Appeal – A request made by a provider or member for a neutral party to review an adverse action taken by the Contractor to determine whether the action complied with the Medicaid laws, regulations, and/or policy. The appeal shall be governed by the Department’s regulations and any and all applicable laws and court orders.
6. Benefits - A schedule of dental services to be administered by the Contractor to members pursuant to this RFP.
7. Business Days – Monday through Friday, 8:00 AM to 5:00 PM, Eastern Standard Time, unless otherwise stated.
8. Case Management – The process of identification of patient needs and the development, implementation, monitoring, and revising (as necessary) of a plan of care to efficiently achieve the optimum quality patient outcomes in the most cost-effective manner.
9. Case Manager - An organization or a provider responsible for supervising or coordinating the provision of initial and primary care to patients; for initiating and/or authorizing referrals for specialty care, and for monitoring the continuity of patient care services.
10. Claim – An itemized statement requesting payment for services rendered by health care providers (such as hospitals, physicians, dentists, etc.), billed electronically or on the CMS 1500, UB-92, and/or ADA Dental claim forms.
11. Clean claim - A claim received by the Contractor for adjudication, and which requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by the Contractor.
12. CMS - Centers for Medicare and Medicaid Services.
13. Contract - The signed and executed document resulting from this RFP.
14. Contract Modifications - Any changes or modifications to the Contract that are mutually agreed to in writing by the Contractor and the Department or are mandated by changes in Federal or State laws or regulations.
15. Contractor - The entity that contracts with the Department, under the State Plan and in return for a payment, to process claims, to pay for and administer dental services, or to enhance the Department’s capability for effective administration of the program.
16. Covered Service - Medically necessary dental services for Medicaid/FAMIS Plus children under 21 years of age and under age 19 for FAMIS children and limited medically necessary oral surgery for Medicaid eligible individuals age 21 and over as described in Sections 4 and Attachment I of this RFP.
17. Dental Benefits Administrator (DBA) - An entity that manages or directs a dental benefits program on behalf of the program’s sponsor. For the purposes of this RFP and resulting contract, the DBA is responsible for administering the Department’s dental benefits program statewide for Title XIX Medicaid members and Title XXI FAMIS children to include coordination, management, and reimbursement of such dental services.
18. Department - The Virginia Department of Medical Assistance Services.

19. Disenrollment - The discontinuance of a member's eligibility to receive covered services under the terms of this RFP, and deletion from the approved list of members furnished by the Department to the Contractor.
20. DMAS - The Department of Medical Assistance Services also referred to as "the Department."
21. Eligible Person - Any person certified by the Department as eligible to receive services and benefits under the Department's Program.
22. Emergency Dental Condition - A dental or oral condition that requires immediate services for relief of symptoms and stabilization of the condition; such conditions include severe pain; hemorrhage; acute infection; traumatic injury to the teeth and surrounding tissues; or unusual swelling of the face and gums.
23. Emergency Medical Services (or Emergency Services) - Covered dental services furnished by a qualified participating provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard.
24. Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.
25. Encounter - Any covered service received by a member and processed by the Contractor.
26. Encryption - A security measure (process) involving the conversion of data into a format that cannot be interpreted by unauthorized parties.
27. Enrollment - The process by which a person is entered into the Contractor's database through the Department.
28. EPSDT - The Early and, Periodic, Screening, Diagnosis, and Treatment services mandated by 42 U.S.C. § 1396d (e) and amended by OBRA 1989. By statute, the State "must provide or arrange for" four separate screens: medical, vision, hearing and dental.
29. FAMIS Member - A person enrolled in the Department's FAMIS program who is eligible to receive dental services under the State Child Health Insurance Plan under Title XXI, as amended.
30. FAMIS Plus Members - Children under the age of 19 who meet "medically indigent" criteria under Medicaid program rules, and who are assigned an aid category code of 90; 91 (under 6 years of age); 92 and 94. FAMIS Plus children receive the full Medicaid benefit package and have no cost-sharing responsibilities. Additionally, for the terms set forth in this Contract, FAMIS Plus and Medicaid members shall be treated in the same manner. Any information sent to FAMIS Plus and Medicaid members must appropriately address the entire intended population. For example, enrollment and benefit materials cannot specify "Medicaid" unless they also specify "FAMIS Plus." If the material does not specify "Medicaid," it does not need to specify "FAMIS Plus." (Note: Some of these designated program categories may change under the federal health reform effort starting in 2014.)
31. Facility - Any premises (a) owned, leased, used or operated directly or indirectly by or for the Contractor or its affiliates for purposes related to this RFP; or (b) maintained by a subcontractor or provider to provide services on behalf of the Contractor.
32. Fee-for-Service - A method of making payment for health services based on a fee schedule that specifies payment amounts for defined services.
33. Federally Qualified Health Centers (FQHCs) - Those facilities as defined in 42 C.F.R. § 405.2401(b), as amended.
34. Fiscal Year (State) - July 1 through June 30.
35. Fraud - Intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in payment of an unauthorized benefit. It includes any act that constitutes fraud under applicable Federal or State law.
36. FTE - Full time equivalent position.

37. Grievance – A complaint expressing dissatisfaction with the quality of services provided or authorized by the Contractor.
38. Health Insurance Portability & Accountability Act of 1996 (HIPAA) - Title II of HIPAA requires standardization of electronic patient health, administrative and financial data; unique health identifiers for individuals, employers, health plans, and health care providers, and security standards protecting the confidentiality and integrity of individually identifiable health information past, present, or future.
39. Inquiry – An oral or written communication by or on the behalf of a member that may be: 1) questions regarding the need for additional information about eligibility, benefits, plan requirement or materials received, etc.; 2) provision of information regarding a change in the member’s status such as address, family composition, etc. or; 3) a request for assistance such as selecting or changing a provider, obtaining translation or transportation assistance, obtaining access to care, etc. Inquiries are not expressions of dissatisfaction.
40. Liquidated Damages - a dollar amount stipulated in this contract which the parties agree is a reasonable estimation of the damages that would be owed to DMAS in the event of a breach by the Contractor.
41. Managed Care Organization (“MCO”) - An entity that meets the participation and solvency criteria defined in 42 CFR Part 438 and has an executed agreement with the Department to provide services covered under the Medallion II and FAMIS programs.
42. Marketing - Any activity conducted by or on behalf of the Contractor where information regarding the services offered by the Contractor is disseminated in order to persuade eligible persons to utilize their covered dental services and to be aware of the services offered by the Contractor pursuant to this RFP.
43. Medicaid Expansion – A Child age 6 years to 19 years with family income between 100% to 133% poverty limit who is uninsured and is enrolled in the program under aid category 94. The Medicaid Expansion program is funded by Title XXI funds.
44. Medicaid Management Information System (MMIS) - The medical assistance eligibility, enrollment, and payment information system of the Virginia Department of Medical Assistance Services. (also referred to as VaMMIS)
45. Medical Record - A single complete record kept at the site of the member's treatment(s), which documents all of the treatment plans developed, medical services ordered for the member and medical services received by the member.
46. Medically Necessary - Services or supplies provided by an institution, physician, or other provider that are required to identify or treat a member’s illness, disease, or injury and which are:
  - a Consistent with the symptoms or diagnosis and treatment of the member's illness, disease, or injury; and
  - b Appropriate with regard to standards of good dental or medical practice; and
  - c Not solely for the convenience of a member, dentist, physician, institution or other provider; and
  - d The most appropriate (in terms of cost and effectiveness) supply or level of service that can safely be provided to the member and that is sufficient in amount, duration, or scope to reasonably achieve their purpose. When applied to the care of an inpatient, it further means that services for the member's medical symptoms or condition require that the services cannot be safely provided to the member as an outpatient; and
  - e When applied to a member who is under 21 years of age, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.
47. Member – An individual having current Medicaid/FAMIS Plus or FAMIS eligibility who shall be authorized by the Department to participate in the dental program.

48. Member Funding Category – For the purposes of this RFP, member funding categories shall include Medicaid Children under age 21, Medicaid Expansion children (member aid category 94), FAMIS members, and Medicaid adults age 21 and over. Eligible Medicaid, Medicaid Expansion, and FAMIS children categories make up the pediatric PMPM rate category. (See Section 6.2 of this RFP).
49. Monthly – For the purposes of contract reporting requirements, monthly shall be defined as the 15<sup>th</sup> day of each month for the prior month’s reporting period. For example, January’s monthly reports are due by February 15<sup>th</sup>; February’s are due by March 15<sup>th</sup>, etc.
50. Network Provider - The health care entity or health care professional who is either employed by or has executed a provider agreement with the Contractor, or its subcontractor, to render covered services, as defined in this Contract, to members.
51. Non-Contract Provider - Any person, organization, agency, or entity that is not directly or indirectly employed by or through the Contractor or any of its subcontractors pursuant to the RFP between the Contractor and the Department.
52. Offeror - The entity that seeks to contract with the Department, under the State Plan and in return for a payment, to process claims, to pay for and administer dental services, or to enhance the Department’s capability for effective administration of the program.
53. Out-of-Plan Services - Services provided by a non-contract provider.
54. Participant - See member.
55. Patient Protection and Affordable Care Act (PPACA) - The federal health reform legislation enacted March 23, 2010 which will expand the Medicaid program, and reauthorizes the CHIP program through September 30, 2015, among many other provisions.
56. Pediatric Dental – For the purposes of this contract, shall include Medicaid children under the age of 21, Medicaid Expansion members with an aid category of 94, and FAMIS children.
57. Post Payment Review - A process administered by the Contractor to provide review after service has been provided and payment has been made.
58. Prepayment Review - A process administered by the Contractor to provide review prior to payment of CDT codes designated by SFC to assure appropriateness of care and payment and should not be confused with Service Authorization. Review is completed after the service is provided but in advance of payment being made.
59. Primary Care Physician - A physician responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care. A primary care physician is a physician who has limited his practice of medicine to general practice or who is a Board Certified or Eligible Internist, Pediatrician, Obstetrician/Gynecologist, or Family Practitioner.
60. Primary Care Provider - A primary care physician or nurse practitioner practicing in accordance with state law who is responsible for supervising, coordinating, and providing initial and primary medical care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care.
61. Protected Health Information (PHI) - Individually identifiable information, including demographics, which relates to a person's health, health care, or payment for health care. HIPAA protects individually identifiable health information transmitted or maintained in any form or medium.
62. Provider - An institution, facility, agency, person, corporation, partnership, or association approved by the Department which accepts as payment in full for providing benefits the amounts paid pursuant to a provider agreement with the Contractor.
63. Provider Agreement - An agreement between a Dental Benefits Administrator (DBA) and a provider or DBA's subcontractor and a provider of oral health care services, which describes the conditions under which the provider agrees to furnish covered services to DBA’s members.

64. Quality Monitoring (QM) - The ongoing process of assuring that the delivery of health care is appropriate, timely, accessible, available, and medically necessary and in keeping with established guidelines and standards and reflective of the current state of medical/dental knowledge.
65. Quarterly – For the purposes of contract reporting requirements, quarterly shall be defined as within 30 calendar days after the end of each quarter, unless otherwise specified by the Department.
66. Quarters - Calendar quarters starting on January 1, April 1, July 1, and October 1.
67. Rural Health Clinic - A facility as defined in 42 C.F.R. § 491.2, as amended.
68. Semi-annually - For the purpose of contract reporting requirements, semi-annually shall be defined as no later than 30 calendar days after the end of the six-month time frame.
69. Services - See covered service.
70. Service Authorization - The act of authorizing specific services or activities before they are rendered or activities before they occur.
71. Service Location - Any location at which a member obtains any oral health care service covered by the Contractor pursuant to the terms of this RFP.
72. Shall - Indicates a mandatory requirement or a condition to be met.
73. Smiles For Children (SFC) - The name of the Virginia Medicaid dental program.
74. Specialty Services – Includes Pediatric Dentistry, Oral Surgery, Endodontics, Periodontics and Orthodontics.
75. State - Commonwealth of Virginia.
76. State Plan for Medical Assistance (State Plan) - The comprehensive written statement submitted by the Department to CMS for approval, describing the nature and scope of the Virginia Medicaid program and giving assurance that it will be administered in conformity with the requirements, standards, procedures and conditions for obtaining Federal financial participation. The Department has the authority to administer the State Plan for Virginia under Code of Virginia § 32.1-325, as amended.
77. Subcontract - An agreement entered into by the Contractor with any other organization or person who agrees to perform any administrative function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Department under the terms of this RFP, (e.g., claims processing, marketing) when the intent of such an agreement is to delegate the responsibility for any major service or group of services required by this RFP. Agreements to provide covered services as described in Attachment I of this RFP shall be considered Provider Agreements and governed by 4.8 of this RFP.
78. Subcontractor - Any State approved organization or person who provides any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Department under the terms of this RFP. For the purposes of this Contract, the subcontractor's providers shall also be considered providers of the Contractor.
79. Third Party Resource - Any entity or funding source other than the member or his/her responsible party, which is or may be liable to pay for all or part of the cost of medical/dental care of the member.
80. Third Party Liability – Any amount due for all or part of the cost of medical care from a third party.
81. Urgent Dental Condition – A dental or oral condition that requires services for relief of symptoms and stabilization of the condition within a reasonable period of time, as determined by the treating dentist, other dental professional, primary care provider, or triage nurse who is trained in dental care and oral care. Such conditions may include minor tooth fracture; an oral tissue lesion that is visible to the member; and lost restoration.
82. Utilization Management – The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria.
83. VaMMIS (MMIS) – Virginia's Medicaid Management Information System

## 2. BACKGROUND

In 1998, the General Assembly directed the Department to report on its efforts to expand the availability and delivery of dental services to pediatric Medicaid members. The Department commenced the submission of annual reports in 1998 to the General Assembly describing the status of access to dental services for Medicaid children. Reports to the General Assembly can be found on the Department's dental website at [http://dmasva.dmas.virginia.gov/Content\\_pgs/dnt-home.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/dnt-home.aspx)

One of the major developments of 1998 was the formation of a Dental Advisory Committee (DAC). The DAC is composed of 22 members, with the large majority of who are dental providers from across the state, including representatives from the Virginia Dental Association, Virginia Primary Care Association, Virginia Commonwealth University School of Dentistry, the Virginia Department of Health, and the Department. The DAC's membership was recently expanded to enhance the representation of minority and specialist providers and to provide better geographic balance. The DAC meets four times a year to discuss ways to improve access to dental care for Medicaid/FAMIS Plus and FAMIS children.

Collaboration between the Department, the Department's Dental Advisory Committee (DAC) and the Virginia Dental Association (VDA) led to the recommendation that the Department carve dental services out of MCO contracts and consolidate dental services under a unified dental administrative arrangement.

The 2004 Appropriations Act (see Attachment VII-2010 Appropriations Act Language) authorized the Department to amend the Medallion II waiver to allow for the carve out of dental services provided to managed care members. In addition, the Act provided the Department with the authority to amend the State Plans for Titles XIX (Medical Assistance) and XXI (Family Access to Medical Insurance Security) of the Social Security Act, as required by applicable statute and regulations, to provide dental services to individuals enrolled in these programs on a fee-for-service basis. It further allowed the Department to outsource the administration of such dental services to an administrative services contractor.

Today, *Smiles For Children* is one of the most highly recognized Medicaid dental programs in the country. CMS and other states look to Virginia as an example of how to improve dental care delivery for Medicaid enrollees. It is collaboration with the provider community, combined with improvements to reimbursement, expanded outreach, modeling after commercial payers, and the involvement of key oral health players throughout the state that has resulted in *Smiles For Children* significantly expanding access and increasing utilization. The Department provides all oversight of the *Smiles For Children* Program.

### Utilization

Table 2 captures Virginia Medicaid dental utilization data in the format of the Centers for Medicare and Medicaid Services' (CMS) "416 Report". It categorizes by age Virginia Medicaid/FAMIS Plus and FAMIS members who are eligible for the dental program and identifies their approximate utilization of dental services. (The CMS 416 report provides basic information on participation in the Medicaid child health program, including receipt of dental services.) The report indicates that for state fiscal year (SFY) 2008-2009 more than 501,000 Medicaid/FAMIS Plus/FAMIS members over the age of three and under the age of 21 were eligible for dental services.

This table includes dental utilization data from Medicaid/FAMIS Plus/FAMIS and indicates an increase in dental utilization from state fiscal year 2008 to fiscal year 2009.

**Table 2: Virginia Pediatric Dental Utilization**

Member Age	Total Members Eligible		Total Members Receiving Any Dental Services		% Receiving Services	
	SFY 08	SFY 09	SFY 08	SFY 09	SFY 08	SFY 09
3 to 5	111,094	121,099	47,434	54,836	42.70%	45.28%
6 to 9	128,344	139,335	66,997	76,856	52.20%	55.16%
10 to 14	132,325	142,434	66,934	75,315	50.58%	52.88%
15 to 18	101,027	107,067	42,974	47,964	42.54%	44.80%
19 to 20	29,085	31,302	6,365	7,615	21.88%	24.33%
<b>Total</b>	<b>501,875</b>	<b>541,237</b>	<b>230,704</b>	<b>262,586</b>	<b>45.97%</b>	<b>48.52%</b>

Although the participation of Virginia dentists continues to increase, expansion of the provider network continues to be a goal. Virginia has approximately 6,335 licensed dental providers. Approximately 1,387 (22%) of these licensed providers participate in the Medicaid/FAMIS Plus and FAMIS programs.

Dental provider participation has increased from approximately 620 providers in 2005 to 1,387 in 2010. This increase in the number of providers has been key to increasing the access and utilization of program members. The long-term goal of SFC is to continue to increase the participation rate of dental providers with particular emphasis on pediatric dentists and dental specialists, including those providing care to children and children with special needs. Of particular importance to the program is the need to increase the number of providers in rural and underserved areas. The Department, Virginia Dental Association, and the Dental Advisory Committee continue to collaborate on developing the SFC network. The DMAS Dental Provider Listing is available on the Department's web site at: <http://www.dmas.virginia.gov/dental-home.htm>.

### 2.1 Directives from the General Assembly

The legislature has repeatedly expressed its desire to see the dental access problem addressed and has issued various directives requesting different entities to identify major issues critical to addressing problem.

DMAS, through *Smiles For Children*, has significantly increased access to and utilization of dental care for children since the program began in 2005. DMAS continues its efforts to improve the program through issuance of this ASO contract.

### 3. NATURE AND SCOPE OF SERVICES

The significant responsibility of the Contractor shall be the implementation and operation of an enhanced dental provider network matching or exceeding in scope the existing SFC provider network. There are currently 1387 dentists in the SFC network including 1034 general, 113 pediatric and 248 specialty dentists. Another major responsibility of the Contractor shall be to develop strategies, to include, development of outreach campaigns, designed to significantly increase Medicaid/FAMIS Plus and FAMIS member utilization of pediatric dental services. Such an increase would be consistent with The

American Academy of Pediatric Dentistry (AAPD) recommendations regarding the periodicity of professional dental services for children, and with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program requirements, as mandated by 42 U.S.C. § 1396d(e) and amended by OBRA 1989. (See Attachment II of this RFP)

A Dental Benefits Administrator is being sought in an effort to achieve the following overall objectives:

- To ensure Medicaid/FAMIS Plus and FAMIS members receive high quality, appropriate, and cost-effective dental services;
- To increase the number of participating Virginia Medicaid dental providers including general, pediatric and specialty providers and to ensure provider network adequacy; to include maintaining at minimum, the current level of participation and provider satisfaction;
- To assure compliance with requirements set forth in state and federal health care reform initiatives;
- To conduct regularly scheduled outreach activities designed to 1) educate Medicaid/FAMIS Plus and FAMIS members regarding good oral hygiene, 2) the availability and importance of receiving dental services, 3) keeping dental appointments, and 4) how to access dental care services;
- To monitor and encourage increased utilization of pediatric dental services;
- To manifest understanding of, and dedication to, the special needs of a diverse Medicaid/FAMIS Plus and FAMIS population;
- To ensure that the ongoing development, and administration of the dental benefits program is implemented in a manner including the input of interested parties, and inclusive of (but not limited to) that of the Virginia Medicaid Dental Advisory Committee (DAC), and the Virginia Dental Association (VDA) and the Old Dominion Dental Society;
- To provide an effective, efficient operation that 1) makes full use of technology; 2) reduces the administrative burden on dental providers and members; 3) provides for coordination of complex dental care; 4) provides for flexible operations allowing the State to react to program changes in a timely manner; and 5) implementing outreach supporting providers and members;
- To develop and implement a plan to inform dental care providers about the management of those specific oral health conditions typically associated with pregnancy and the identification of approaches to inform pregnant members about the importance of nutrition, good oral health, and the general access to dental care during pregnancy;
- To assure compliance with requirements set forth in federal requirements including, but not limited to H.R. 2; the Children's Health Insurance Program Reauthorization Act of 2009, or CHIPRA and federal/state health care reform;

The Contractor shall perform all services under this RFP. Contractor shall comply with all applicable administrative rules and the Department's written policies and procedures, as such policies and procedures may be amended from time to time. Copies of all such rules and policies are available from the Department.

## **4. TECHNICAL PROPOSAL REQUIREMENTS**

This section contains the technical proposal requirements for this RFP. The Offeror shall provide a detailed narrative of how it will define and perform each of the required tasks listed in this section and by cross-referencing the Offeror's proposal response to each RFP requirement. The narrative shall demonstrate that the Offeror has considered all the requirements and developed a specific approach to meeting them that will support a successful project. It is not sufficient to state that the requirements will be met. The description shall correspond to the order of the tasks described herein.

The Offeror may perform all of these processes internally or involve subcontractors for any portion. Major subcontractors shall be identified by name and by a description of the services/functions they will be performing. The Offeror shall be wholly responsible for the entire performance of this contract whether or not subcontractors are used.

The Offeror shall make maximum efforts to ensure minimum disruption in service to members and providers and a smooth interface of any claims processing or system changes to transfer necessary information without material disruption during implementation of the program.

### **4.1 Enrollment and Eligibility Verification**

#### **4.1.1 Enrollment**

The local Departments of Social Services (DSS) offices enroll individuals into Medicaid on a daily basis. In addition, individuals can be enrolled into Medicaid for retroactive dates of service.

The Department is responsible for the enrollment of members with the Contractor. For the purposes of this contract, all Medicaid/FAMIS Plus/FAMIS eligible individuals are considered enrolled with the Contractor. Reference the Dental Office Reference Manual (ORM) Chapter 2 for additional information on Medicaid eligibility. The ORM is located at [http://www.dmas.virginia.gov/dental-providers\\_home.htm](http://www.dmas.virginia.gov/dental-providers_home.htm) under Dental Provider Information.

Eligibility and enrollment verification must be based upon VAMMIS on-line eligibility information as this represents the most up-to-date eligibility information. Enrollment shall begin at 12:01 a.m. on the effective date that the member is enrolled with the Contractor and shall end at 12:00 midnight on the date that the member is disenrolled pursuant to the criteria in Department policy and/or Department rules and regulations.

#### **4.1.2 Health Care Reform**

The Contractor shall accept additional enrollment from the Department which may result from state and federal health reform initiatives.

#### **4.1.3 Disenrollment**

The Department is responsible for the disenrollment of members from the Contractor. The Contractor shall not disenroll members. The Contractor may, however, provide the Department with any information it deems appropriate for Department use in making a decision regarding loss of eligibility or disenrollment of a particular member. The Contractor cannot grieve disenrollment actions taken by the Department.

#### 4.1.4 Eligibility Verification

The Contractor shall verify eligibility through the Contractor's access to the Department's VAMMIS. The Contractor shall be responsible for the provision of all services covered under this RFP (including but not limited to call center services, outreach, member materials, service authorization, claims processing, etc.) and resulting Contract for eligible members if in VAMMIS regardless of their current status.

#### 4.1.5 Dental Care Outside of Eligibility Effective Dates

Except where required by this Contract with the Department or by applicable federal or state law, rule or regulation, the Contractor shall not make payment for the cost of any dental care provided prior to the effective date of the member's Medicaid/FAMIS Plus or FAMIS eligibility begin date or prior to the begin date with the Contractor. Additionally, the Contractor shall not make payment for the cost of any dental care after the effective date of the disenrollment, except for orthodontic cases initiated prior to the date of disenrollment. The Contractor shall make payment for the cost of any covered services obtained on or after 12:01 a.m. on the effective date of member's Medicaid/FAMIS Plus or FAMIS eligibility begin date and on or after the begin date of the Dental Administrator Contract.

### 4.2 Member Materials and Communications

The Contractor shall design, produce and distribute (to include all distribution costs such as postage) various types of member materials, including but not limited to brochures, provider directories, fact sheets, notices, or any other material necessary to provide information to members as agreed upon and required by the Contract resulting from this RFP. In response to this RFP, the Offeror must submit copies and examples of materials utilized in contracts of a similar scale to the requirements outlined in this RFP.

The Contractor may distribute additional materials and information, other than those required by this Section, to members in order to promote health and/or educate members. Any cost added services provided above the base requirements (described in Section 4.2) must be listed separately in the Offeror's Cost Proposal. All materials sent to members and member communications including form letters, mass mailings and system generated letters, whether required or otherwise, shall require written approval by the Department prior to dissemination as described herein and shall be designed and distributed in accordance with the minimum requirements as described in this RFP. Letters sent to members in response to an individual query do not require prior approval. The required member materials include the following:

#### 4.2.1 Member Information

The Offeror shall specify within its response to this RFP how it plans to educate members about the *Smiles For Children* program and the participating provider network, and how the Offeror will disseminate such information to members. Member information must be sent to members at a 6<sup>th</sup> grade reading level and within 30 days of enrollment.

Member information materials shall, at a minimum, be in accordance with all applicable requirements described in this RFP. The member materials shall include information about preventive dental services for children under age 21 and provide notice that preventive services are available at no cost and without cost sharing responsibilities. Additionally, the material must list the Contractor's toll-free telephone number combined with a statement that the member may contact the plan regarding questions and to obtain appointment assistance including for appointments with specialty providers. The material should also advise the member how to obtain emergency and urgent dental care services.

#### 4.2.2 Provider Listing

The Contractor shall provide all members (or heads of households) with a provider listing, sorted by region and specialty, and listing all satellite offices if possible, within thirty (30) days of initial enrollment (at the same time the member material described in 4.2.1 is distributed), and upon request. Such list shall include current provider name, address, telephone numbers, office hours, languages spoken, specialty and whether or not the provider is accepting new patients. This list shall be updated on the web site as providers are added or terminated and made available at all times electronically and in written format.

#### 4.2.3 Pediatric Dental Utilization Post Card

As described in Section 4.20.13 of this RFP, the Contractor shall develop and maintain a pediatric dental care tracking system. This tracking system shall monitor a member's level of compliance with preventive dental care in accordance with The American Academy of Pediatric Dentistry (AAPD) recommendations regarding the periodicity of professional dental services for children. Where the member's utilization is not compliant with AAPD standards, the Contractor shall send a post card educating the member on what services are needed to bring their dental treatment up-to-date and how to obtain the dental services identified. Each Offeror must submit an outline of this process with its proposal. The Offeror should include copies of any sample post cards it has used for like purposes for its other business products.

#### 4.2.4 Prior Approval Process for Member Materials

The Offeror shall submit a detailed description of any materials it intends to use and a description of any activities prior to implementation or use. This includes but is not limited to all policies (including confidentiality) and manuals, advertisement copy, brochures, posters, fact sheets, video tapes, story boards for the production of videos, audio tapes, letters, and any and all other forms of advertising as well as any other forms for the facilitation of public contact such as to encourage participation in health fairs and/or telemarketing scripts.

All materials submitted by the Contractor shall be accompanied by a plan that describes the Contractor's intent and including procedures for the use of the materials. All written material submitted by the Contractor shall be submitted on paper and on electronic file media. Materials developed by a recognized entity having no association with the Contractor that are related to management of specific oral health diseases or general oral health improvement shall be submitted for approval prior to use; however, an electronic file for such materials may not be required. The electronic files, when required, shall be submitted in a format acceptable to the Department. Electronic files submitted in formats other than those approved by the Department cannot be processed.

The Department shall review the Contractor's materials and either approve, deny or return the plan and/or materials (with written comments) within thirty 30 calendar days following their date of submission. Once the Department has approved materials, the Contractor shall submit one (1) electronic copy of the final product to the Department Dental Program Manager. Problems may not be evident from the materials submitted, but may become apparent upon use. The Department reserves the right to notify the Contractor to discontinue or modify materials, or activities after approval.

#### 4.2.5 Written Material Guidelines

- All materials shall be worded at a 6<sup>th</sup> grade reading level, unless the Department approves otherwise.
- All written materials shall be clearly legible with a minimum font size of 12 pt. unless otherwise approved by the Department.
- All written materials shall be printed with an assurance of non-discrimination.
- The following shall not be used on communication material without the written approval of the Department:
  - a. The Seal of the Commonwealth of Virginia;
  - b. The word “free” can only be used if the service is at no cost to all members.
- All documents and member materials shall be translated and available in Spanish. Within ninety (90) days of notification from the Department all documents designated by the Department must be translated and available to each Limited English Proficiency group identified by the Department constituting five percent (5%) or more of the Department population.
- All written materials shall be made available in alternative formats upon request for persons with special needs or appropriate interpretation services shall be provided by the Contractor.
- To assure that members have access to current policies and procedures, the Contractor shall provide the Department with an updated electronic version of the member handbook on a monthly basis. The member handbook shall be sent to the Department in PDF format and the Department will post the updated version on the *Smiles For Children* website for member use. The Contractor shall also mail the member an updated member handbook upon request. The cost of design, printing, and distribution (including postage) of all member materials shall be borne by the Contractor. The Contractor shall comply with all Federal postal regulations and requirements for the mailing of all materials. Any postal fees assessed on mailings sent by the Contractor in relation to activities required by this RFP due to failure by the Contractor to comply with Federal postal regulations shall be borne by the Contractor and be at no expense to the Department.

#### 4.2.6 Failure to Comply with Member Material and Communication Requirements

All services listed in Attachment I shall be provided as described and the materials must adhere to the listed requirements. Failure to comply with the communication limitations/standards contained in this RFP, including but not limited to the use of unapproved and/or disapproved processes and communication material, may result in the imposition by the Department of one or more of the following sanctions which shall remain in effect until such time as the deficiency is corrected:

- i. Revocation of previously authorized communication methods;
- ii. Application of sanctions as provided in Attachment III of this RFP.

#### 4.3 Establish and Maintain Telephone Call Center Requirement

The Contractor shall provide and maintain a toll-free telephone call center, using the Smiles For Children unique and dedicated toll-free telephone number 1-888-912- 3456. The call center is not required to be within the borders of the Commonwealth of Virginia; however, the Contractor must provide the capacity for the Department to timely monitor calls remotely from DMAS offices at no cost to the Department. The Offeror’s proposal must include a description of methods to enable the DMAS Contract Monitor to perform routine monitoring of calls for all populations covered under the contract resulting from this RFP. Offeror shall enumerate the geographical locations of its firm at the national, regional, and local levels, as applicable. Offeror shall identify all locations that will be used to support a resultant contract and the operations handled from these locations (particularly note any Virginia-based locations that will

be used). Offeror should clearly identify any overseas locations, which may be used to support the resultant contract or any related transactions. The call center shall be available Monday through Friday, except on holidays as defined by the Department. The Offeror shall submit as part of its proposal the holidays currently recognized in its normal business practice. The hours of operation must be at least from 8:00 a.m. to 6:00 p.m., Eastern Time. As it is anticipated that the majority of the inquiries and requests for the dental program shall be received through the call center, DMAS requires a highly effective and responsive operation.

Call Volume during SFY 09 and SFY 10:

SFY 09: 52,674 calls were received from members and 42,814 calls were received from providers.

SFY 10: 54,087 calls were received from members and 41,998 calls were received from providers.

Call volume may change with the Medicaid expansion in 2014 that is part of the overall federal health care reform effort. The Department will provide further information as soon as it is available.

The Contractor shall install, operate, monitor and support an automated call distribution system that has the capability to accept service authorization requests via direct data entry. The Call Center is to be utilized for the following general functions:

- Complete service authorization decisions and to handle grievances, appeals and reconsiderations.
- Provide technical and clinical support functions for providers and members who request assistance on how to complete the functions described under this RFP.
- Provide general information about the program in response to inquiries.
- Provide assistance to members in locating a participating dental provider.
- Accurately respond to questions regarding covered services.
- Handle member/provider inquiries, grievances and appeals.

Communication and Language Needs: The Contractor shall ensure that varying communication and language needs are addressed. This applies to all non-English speaking members and is not limited to prevalent languages. The member cannot be charged a fee for translator or interpreter services. The Virginia Relay service for the deaf and hard-of-hearing must be used when appropriate.

The Call Center shall provide professional, prompt, and courteous customer service. Telephone staff shall greet the caller and identify themselves by name when answering. The Contractor shall establish and maintain an adequately staffed Call Center and shall ensure that the staff treats all callers with dignity and respect the caller's right to privacy and confidentiality. The Contractor shall process all incoming telephone inquiries for dental services in a timely, responsive, and courteous manner.

The Contractor agrees to relinquish ownership of the toll-free numbers upon contract termination, at which time the Department shall take title to these telephone numbers. Any amount owing on these numbers shall be the sole obligation of the Contractor.

**The Call Center shall:**

- Provide a sufficient number of properly functioning toll-free Voice and Telecommunication Device for the Deaf (TDD/TTY) (telephone typewriter or teletypewriter) telephone numbers/lines (in-state and out-of state) for members, providers, and other responsible parties to call for dental care and other program services as described in this RFP.
- Ensure that personnel responding to inquiries and requests are fully trained and knowledgeable about Virginia Medicaid standards and protocols.

- Have the capacity to handle all telephone calls at all times during the hours of operation; have the upgrade ability to handle any additional call volume. Any additional staff or equipment needs, including the cost of addressing such needs, shall be the responsibility of the Contractor. The Contractor is responsible for adequate staffing and equipment during high peak times.
- Provide sufficient telecommunications capacity to meet the State's needs with acceptable call completion and abandonment rates as specified in the performance standards. This capacity must be scalable (both increases and decreases) to demand in the future.
- Provide assistance to licensed dentists participating in the SFC dental network during all hours of call center operation by responding to dental related questions requiring clinical interventions, reconsiderations and consultation. Provide dental support for responses to service authorization and prepayment review requests.
- Effectively manage all calls received by the automated call distributor and assign incoming calls to available staff in an efficient manner.
- Provide detailed analysis of the quantity, length, and types of calls received, and the amount of time required to initially answer them.
- Track the number of callers encountering busy signals or hanging up while on hold.
- Track the amount of time callers are placed on hold.
- Make certain that Contractor staff is responsive, helpful, courteous and accurate when responding to inquiries, and that they maintain member confidentiality. The Contractor will be responsible for a Quality Assurance program implemented to sample calls and follow up on calls to confirm the quality of responses, and caller satisfaction. The Contractor is responsible for reporting on the outcomes of the Quality Assurance program, and for any training required to maintain the highest level of quality.
- Design and implement a management call tracking and reporting capability including an electronic record to generate a synopsis of all calls and to provide a complete audit trail of communication to the call line from providers, members, and other interested parties.
- Provide complete on-line access by the State to all computer files and databases supporting the system for applicable dental programs.
- Develop, maintain, and ensure compliance with Medicaid confidentiality procedures/policies, including HIPAA requirements, within the call line unit.
- Provide a greeting message (when necessary) and educational messages approved by the Department while callers are on hold.
- Install and maintain a telephone line in a way allowing calls to be monitored by a third party for the purposes of evaluating Contractor performance and including a message informing callers that such monitoring is occurring. Call monitoring by a third party, for accuracy and quality of information, must be available at the call center location.
- Ensure that telephone interpreter services are accessible via the toll-free number and that providers/members will not have to hang up to access these services.
- Report on the busiest day by number of calls for assessment purposes.
- Provide detailed weekly reports of abandonment rate, wait time, service levels, etc. The reports should segregate member and provider information and generate cumulative weekly information as required in Attachment XIV.
- Measure the number of calls in the queue at peak times.
- Provide adequate staff to handle service authorization and prepayment review requests received by direct data entry.
- Provide reports on the number of service authorizations and prepayment review requests received by direct data entry.
- Provide TDD/TTY access to the call center.
- Make referrals of non-network providers to appropriate staff to assist with the network application process.
- Make referrals to staff having MMIS access when providers or members question eligibility status.

#### 4.3.1 Call Center Performance Standards

The Contractor is responsible for meeting the following performance standards and is required to provide reports demonstrating performance as follows:

- The call center shall be available to respond to inquiries and service authorization requests, except for prior written approved down time.
- The Contractor shall provide sufficient staff, facilities, and technology so that ninety-five percent (95%) of all call line inquiry attempts are answered. The total number of busy signals and abandoned calls measured against the total calls attempted shall not exceed five percent (5%) per week.
- Calls must be answered within three (3) rings or fifteen (15) seconds. If an automated voice response system is used as an initial response to inquiries, an option must exist allowing the caller to speak directly with an operator. The wait time in the queue should not be longer than 3 minutes for 95% of the incoming calls.
- All call line inquiries that require a call back, including general inquiries and service authorization requests, shall be returned within one business day of receipt one hundred percent (100%) of the time.
- In responding to telephone messages, the Contractor shall have a tracking system in place to identify who returned the call, record when the call was returned, the nature of the call and document the outcome of the call.
- The call center shall respond to members seeking assistance in locating a dentist. The contractor shall report either Emergency, Urgent or Routine need. The report shall include Member Name and Medicaid ID#, Provider Name and Location, Call Date, Urgency Status, Resolution Date and Number of Days to Resolve. Ninety-five (95%) of Emergency Calls shall have an appointment scheduled within 24 hours. Ninety-five (95%) of Urgent Calls have an appointment scheduled within 48 hours. Ninety-five (95%) of Routine Calls shall have an appointment scheduled within 6 weeks.
- Records of call center response times identified in Attachment XIV of the RFP shall be kept by the Contractor and reported to the Department weekly and monthly. At a minimum the report shall identify the total call volume, wait time (in seconds), and the abandonment percentage rate as further described in this Section.

Because call center performance is critical to the success of this project, the Offeror shall describe in detail how it will train staff to perform their duties accurately and efficiently and how it will monitor these standards and perform corrective actions when necessary. Additionally, the Contractor shall notify the Department of any variance from the contractual requirements as outlined in this RFP and must provide a written plan for corrective action addressing the deficiency at the time of notice. The corrective action plan shall include a work plan and date of resolution and shall be submitted within 5 business days of the discovery.

In response to this RFP, the Offeror shall submit call center performance data for contracts of a similar scale as outlined in this RFP.

#### 4.3.2 Call Center Reporting

The Department reserves the right to modify the frequency of requested reports.

Call center reporting shall be provided weekly for the first three months and monthly thereafter and, at a minimum, shall include the following:

- a. Total hours of daily call center access provided, and any downtime experienced, as outlined in Attachment XIV.
- b. Overall call volume, by type of call, including nature of inquiry and source of call (must provide a separate report for provider and member calls) and must include counts and percentages of the ten most frequent types of calls.
- c. Call abandonment rate, and average time prior to abandonment, including for calls placed on hold, number and percentage of calls answered with wait time 3 minutes or less as outlined in Attachment XIV.
- d. Detailed statistics regarding member or provider grievances to include but not limited to: (1) the member's inability to locate a provider within Contract standards; (2) provider service authorization and billing issues; (3) handling of grievances/appeals, and (4) resolutions taken to resolve grievances.
- e. The number of member and provider grievances, reconsideration requests, and appeal requests
- f. Average time required to call back providers and members when a call back was required.
- g. Average length of calls handled as outlined in Attachment XIV.
- h. Report the number of calls in the queue and abandoned based on 30 minute intervals.
- i. Outcomes of quality improvement measurements.
- j. The Department should be able to monitor provider and member calls.
- k. Ad Hoc reports as requested by the Department.
- l. Request A Dentist report as outlined in 4.20.3a of this RFP.

The call center shall have the capacity to track individual provider and member call activity and capture all important aspects of the call transaction. The Contractor shall report individual call activity data to the Department upon request.

#### **4.4 Staffing Requirements**

##### **4.4.1 Office Location**

The Contractor must maintain a physical business office in Virginia. At minimum, the Project Director staff shall be located in the Virginia business office.

##### **4.4.2 Staffing Plan**

4.4.2.a The Contractor shall not have an employment, consulting or any other agreement with a person that has been debarred or suspended by any federal agency from the provision of items or services that are significant and material to the entity's contractual obligation with the State.

4.4.2.b The staffing for this RFP shall be capable of fulfilling the requirements of this RFP. A single individual may not hold more than one (1) position unless otherwise specified. The minimum staff requirements are as follows:

1. A full-time administrator (Project Director), dedicated 100% to the project, tasked with overall responsibility for all aspects of performance, including the coordination and operation, of this RFP. This person shall be at the Contractor's officer level and must be approved by the Department, including upon replacement. Said designee shall be responsible for the coordination and operation of all aspects of the RFP.

2. Sufficiently trained and experienced full-time support staff to conduct daily business in an orderly manner, including such functions as administration, accounting and finance, service authorizations, appeal resolution system, and claims processing and reporting, as determined through management and medical reviews.
3. Experienced, sufficiently trained administrative and clinical full-time staff who can address the unique needs of the members while addressing any participating dental provider service limitations to assure that services are provided in the most economical manner.
4. Provider Relations Director, and provider relations staff, whose primary duties include development and implementation of the Contractor's on-going strategies to increase provider participation and carry out related provider relations activities. The Offeror shall describe its staffing plan in relation to provider network development and maintenance strategies and retention activities. This position shall be directly accessible to providers.
5. A full-time Virginia based Outreach Coordinator and/or outreach staff, whose primary duties include development and implementation of the Contractor's on-going strategies to increase utilization of dental services, to lead the Contractor's program for dealing with non-compliant members, as described in Section 4.7.3, and to perform other necessary outreach activities.
6. A dentist who is licensed in and physically located in the Commonwealth of Virginia to serve as Dental Director to chair and oversee the Contractor's Peer Review Committee which ensures the proper provision of covered services to members.
7. A staff of qualified, medically trained personnel, whose primary duties are to assist in evaluating medical necessity.
8. A quality assurance coordinator to coordinate the requirements described in Section 4.12 of this RFP.
9. A person who is trained and experienced in information systems, data processing and data reporting to provide necessary and timely reports to the Department.
10. Sufficiently trained and experienced full-time staff to maintain a toll-free Member or Customer Services function to be operated during regular call center hours to be responsible for explaining the program, assisting members in the selection of dental providers; assisting members in making appointments and obtaining services; and to handle member inquiries and grievances.
11. The Contractor shall appoint a staff person to be responsible for communicating with the Department regarding provider service issues. Further, the Contractor shall have a provider service line staffed adequately to respond to providers' questions during regular call center business hours, to include appropriate and timely responses regarding service authorization requests as described in this RFP. The provider service lines shall be adequately staffed and trained to accurately respond to questions regarding the

Department's program, including but not limited to EPSDT dental, billing and other benefit related inquiries.

12. The Contractor's staffing plan shall include the materials and methods used (on-going) for training staff, including the handling of telephone requests from members, participating dental providers and dentists. The Contractor shall include copies of all training materials and a description of methods used for training staff with this RFP submission and to the Department annually thereafter.
13. The Contractor shall identify in writing the name and contact information for the Project Director, Dental Director, Provider Relations Director and Outreach Coordinator. Key contact persons shall also be provided for Accounting and Finance,

Service Authorizations, Claims Processing, Information Systems, Member Services, Provider Services, and Appeal System Resolution, within thirty (30) days of RFP execution. The Department reserves the right to require the Contractor to select another applicant for any of these positions. The Contractor must notify the Department of any changes in staff persons during the term of this RFP in writing within 10 business days.

14. If any member of the project management team, as identified in the Contract, becomes unavailable for any reason, the Contractor shall advise the Department immediately, and shall provide an expected timeline for the re-hire. The Department reserves the right to approve rehires to project management level positions.
15. Failure to maintain the required staffing level to meet contract requirements may result in a reduction in the Department's reimbursement to the Contractor. Reductions in staffing levels may only be made with the prior approval of the Department and may result in a loss of revenue for the Contractor. The Contractor shall not maintain positions deemed nonessential for the purpose of maintaining the current reimbursement level.

4.4.2.2.c The Contractor's failure to comply with staffing requirements as described in this RFP shall result in the application of intermediate sanctions and liquidated damages as specified in Attachment III of this RFP.

#### 4.4.3. Licensure

The Contractor is responsible for assuring that all persons, whether they are employees, agents, subcontractors, providers or anyone acting for or on behalf of the Contractor, are legally authorized to render service under applicable state law and/or regulations. Failure to adhere to this provision shall result in assessment of \$250 per calendar day for each day that personnel are not licensed as required by applicable state law and/or regulation and the Department may terminate this RFP for cause as described in Section 10.7 of this RFP.

### **4.5 Provision of Covered Benefits**

The Contractor shall be responsible for administering the Medicaid/FAMIS Plus and FAMIS State Plan dental benefit package to members in accordance with 12VAC 30-50-190, 12VAC30-141-200, as amended, and the terms of this RFP. The following represents a summary of the Medicaid/FAMIS Plus

and FAMIS State Plan covered benefits. Reference Attachment I to this RFP for a listing of services by ADA procedure code, and the Office Reference Manual available on-line at [http://www.dmas.virginia.gov/dental-providers\\_home.htm](http://www.dmas.virginia.gov/dental-providers_home.htm) for an all inclusive list of covered benefits, coverage criteria and guidelines.

#### 4.5.1 Medicaid/FAMIS Plus and FAMIS Children

The Contractor shall provide or arrange for all medically necessary diagnostic, preventive, restorative, and surgical and orthodontic dental procedures, administered by, or under the direct supervision of a dentist. Additionally, coverage is available for orthodontics to Medicaid/FAMIS Plus individuals under 21 when an orthodontic treatment plan is approved prior to the member attaining 20 1/2 years of age, and treatment is initiated prior to the member attaining 21 years of age, or when orthodontic treatment is the result of facial hemiatrophy or congenital birth defects (if member was covered by the Department at birth). For FAMIS members, coverage is available for orthodontics under age 19 when an orthodontic

treatment plan is approved prior to member attaining 18 and ½ years of age. The Contractor shall follow the Department's established coverage criteria for orthodontic procedures and shall pay at least 40% of the Department's allowable reimbursement at banding. The Contractor shall continue to provide reimbursement for orthodontic treatment quarterly or monthly up to the Department's established rate of reimbursement. Orthodontic care shall be paid in full regardless of loss of Medicaid/FAMIS Plus and FAMIS eligibility, as long as the member was eligible on the date of banding. Coverage criteria and guidelines are detailed in the Office Reference Manual available on-line at [http://www.dmas.virginia.gov/dental-providers\\_home.htm](http://www.dmas.virginia.gov/dental-providers_home.htm) (refer to section 1).

#### 4.5.2 Adults

Limited medically necessary oral surgery coverage and associated diagnostic services is available for members 21 years of age and older when performed by a participating dentist and only when the service is one that is either generally covered under Medicare and/or is medically necessary. Examples of medically related covered services for adults include removal of cysts and tumors not related to the teeth, biopsies for suspected malignancies, repair of traumatic wounds, and extraction of teeth for severe abscesses complicating a medical condition or contributing to poor general health. The Contractor shall make referrals to other non-Medicaid dental assistance resources when applicable.

#### 4.5.3 Pregnancy and Oral Health

The Offeror shall provide to the Department a plan indicating how dental care providers will be informed on the management of oral health conditions typically seen during pregnancy and how outreach to pregnant members (under age 21) will be performed to educate members on the importance of nutrition, good oral health, and accessing dental care during pregnancy. The Contractor shall assure compliance with future requirements of federal initiatives such as CHIPRA and/or other federal/state health care reform activity.

#### 4.5.4 Pediatric Periodicity Requirements

The Contractor shall ensure that pediatric dental services are provided as medically necessary to children under the age of twenty-one, in accordance with EPSDT federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989, whether or not such services are covered under the Department's state plan and without regard to any service limits otherwise established in this RFP. This requirement shall be met by either direct provision of the service by the Contractor or by referral in accordance with 42 CFR 441.61.

Pediatric dental utilization shall be in accordance with The American Academy of Pediatric Dentistry (AAPD) recommendations regarding the periodicity of professional dental services for children, and EPSDT guidelines for dental, as detailed in Attachment II to this RFP.

#### 4.5.5 Coordination of Transportation Services

Non-emergency transportation to covered dental services is a covered service for Medicaid/FAMIS Plus members and is the responsibility of the member's MCO or the Department's contracted transportation vendor for Medicaid/FAMIS Plus FFS children. Non-emergency transportation is not covered for FAMIS children enrolled in an MCO. FAMIS children enrolled in the Department's FFS FAMIS program may receive transportation services through the Department's contracted transportation vendor. Transportation services are covered under a separate contract by the Department with the member's MCO or the Department's contracted transportation vendor for Medicaid/FAMIS Plus FFS children.

The primary responsibility for transportation belongs to the custodial parent or guardian of a child. Transportation can be provided by the contracted vendor if the parent or guardian does not have a car, if the parent/guardian has to work or if the member is in foster care. Questions pertaining to eligible transportation services should be directed to the contracted broker. In cases where the Contractor is made aware that transportation issues are preventing access to dental services, is a barrier to dental access, the Contractor shall notify the MCO or the FFS Transportation Contractor to coordinate transportation services. If a general question or complaint is received by the Contractor, the caller should be referred to the appropriate party for resolution. The Contractor shall also notify the Department when the MCO or FFS transportation vendor fails to respond to or resolve a transportation related issue.

#### 4.5.6 Medical Necessity

The determination of medical necessity shall be made on a case-by-case basis. The Contractor shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each member and his/her medical history. The Contractor shall have the ability to place tentative limits on a service; however, such limits shall be exceeded when medically necessary based on a patient's individual characteristics. The Contractor shall not require service authorization on any pediatric preventive dental services. Any procedures used to determine medical necessity shall be approved by the Department and shall be consistent with the following definition:

- 4.5.6.a Services or supplies provided by an institution, physician, or other provider that are required to identify or treat a member's illness, disease, or injury and which are:
- i. Consistent with the symptoms or diagnosis and treatment of the member's illness, disease, or injury;
  - ii. Appropriate with regard to standards of good dental practice;
  - iii. Not solely for the convenience of a member, dentist, physician, institution or other provider;
  - iv. The most appropriate (in terms of cost and effectiveness) supply or level of service that can safely be provided to the member and that is sufficient in amount, duration, or scope to reasonably achieve their purpose. When applied to the care of an inpatient, it further means that services for the member's medical

symptoms or condition require that the services cannot be safely provided to the member as an outpatient; and

- v. When applied to members under 21 years of age, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.

4.5.6.b The Contractor shall be responsible for determining “medical necessity” in accordance with 38.2-3418.12 of the Code of Virginia for dental services rendered in a non-dental office setting. To ensure timely access for members requiring these services and efficiency to the dental providers, the Contractor shall serve as the central point of contact for the dental provider, medical facility, medical anesthesiologist, MCO, the Department, and any other required provider. The Contractor shall render a decision (approve, deny, or pend) as expeditiously as the member’s dental condition requires and within 2 business days of receipt. The Contractor shall consider alternate service delivery mechanisms for OR anesthesia.

Additionally, all of the following requirements must be included in the Contractor’s prior approval process for these types of procedures:

- i. The dental provider must submit the request for authorization directly to the Contractor.
- ii. Once the Contractor has reviewed and approved the case based upon medical necessity the Contractor coordinates anesthesia and hospitalization authorization for non-dental services with the Department and the MCOs, within the respective MCO’s provider network. (The Department’s MCO contracts require the MCO to respond to the DBA’s request for authorization within 2 business days of receipt of the request.) The DBA’s proposal should describe the methods available through the Contractor for communicating/coordination with the MCOs, including fax, telephone, and web-based formats.
- iii. Denial of authorization must be made in direct consultation with the submitting provider and the Dental Director.
- iv. Claims related to the facility and anesthesia services rendered in a non-dental setting shall be handled as follows:
  - a. MCO Members
    - i. If the dental provider performs the anesthesia services in a non-dental setting, all dental and anesthesia services are handled by and billed to the Dental Contractor. In such cases, facility charges shall be billed directly to the MCO.
    - ii. If the dental provider does not perform the anesthesia services for dental services provided in a non-dental setting, the dental services are handled by and billed to the Contractor. In such cases, both facility and anesthesia charges are billed directly to the MCO and within the MCO provider network.
  - b. FFS Members/MEDALLION
    - i. For Medicaid/FAMIS Plus and FAMIS eligible individuals who are not enrolled in an MCO on the date of service (served by the Department’s FFS program) the Contractor must ensure that the facility and anesthesia and any required medical providers participate in the FFS Medicaid program.

- 4.5.6c The Contractor shall adjudicate all requests/claims received from dental providers submitted using CDT codes. Any requests or claims received by the Contractor for medical/oral surgical procedures with CPT codes such as osteotomies, fractures, lacerations, excisions of bony/soft tissue lesions, TMJ surgery and any associated diagnostic services, shall be forwarded by the Contractor to the appropriate medical coverage entity (MCO or the Department) for review, approval and/or payment. For MCO members, the request must be forwarded for review/payment to the member's MCO. For FFS members, the request must be forwarded using the appropriate CPT code for review/payment to the Department. The Contractor shall provide notice to the requesting dental provider and the member that such requests have been forwarded to the appropriate entity for medical review. The Contractor shall offer assistance to members and providers to assure that coordination of these benefits occur timely and efficiently. This requirement does not preclude the dental provider, when rendering a medical service, from submitting requests (using the appropriate CPT code) for medical/oral surgical treatment review directly to the appropriate MCO or to the Department.

#### 4.5.7 Optional Services

The Department is interested in the Offeror's capabilities and expertise with the following *optional* services (Enhanced Benefits). These services may be implemented at some point within the duration of the contract resulting from this RFP. If the Offeror is interested in operating any of the following initiatives, information in the Offeror's technical proposal must describe the Offeror's abilities, experience, and method(s) for accomplishing the selected services at a reasonable cost to the Commonwealth. The Offeror's cost shall be submitted in the cost proposal (Attachment X), separate from the technical proposal, for each of these optional services.

##### Innovative Strategies

The Offeror may describe innovations that can be implemented that would benefit Virginia's dental program. List all states, specifically state Medicaid programs as well as commercial payers, where these innovations have been implemented and describe the quantitative evidence to support the outcomes and success. This may include real time provider question submission and response via the Internet of clinical questions, provider chat room capability for dental issues, cost savings initiatives, enhanced web/Internet based strategies for claims submission and payment in order to support SFC providers and initiatives.

##### Service Authorization

The Offeror may propose additional automated functions to streamline the service authorization process. Automated functions must include the Offeror's solution for necessary interface to other systems. The Offeror's automated function must comply with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. In addition, the Offeror must ensure that any proposed systems and/or business solutions, including files and data transfer format of the Offeror's internal system, will comply with Electronic Data Interchange (EDI), and Security requirements throughout the Contract period.

##### Quality Improvement

The Offeror may propose additional quality measurement strategies supporting improvements in incidence of oral pathology and associated treatment beyond requirements set forth in section 4.12.

Measurement strategies outlining the effect of any specific program changes implemented may be a part of the submission. Provider chart audits may be included as part of the review process.

#### Individual Tracking Assessment

The Offeror may propose a program which will identify and follow the oral progression of individuals identified by the Department or the Offeror. The assessment process will begin with the initial evaluation of the enrollee through treatment into a stable dental health environment without new or reoccurring preventive strategies. This would allow assessment of preventive and restorative strategies.

#### Pregnancy and Oral Health

The Offeror may propose a program for outreach and the administration of dental benefits for all pregnant women. As part of this RFP, the Offeror shall prepare a completely separate technical and cost proposal to provide outreach, education, and access to dental services for eligible pregnant women age 21 and over. In the instance where the Offeror's technical proposal for pregnant women is the same as that proposed for the child/limited adult population described above, the Offeror may include a clear reference to that effect. The Offeror must however include separate pricing in the cost proposal for pregnant women over age 21.

#### Adult Dental Services

The Offeror shall submit a program for the provision of adult dental services for all enrollees over age 21. The program shall include routine preventive and restorative care and shall include cleanings, exams, x-rays, fillings, and crowns. Braces should not be considered a part of the benefit package. Included with these optional services shall be a network development strategy and timelines which support federal health care reform initiatives. The program shall also describe applicable commercial adult benefit programs and results. Pricing shall include a program using current adult enrollment and projected increased health reform enrollment for adults.

### **4.6 Access to and Availability of Care**

The Contractor shall arrange for the provision of all dental services described as covered in this RFP. The Contractor shall maintain under contract, a statewide provider network, including general and pediatric dentists and dental specialists, at geographical locations that meet the accessibility requirements outlined in this RFP.

#### 4.6.1 Access to Care

The Contractor shall maintain a network of dental providers with a sufficient number of providers who accept new Medicaid/FAMIS Plus and FAMIS members within each geographical location in the Commonwealth. The Offeror shall document in its proposal its standards for appointment waiting times and how it will provide access to services for urgent and emergency dental and oral conditions or injuries without requiring service authorization.

Where there is not a participating provider within the contract access standards, the Contractor must provide care coordination services, as described in Section 4.12.10 of this RFP, to assist the member in accessing timely services from the nearest participating provider available. Additionally, the Contractor must notify the Department of any variance from the network requirements as outlined in this RFP and must provide a plan for corrective action that addresses the network deficiency and includes the requirements described in Section 4.8 of this RFP.

#### 4.6.2 Provider Choice

Each member shall be permitted to obtain covered services from any general dentist, pediatric dentist, or other dental specialist participating in the Contractor's network accepting new patients.

#### 4.6.3 Referral Requirements

The Department prefers (does not require) that a patient be evaluated (and referred as appropriate) by a general or pediatric dentist before seeking orthodontic treatment services.

#### 4.6.4 Contract Time and Distance Standards

The Contractor shall maintain under contract a network of dental providers to provide the covered services specified in Attachment I statewide. The Contractor shall make services and service locations available and accessible so that patient transport time to dental providers will not exceed thirty (30) minutes, except in rural areas where documented community standards will apply.

The Contractor shall ensure that a member is not required to travel in excess of thirty (30) miles in an urban area and sixty (60) miles in a rural area to receive services from a dentist or dental specialists, unless the member so chooses. An exception to this standard may be granted when the Contractor has established, through utilization data provided to the Department, that a normal pattern for securing dental care services within an area falls beyond the prescribed travel distance.

#### 4.6.5 Appointment Standards

The Contractor must comply with appointment standards defined in this contract.

- i. emergency services as defined in Section 1.2 (Definitions),
- ii. urgent dental condition as defined in Section 1.2 (Definitions), and
- iii. routine dental care.

#### 4.6.6 Monitoring Access to Care

The Contractor shall establish a system to monitor access to care to ensure that the access standards set forth in this Contract are met. The Contractor shall be prepared to demonstrate to the Department that these access standards have been met or must take corrective action when there is a failure to comply.

### **4.7 Outreach Activities**

#### 4.7.1 Contractor's Outreach to Increase Pediatric Dental Utilization

The Contractor shall conduct regionally located and regularly scheduled outreach activities designed to inform members about the availability of dental services and to significantly increase the number of children receiving services. The results of the outreach activities should be measurable and support the overall goal of increasing awareness of and/or utilization of dental services. Within 45 calendar days of execution of this RFP, the Contractor shall submit an outreach plan. The Contractor shall identify the target population, service areas, specific outreach activities scheduled for completion and include copies of any materials to be released to members. The outreach plan shall be updated at least annually. The proposed plan and any related material is subject to approval by the Department. The Department shall have thirty (30) calendar days to review material and provide notice of approval or notice to make changes. The cost of design, printing, and distribution (including postage) shall be borne by the

Contractor. The Contractor shall attend and participate in the Mission of Mercy projects with the Virginia Dental Association as directed by the Department. The Contractor will coordinate outreach through Boys and Girls Clubs in addition to other organizations designated by the Department. The Department may require the Contractor to coordinate its efforts with outreach projects being conducted by the Department or other state agencies. The Contractor shall submit a semi-annual report to the Department identifying results of its outreach activities including revisions to the outreach plan determined during the reporting period.

The Contractor shall comply with all Federal postal regulations and requirements for mailing of all materials. Any postal fees assessed on mailings sent by the Contractor in relation to activities required by this RFP due to failure by the Contractor to comply with Federal postal regulations shall be borne by the Contractor at no expense to the Department.

Failure to comply with the requirements of this Section may result in the application of intermediate sanctions or liquidated damages as provided in Attachment III of this RFP.

#### 4.7.2 Appointment Assistance

The Contractor shall make reasonable efforts to assist members in obtaining appointments for covered services, including facilitating member contact with a participating dental provider to establish an appointment. Contractor shall provide special assistance to individuals calling to express their difficulty in accessing an appointment with an in-network provider. This special assistance includes following-up with the member (and when necessary the dental provider) to make sure that the member receives an appointment for the needed services within the contract appointment and distance standards. The Contractor shall track and report to the Department monthly the number of requests for assistance to obtain an appointment, including the city/county area, % of requests per city/county area and the average length of time required to assist the member(s).

Where there is not a participating provider within the contract access standards, the Contractor must provide assistance to the member in accessing timely services from the nearest participating provider available including coordinating/calling transportation services when needed. Additionally, the Contractor must notify the Department of any network deficiencies and must provide a detailed, written plan for corrective action with a timeline that addresses the network deficiencies.

#### 4.7.3 Non-compliant Members

The Contractor shall establish an outreach program for dealing with individuals identified by dental providers as being non-compliant with treatment or who have missed appointments. The program, at a minimum, shall follow up with members who miss appointments, and also members who are not compliant with routine cleanings, follow-up treatment, or good oral hygiene practices. Follow up shall include written correspondence, telephone calls, and/or face to face meetings with the member. An outline of this program describing activities conducted to address non-compliance and methods for measuring and monitoring performance outcomes must be provided with the Offeror's proposal and also as a quarterly report by the Contractor.

#### 4.7.4 Coordination with Public Health

The Contractor shall work closely and cooperatively with the State and Local Health Department(s) to accomplish the goals of their Public Health Dental Programs. Identification of eligible children with urgent dental needs as well as identification of children with unmet needs will require Contractor to arrange care for these eligible children according to the access standards identified in Section 4.6 of this

RFP. Close coordination between the Division of Dental Health of the Virginia Department of Health and the Contractor will be necessary to facilitate referral arrangements.

#### 4.7.5 Coordination with Other Entities

The Contractor shall work closely and cooperatively with external and community entities, including but not limited to case management providers in local communities, community services organizations, advocacy groups, dental providers, managed care organizations, transportation vendors, schools, health departments, local departments of social services, family members, and other interested parties, when such parties are working on behalf of the member in relation to securing needed dental care for the member. The Contractor's response shall comply with HIPAA and Medicaid confidentiality requirements, and at minimum shall include following up with the member or the member's responsible party in relation to the issue/need communicated by the interested party.

### 4.8 Network Development and Provider Relations Requirements

Medicaid/FAMIS Plus and FAMIS members' access to dental care is highly dependent on a reliable network of dental providers who are treated respectfully for their work. The Contractor shall have an effective and efficient program for recruiting dentists to join the Contractor's provider network on an on-going basis. As described in Section 4.8.6, the Department's Medicaid agreement shall be included as part of the Contractor's provider credentialing packet. The Contractor's recruitment program shall include strategies to address barriers to provider participation throughout the Commonwealth, but should also reflect targeted efforts for the rural areas of the Commonwealth, and for members with special treatment needs. The Contractor shall report the provider recruitment activities initiated, (including what, when, where and how) to the Department on a monthly basis, and must include a network analysis reflecting recruitment/retention totals by region. The Contractor shall coordinate its efforts with the dental provider community, including the Virginia Dental Association and the Old Dominion Dental Society. The DMAS Dental Provider Listing is available on the Department's website at [http://dmasva.dmas.virginia.gov/Content\\_pgs/dnt-home.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/dnt-home.aspx).

Contractor shall educate providers to follow practice guidelines for preventive health services identified by the Department consistent with The American Academy of Pediatric Dentistry (AAPD) recommendations regarding the periodicity of professional dental services for children, and with EPSDT program requirements. (See <http://www.aapd.org> and Attachment II of this RFP.) Practice guidelines for pediatric dental utilization includes timely provision of exams, cleaning, fluoride treatment, sealants and any medically necessary referral for treatment of child members.

#### 4.8.1 Dental Services Delivery System

The Contractor shall arrange for and administer covered dental services to Medicaid/FAMIS Plus and FAMIS eligible members and must ensure that its dental services delivery system will provide available, accessible and adequate numbers of dental, dental specialty providers, and appropriate locations for the provision of covered services. The Contractor shall document in the response to this RFP how this delivery system will be established. In establishing and maintaining the network, the Contractor shall consider all of the following:

- i. the anticipated Medicaid/FAMIS Plus and FAMIS enrollment;
- ii. the expected utilization of services, taking into consideration the characteristics and health care needs of the anticipated Medicaid/FAMIS Plus and FAMIS population to be served;

- iii. the numbers and types (in terms of training and experience, and specialization) of providers required to furnish the contracted services;
- iv. the numbers of network providers not accepting new Medicaid/FAMIS Plus and FAMIS patients;
- v. the geographic location of providers and members, considering distance, travel time, and the means of transportation (including public transit) ordinarily used by Medicaid/FAMIS Plus and FAMIS members; and
- vi. whether the location of service provision provides physical access for members with disabilities.

#### 4.8.2 Provider Network Requirements

The Contractor's network shall include the following classes of providers in numbers that are sufficient to enable Contractor to furnish services described in this RFP in accordance with the timeline, geographic and other standards described in Section 4.6 of this RFP:

- a Dentists and dental hygienists, and other recognized dental professionals who are trained in dental care and oral health and experienced in performing triage for such care; pediatric dentists; orthodontists; periodontists; endodontists; prosthodontists; oral pathologists; and oral and maxillofacial surgeons; and
- b Dentists and other health and dental professionals described above with demonstrated experience in the provision of services to children with acute and chronic medical conditions or special circumstances, including but not limited to cardiovascular conditions; HIV infection, developmental disability, cancer, behavioral disorder, or foster care children; and
- c Dental specialists and sub specialists that furnish multidisciplinary treatment of cranio-facial anomalies;
- d Pediatric dentists and specialists that serve children with special needs, including those with mental health and developmental disabilities.

The Contractor shall include in the dental network licensed providers who meet credentialing standards and are willing to participate in the Department's dental program. As described in Section 4.8.6, the Department's Medicaid agreement shall be included as part of the provider credentialing packet. The Contractor is also encouraged to develop and maintain a list of referral sources which includes community agencies, State agencies, "safety net" providers, teaching institutions and facilities that are needed to ensure that the members are able to access and receive the full continuum of treatment services and support.

#### 4.8.3 Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Local Health Departments

The Contractor is encouraged to contract with Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Local Health Departments that have the capacity to deliver dental services.

#### 4.8.4 Comprehensive Network of Dental Providers with Appropriate Demographic Placement and Specialties

The Offeror shall submit the following provider network analysis report as part of its proposal package. In lieu of letters of intent, the Offeror can provide a detailed strategy for provider recruitment and development activities. The Offeror's strategy should include a quantitative analysis of the planned activities and expected recruitment results based upon the Offeror's prior experience or related research analysis. Additionally, upon implementation of the Contract resulting from this executed RFP, the Contractor must submit the required network analysis information on a monthly basis and annually:

- i. A listing in Microsoft Excel, on diskette or CD, in a format agreed upon by the Department and the Contractor, of all enrolled providers within the Contractor's proposed network. (Letters of intent will be acceptable for purposes of this RFP). Column headings shall be those listed below:
  - Provider First name
  - Provider Last name
  - Provider type and specialty, example: General Dentist, Pediatric Dentist, Orthodontist, Endodontist, Oral Surgeon, etc. (if internal company abbreviations are used, supply a cross reference)
  - City, State, Zip of the physical office location NOT the billing/payment location
  - County
  - Office telephone number
  - Tax ID number
  - NPI number
  - Email if available
  - Additional language abilities (other than English)
  - Status of contract (letter of intent or signed contract)
  - In lieu of letters of intent, the Offeror can provide its detailed strategy for provider recruitment and development activities. The Offeror's strategy should include a quantitative analysis of the planned activities and expected recruitment results based upon the Offeror's prior experience or related research analysis.
  - Panel limitations [accepting new Medicaid/FAMIS Plus and FAMIS members, accepting current Medicaid/FAMIS Plus and FAMIS members only, accepting a limited number (include specifics),etc.]
- ii. Sample contracts for each provider type.
- iii. A discussion of how the network will address the special needs of children and pregnant women.
- iv. A description of educational, outreach, training programs and any other services that are rendered by the Offeror to its providers, including any provider telephone help lines.
- v. A description of claims and service authorization processing policy and procedures, including service authorization and claims submission options for services requiring service authorization, timeframes/standards for authorization approvals and provider payment.
- vi. As part of on-going network management activities, the Contractor shall track provider network changes to include office location and dental provider changes/terminations, and when possible shall capture the reasons for provider termination/disenrollment. Reasons for provider termination/disenrollment and attempts made to retain provider (if attempt is warranted) must be reflected in the Contractor's monthly and annual provider network analysis report to the Department.

#### 4.8.5 Policy of Nondiscrimination

The Contractor shall ensure that its providers provide contract services to members under this Contract at the same quality level and practice standards as provided to non-Medicaid members. Additionally, the Contractor shall ensure that its network providers treat members with the same level of dignity and respect as served in the Contractor's commercial products.

##### 4.8.5a Nondiscrimination-Special Needs

The contractor shall ensure that its providers provide contracted services without discrimination to Medicaid members with special needs to include communication and language barriers.

##### 4.8.5b Effective Communication

The contractor shall ensure that its providers can communicate effectively and when necessary, can assist the provider in obtaining the appropriate accommodations. Providers may be reimbursed for any costs incurred in the provision of additional services through an established billing process approved by the Department and agreed to by the contractor. Providers shall not be required to accept or continue treatment of a member with whom the Provider feels he/she cannot establish and/or maintain a professional relationship, or is beyond the scope of Provider's expertise or ability.

#### 4.8.6 Provider Licensure, Credentialing and Certification Standards

The Contractor shall demonstrate that dentists in the SFC network are licensed by the State and have received proper certification or training to perform dental services contracted for under this RFP. Should the network include dentists from states in close proximity to the Commonwealth, the contractor shall demonstrate that dentists are licensed in the state in which they practice and have received proper certification or training to perform dental services contracted for under this RFP. The Contractor shall not execute provider agreements with providers who have been excluded from participation in the Medicare and/or Medicaid programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the Department program or applicable licensing board. The Contractor's standards for licensure and certification shall be included in its participating provider network agreements. The Contractor shall ensure that providers include any disciplinary action histories from the Virginia Board of Dentistry or any other regulatory authority.

The Contractor shall have written policies and procedures for their credentialing process. The Contractor's recredentialing process shall include the consideration of performance indicators obtained through the quality improvement plan (QIP), utilization management program, grievance and appeals system, and member satisfaction surveys. The Contractor shall perform an annual review on all subcontractors to ensure that the health care professionals under contract with the subcontractor are qualified to perform the services covered under this RFP and resulting Contract. The Contractor must have in place a mechanism for reporting to the appropriate authorities any actions that seriously impact quality of care and which may result in suspension or termination of a practitioner's license. The Offeror shall submit a copy of their provider credentialing standards in the response to this RFP. The Department reserves the right to negotiate final approval of the Contractor's credentialing requirements for the Department's dental program. The DBA's credentialing packet shall include Federal, State, and DMAS' provider participation requirements. See the current *Smiles For Children* Provider agreement, which includes these requirements (Federal, State, and DMAS) as well as the current DBA's participation requirements, available on the web at: <http://websrvr.dmas.virginia.gov/Forms/Dnt-Agrmnt/Default.aspx>. DMAS reserves the right to approve the DBA's SFC credentialing packet/participation agreement at start-up and prior to implementing any changes.

#### 4.8.7 Provider Enrollment into Medicaid

The Contractor shall ensure that, as part of its credentialing process, all dental providers enroll in the Virginia Medicaid program, Smiles For Children. The Contractor shall coordinate provider enrollment of dental providers into the Medicaid program with the DMAS Provider Enrollment Contractor.

#### 4.8.8 Provider Contract Agreements

The Offeror shall submit with its proposal a complete copy of the provider agreement packet. The Contractor's final provider network agreement for participation in the *Smiles For Children* program shall

be consistent with all applicable Federal and State laws and regulations and the requirements described in this RFP. The final provider network agreement language shall be developed by the Contractor and the Department, and must be approved by the Department prior to implementation and upon any revision.

All provider agreements executed by the Contractor, and all provider agreements executed by subcontracting entities or organizations, pursuant to this RFP shall comply with HIPAA privacy and security rules and regulations as described in Section 10 of this RFP.

Provider agreements shall specify that the provider shall accept payment or appropriate denial made by the Contractor (or, if applicable, payment by the Contractor that is supplementary to the member's third party payer) as payment in full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the member. Member shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the patient being served.

Provider agreements shall include a provision whereby either the Contractor or the provider may terminate the provider agreement without cause within 30 days advance notice. The Contractor shall maintain an electronic copy of the provider application on file, and shall provide a copy of the provider application to the Department upon request.

#### 4.8.9 Provider Termination

The Contractor or the dental provider may terminate the provider agreement without cause with 30 days advance notice. The Contractor shall provide written notice to patients of a provider within fifteen (15) calendar days from the date that the Contractor becomes aware that the provider will no longer be available to render services. Additionally, the Contractor shall provide the names of other dental providers accepting Medicaid/FAMIS Plus and FAMIS patients in the member's locality. Each notice shall include all components identified in the notice template to be developed by the Contractor and approved by the Department. The timing requirement for the provision of this notice shall be waived in instances where a provider becomes physically unable to care for members due to illness, death or the provider moves from the service area and fails to notify the Contractor or when a provider fails credentialing, and instead the Contractor shall ensure that patients are made aware immediately upon the Contractor becoming aware of the circumstances. (Notice shall be issued in advance of the provider termination when possible or immediately upon the Contractor becoming aware of the circumstances.)

#### 4.8.10 Change in Provider Network Status

Upon final notification of a change in provider network status, or any variation from the requirements of this RFP, which shall be based on the requirements of this RFP, the Contractor shall immediately provide written notice to members living in the affected area of change in the Contractor's network. The notice content shall be consistent with the notice template to be developed by the Contractor and approved by the Department. Additionally, the Contractor shall prepare and submit to the Department within 5 business days of identifying any network deficiency a plan of corrective action to include a timeline for correction. The plan must detail the activities and associated time-lines the Contractor will employ to address the network deficiency and the assistance in locating a provider that it will provide to members that reside in the locality experiencing the deficiency.

#### 4.8.11 Notice of Provider Termination to the Department

The Contractor shall notify the Department of any provider termination and submit a template copy of the member notice sent as well as an electronic listing identifying each member to whom a notice was sent. The

Contractor shall maintain a copy of the actual notice on-site and forward a copy of the notices upon request from the Department. If the provider initiated the termination, said notice shall include a copy of the provider's notification to the Contractor.

#### 4.8.12 Provider Education

The Contractor shall provide continuing training for participating dental providers throughout the Commonwealth. The Contractor shall hold at least two training sessions per year for each region (Tidewater, Northern Virginia, Richmond/Petersburg, Charlottesville, Roanoke, and Abingdon/Far South Western Region) in the state. At least one session must be held physically within the designated regions. The Department may approve that the second and subsequent trainings be provided via Internet-based technology such as Web-ex or another application. The Contractor shall have the ability to provide individual training and education as needed and as requested by providers. At a minimum, training shall address pediatric dental utilization, billing procedures, and other pertinent provisions of the dental program. The Contractor shall submit all training material to the Department for approval at least sixty (60) calendar days prior to the training session. The Department shall have fifteen (30) calendar days to review and request changes, if necessary. If changes are requested, the Contractor must resubmit the training material within ten (10) calendar days of receipt of the Department's comments.

The Contractor shall provide documentation of all formal training activities and individualized corrective action assistance to the Department on a quarterly basis.

#### 4.8.13 Provider Manual/Office Reference Manual (ORM)

The Contractor shall produce and distribute a dental program criteria manual also referred to as the Office Reference Manual (ORM), following the amount, duration and scope of coverage provisions of the Department's Dental Provider Manual and specific to Virginia Medicaid/FAMIS Plus and FAMIS coverage, to assist participating dental providers. The manual shall be updated annually and as needed and clearly define covered services, limitations, exclusions, and utilization management procedures including, but not limited to: prior approval requirements/options and special documentation requirements for treatment of members. The manual shall include a detailed description of billing requirements for participating dental providers and shall contain a copy of Contractor's paper billing forms and electronic billing format. The Contractor shall produce and distribute revisions to the manual to participating providers prior to the effective date. The provider manual and any revisions thereto must be submitted to

the Department for review and approval prior to distribution. Once approved by the Department, the Provider Manual and any attachments must be submitted in a PDF and Word file to the Department for inclusion on the DMAS website, and must also be published on the Contractor's website. The Department's dental coverage criteria and guidelines are detailed in the Office Reference Manual available on-line at: [http://www.dmas.virginia.gov/dental-providers\\_home.htm](http://www.dmas.virginia.gov/dental-providers_home.htm)

#### 4.8.14 Provider Reconsideration Process

The Contractor shall develop policies and procedures to allow providers an opportunity for review and reconsideration of Contractor decisions. The reconsideration process shall be defined in the Contractor's agreement with the dental provider. The Contractor's review and reconsideration process must be reviewed and approved by the Department prior to implementation. The Contractor shall notify providers of their rights to appeal adverse actions to the Department if the review and reconsideration does not resolve the provider's challenge(s). The Contractor will provide DMAS with monthly reports indicating the number of reconsideration requests received as well as their detailed analysis and final disposition.

#### 4.8.15 Provider Appeals to DMAS

Medicaid providers have the right to appeal adverse decisions to the Department. The Contractor shall inform providers of their right to appeal to the Department. The Contractor shall assist DMAS by presenting the Department's position in the administrative appeals process in conjunction with appeals of Contractor actions filed by providers. In addition to the reconsideration process, DMAS has two levels of administrative appeals generally referred to as the informal level and the formal level. At the informal level the Contractor prepares the DMAS appeal summary and represents DMAS at an informal conference with the provider before a DMAS employee Appeals Agent. At the formal level, the Contractor assists DMAS staff counsel in preparing the case summary, complies with any subpoena or deposition requests that may be issued pursuant to the Virginia Administrative Process Act, and acts as a witness at a hearing before a hearing officer as appointed by the Virginia Supreme Court. Upon receipt of notification of an appeal by the Department, the Contractor shall prepare and submit appeal summaries to the DMAS Appeals Division, the DMAS Contract Monitor, and the provider involved in the appeal in accordance with required applicable regulatory requirements and timeframes. The appeal summary content and timelines are specified by appeal regulations. The Contractor shall comply with all state and federal laws, regulations, and policies regarding the content and timeframes for appeal summaries. Failure to submit appeals summaries within the required timeframe and according to the applicable regulatory requirements shall result in the Contractor being liable for any costs that DMAS incurs as a result of the Contractor's noncompliance, including but not limited to the amount in dispute together with costs and legal fees. The Contractor shall attend and defend the Contractor's decisions at all appeal hearings or conferences, whether informal or formal, or whether in person or by telephone, or as deemed necessary by the DMAS Appeals Division. All appeal activities, including but not limited to, travel, telephone expenses, copying expenses, staff time, document retrieval and storage, shall be borne by the Contractor. Failure to attend or defend the contractor's decisions at all appeal hearings or conferences shall result in the Contractor being liable for any costs that DMAS incurs as a result of the Contractor's noncompliance, including but not limited to the amount in dispute together with costs and legal fees and as provided in Attachment III of this RFP.

### **4.9 Member Grievance Process**

The Contractor shall have a grievance process in place available to Medicaid/FAMIS Plus and FAMIS members who wish to file a grievance or reconsider adverse actions. This process must assure that appropriate decisions are made as promptly as possible. The appeals process shall include provisions for expedited appeals within 3 working days. The Contractor must develop policies and procedures regarding

the grievance and reconsideration processes. These must be reviewed and approved by the Department prior to implementation. The Contractor shall notify members of their rights to grievances and reconsideration requests with the Contractor. The Contractor will provide DMAS with monthly reports indicating the number of grievances, reconsideration requests, and appeal requests received as well as the detailed analysis and disposition.

#### **4.10 Member Appeals to DMAS**

Medicaid/FAMIS Plus and FAMIS Members have the right to appeal most adverse actions directly to the Department as described in 42 CFR §431 *et seq.*, and the Virginia Administrative Code at 12VAC30-110-10 through 370. The Contractor shall notify the members of their right to appeal to the Department. Upon receipt of notification by the Department of an appeal, the Contractor shall prepare and submit appeal summaries to the DMAS Appeals Division, the DMAS Contract Monitor, and member involved in the appeal in accordance with required time frames. The Contractor shall comply with all state and federal laws, regulations, and policies regarding the content and timeframes for appeal summaries. Failure to attend and defend the contractor's actions at all appeal hearings and/or conferences shall result in the application of liquidated damages and/or immediate sanctions as described in Attachment III of this RFP.

The Contractor shall attend and defend the Contractor's decisions at all appeal hearings or conferences, or whether in person or by telephone, or as deemed necessary by the DMAS Appeals Division. Contractor travel and telephone expenses in relation to appeal activities shall be borne by the Contractor.

#### **4.11 Subcontractors**

##### **4.11.1 Legal Responsibility**

In accordance with requirements described in 42 C.F.R. § 455 Subpart B, and the State Medicaid Director Letter SMDL #08-003 (available at <http://www.cms.gov/smdl/downloads/SMD061208.pdf>), the Contractor shall comply with all of the following Federal requirements. Failure to comply with accuracy, timeliness, and in accordance with Federal and Contract standards may result in refusal to execute this Contract, termination of this Contract, and/or sanction by the Department.

##### **1. Contractor Owner, Director, Officer(s) and/or Managing Employees**

(a) The Contractor and or its subcontractors shall not knowingly have a relationship of the type described in paragraph (b) of this section with:

- (1) An individual or entity who is debarred, suspended, or otherwise excluded from participating in Federal health care programs, as listed on the federal List of Excluded Individuals/ Entities (LEIE) database at [http://www.oig.hhs.gov/fraud/exclusions/exclusions\\_list.asp](http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp) or excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- (2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1) of this section.

(b) The relationships described in this paragraph are as follows:

- (1) A director, officer, or partner of the Contractor
- (2) A person with beneficial ownership of five percent or more of the Contractor's equity.

(3) A person with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this contract with the Department.

(c) Consistent with Federal disclosure requirements described in 42 C.F.R. § 455.100 through 42 C.F.R. and § 455.106 the Contractor and its subcontractor(s) shall disclose the required ownership and control, relationship, financial interest information; any changes to ownership and control, relationship, and financial interest, and information on criminal conviction regarding the Contractor's owner(s) and managing employee(s). The Contractor shall provide the required information using the *Disclosure of Ownership and Control Interest Statement (CMS 1513)* included as part of the MCO Specific Contract Terms and Signature Pages, annually at the time of Contract signing.

(d) The Contractor and its subcontractor(s) shall perform, at a minimum, a monthly comparison of its owners and managing employees against the LEIE database to ensure compliance with these Federal regulations. The LEIE database is available at [http://www.oig.hhs.gov/fraud/exclusions/exclusions\\_list.asp](http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp).

(e) The Contractor shall report to the Department within five business days of discovery of any Contractor or subcontractor owners or managing employees identified on the Federal List of Excluded Individuals/Entities (LEIE) database and the action taken by the Contractor.

(f) Failure to disclose the required information accurately, timely, and in accordance with Federal and Contract standards may result in refusal to execute this Contract, termination of this Contract, and/or sanction by the Department.

## **2. Contractor and Subcontractor Service Providers**

(a) In accordance with 1902(a)(39) and (41), 1128, and 1128A of the Social Security Act, § 438-610, 42 C.F.R. § 1002, and 12 VAC 30-10-690 of the Virginia Administrative Code and other applicable federal and state statutes and regulations, the Contractor (including subcontractors and providers of subcontractors) shall neither participate with nor enter into any provider agreement with any individual or entity that has been excluded from participation in Federal health care programs or who have a relationship with excluded providers of the type described in paragraph 1(b) above. Additionally, the Contractor and its subcontractor is further prohibited from contracting with providers who have been terminated from the Medicaid or FAMIS programs by DMAS for fraud and abuse. Additional guidance may be found in the Department's 4/7/09 Medicaid Memo titled Excluded Individuals/Entities from State/Federal Healthcare Programs.

(b) The Contractor shall inform providers and subcontractors about Federal requirements regarding providers and entities excluded from participation in Federal health care programs (including Medicare, Medicaid and CHIP programs). In addition, the Contractor should inform providers and subcontractors about the Federal Health and Human Services – Office of Inspector General (HHS-OIG) online exclusions database, available at <http://exclusions.oig.hhs.gov/>. This is where providers/subcontractors can screen managing employees, contractors, etc., against the HHS-OIG website on a monthly basis to determine whether any of them have been excluded from participating in Federal health care programs. Providers and subcontractors should also be advised to immediately report to the Contractor any exclusion information discovered. The Contractor must also require that its subcontractor(s), have written policies and procedures outlining provider enrollment and/or credentialing process. The Contractor and its

subcontractor(s) shall perform, at a minimum, a monthly comparison of its providers against the LEIE database to ensure that their contracted health care professionals have not been included on the Federal List of Excluded Individuals/ Entities (LEIE) database, available at [http://www.oig.hhs.gov/fraud/exclusions/exclusions\\_list.asp](http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp). Federal health care programs include Medicare, Medicaid, and all other plans and programs that provide health benefits funded directly or indirectly by the United States.

(c) The Contractor shall report to the Department within five business days of discovery of any network providers or its subcontractor providers that have been identified on the Federal LEIE database and the action taken by the Contractor.

(d) Failure to disclose the required information accurately, timely, and in accordance with Federal and Contract standards may result sanction by the Department in accordance with this subsection of the Contract.

#### 4.11.2 Claims Processing

All claims for services furnished to a member filed with the Contractor must be processed by either the Contractor or by one (1) subcontractor retained by the organization for the purpose of processing claims.

#### 4.11.4 Notice of Subcontractor Termination

When a subcontract that relates to the provision of services to members or claims processing services is being terminated between the Contractor and a subcontractor, the Contractor shall give at least thirty (30) days prior written notice of the termination to the Department. Such notice shall include, at a minimum, a Contractor's intent to change to a new subcontractor for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed. In addition to prior written notice, the Contractor shall also provide the Department with a transition plan, when requested, which shall include, at a minimum, information regarding how service authorization requests will be handled during and after the transition, and how continuity of care will be maintained for the members. The Contractor's transition plan shall also include provisions to notify impacted or potentially impacted providers and members of the change. Failure to adhere to guidelines and requirements regarding administrative responsibilities, including subcontract requirements may result in the application of liquidated damages or intermediate sanctions as described in Attachment III of this RFP. The Department reserves the right to require this notice requirement and procedures for other subcontracts if determined necessary upon review of the subcontract for approval.

### **4.12 Quality and Utilization Management**

#### 4.12.1 Quality and Appropriateness of Care

The Contractor shall prepare for the Department's approval a written description of a quality monitoring/quality improvement (QM/QI) program, a utilization review program and peer review program to include policies and procedures outlining the objectives, scope, activities for ongoing monitoring, evaluation and improvement of the quality and appropriateness of dental services, and a strategy to improve broken appointment rates. The written program shall include an outcomes measurement tool for reporting and measuring results. The plan(s) shall describe who is responsible and the role of the Contractor's Dental Director in utilization review.

The QM/QI program shall also include a plan to monitor and report individual member utilization where members routinely seek preventive care from multiple dental providers and shall include a strategy to intervene and educate the member on the importance of establishing a dental home for care. The Department will work with the Contractor to establish additional reporting parameters. Applicable reporting shall occur quarterly.

In response to this RFP, the Offeror must submit QM/QI materials from contracts similar in scale to the requirements outlined in this RFP.

#### 4.12.2 QM/QI Meeting Requirements

The Contractor shall provide the DMAS Dental Manager with ten (10) calendar days advance notice of all regularly scheduled meetings of the Quality Monitoring/Quality Improvement Committee and Peer Review Committee. The Contractor's QM/QI program shall include review of the Contractor's program for dealing with non-compliant individuals as described in subsection 4.7.3 of this RFP. To the extent allowed by law, the DMAS Dental Manager of the Department, or his/her designee, may attend the QM/QI meetings at his/her option. In addition, written minutes shall be kept of all meetings of the QM/QI Committee. A copy of the written minutes for each meeting shall be forwarded to the Department.

#### 4.12.3 Peer Review Committee

The Contractor shall establish a Provider Peer Review Committee that shall meet two times per year (unless additional case reviews are needed) to review the processes and outcomes of Medicaid/FAMIS Plus and FAMIS dental care provided to members. Contractor will submit the names of proposed members to the Department within sixty (60) calendar days after the execution date of this RFP. The Committee shall include at least five (5) Participating Dental Providers who file at least twenty five (25) Medicaid claims per year for each year they are on the Committee. The Contractor's Dental Director shall be the committee chairperson. The Department reserves the right to attend the meetings.

Responsibilities of the Committee Shall Include:

- i. Reviewing and recommending appropriate remedial action for any participating dental provider who has provided poor quality of care, including referrals to the appropriate licensing agency.
- ii. Coordinating with the Department regarding imposition of any sanctions against a participating dental provider who has provided poor quality of care, including termination.
- iii. Coordinating with the Department in regard to issues involving fraud or abuse by any participating dental provider.
- iv. Reviewing and recommending appropriate action on grievances, appeals, or inquiries provided by members, participating dental providers, or other persons regarding quality of care, access or other issues related to the dental program.

#### 4.12.4 Policies and Procedures

The Contractor shall provide annually or more frequently as revisions occur, and upon request a written copy of its dental management policies and procedures to the Department for approval. Said policies and procedures must clearly identify any services for which the Contractor will require network providers to obtain authorization prior to the provision of the service as well as any additional submissions (such as radiographs) that may be required for approval of a service. The Department shall have thirty (30) calendar days to review and approve or request modifications to the policies and procedures. Should the Department not respond in the required amount of time, the Contractor shall not be penalized as a result of implementing the policies and procedures. However, failure to respond timely shall not preclude the Department from requiring the Contractor to respond or modify the policy or operating guideline prospectively.

#### 4.12.5 Standards of Care

Standards of care shall reflect published recommendations of nationally recognized authorities such as: The American Dental Association (ADA), The American Academy of Pediatric Dentistry (AAPD) and the American Association of Oral and Maxillofacial Surgeons (AAOMS). Participating dental providers shall not differentiate or discriminate in the treatment of any member on the basis of race, color, sex, religion, national origin, age, handicap, health, economic status or payment source.

The Contractor shall monitor provider compliance with AAPD and EPSDT requirements related to dental care and standard dental practice. The Contractor shall work with participating dental providers to develop corrective action plans to bring participating dental providers into compliance with community dental practice standards.

#### 4.12.6 Exceptional Quality Improvement and Utilization Management Processes

The Offeror shall submit the following as part of its proposal:

- i. The Offeror's proposed quality improvement plan (QIP), to include linkages with administrative areas, and a description of the QI committee and its composition.
- ii. A description of provider credentialing and monitoring processes, including provider profiling reports.
- iii. A description of how the Offeror's member grievance and appeals process is linked to the QI program.
- iv. A description of the Offeror's system to identify over- and under-utilization of member services, and a description of how this system would extend to network providers.

#### 4.12.7 Performance Reviews

The Contractor shall cooperate with any performance review conducted by the Department, including providing copies of all records and documentation arising out of Contractor's performance of obligations under the RFP. Upon reasonable notice, the Department may conduct a performance review and audit of Contractor to determine compliance with the RFP. At any time, if the Department identifies a deficiency in performance, the Contractor will be required to develop a corrective action plan to correct the deficiency including an explanation of how members will continue to be served until the deficiency is corrected.

#### 4.12.8 RFP Transition Plan

The Offeror shall submit, as part of the proposal response, a transition or continuation of coverage plan that documents how it will provide coverage to the member who is under treatment for medically necessary covered dental services the day before the effective date of this RFP. Offeror's transition plan shall describe any data needed from the Department. The Offeror shall authorize the continuation of said covered services without any form of prior approval.

In order to ensure uninterrupted service delivery, the Contractor shall accept authorization files from the Department's contracted MCOs and/or the Department as directed to identify members for whom prior approvals were issued prior to the effective implementation date of this RFP. To the extent that the approvals are for covered services and are within the parameters of the Department approved policies and procedures for prior approvals, the Contractor will accept and honor those prior approvals.

#### 4.12.9 Transition Management

The Contractor shall coordinate with the Department's current DBA, the FFS program and each of the Department's contracted MCOs (for dental surgeries per 4.5.6.b) to effect a smooth transition of dental care. Transition management includes coordination of care as described in Section 4.12.10 (below) and a process whereby dental inquiries received for dates of service on or after the RFP implementation are redirected to the Contractor.

#### 4.12.10 Coordination of Care and Members with Special Needs

The Contractor shall assist members in need of transitioning from one provider to another, including but not limited to instances where the provider terminates participation with the Contractor or where the member is not satisfied with the quality of care being received, especially where the course of treatment is not yet complete.

Additionally, the Contractor shall provide special assistance to providers and members when the dental care the member needs is dependent on the member receiving services of adjunct dental or medical providers. Examples include, but are not limited to instances where a child may require anesthesia in an outpatient facility in order to receive necessary dental care; where a child in need of orthodontic services must first receive services from an oral surgeon for complex teeth extractions; or by a periodontist for gum related issues before braces can be placed. The Contractor shall assist with coordination of services for individuals that have complex dental care needs involving the services of multiple dental specialist providers.

#### 4.12.11 Service authorization (SA) and Prepayment/Post Payment Claims Review Requests

##### Service Authorization

The Contractor may have an authorization system in place that allows providers to fax service authorization requests (pre-treatment plans) to the contractor for medical necessity review. The Offeror shall submit with its proposal its service authorization requirements and any other options (such as the pended claims option for services requiring service authorizations). The Offeror shall also describe any processes used to amend service authorization requirements based upon internal research of trends, professional guidelines, etc. The Contractor shall not impose service authorization requirements on pediatric preventive dental services. Service authorization requests must be accepted via multiple media, per industry standards, including but not limited to mail, email, fax, internet, direct data entry, or phone.

The Department shall approve final service authorization procedures prior to implementation and upon any revision.

The Contractor shall render a decision (approve, deny, pend or reconsideration) as expeditiously as the member's dental condition requires not to exceed 4 business days from the date of receipt. In cases where the contractor is unable to fully coordinate the member's dental care treatment due to lack of medical authorization, the contractor shall continue to coordinate the remaining medical authorization with the medical plan as quickly as possible. The contractor shall apprise the dental provider of the authorization status. Notification of the authorization determination(s) for all non-emergent cases is mailed by contractor to the provider within 24 hours of the determination. Notification of the authorization determination(s) for all medically emergent cases is faxed by the contractor to the provider. This system will not preclude the Contractor from requesting additional documentation such as x-rays if required for medical necessity review in accordance with the Department's criteria and industry standards of practice. In instances where the Contractor has requested additional medical justification from the dental provider, the Contractor shall render a final decision within 4 business days from the receipt of additional documentation from the provider.

The Contractor shall ensure that any decision to deny a service authorization request be made by a professional who has appropriate clinical expertise in treating the member's condition or disease.

The Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and consult with the requesting provider when appropriate.

The Contractor shall have a method in place that compares newly disenrolled members (per Section 4.17.2) to the Contractor's service authorization file. If a method is not in place, the Contractor must communicate to the provider that the authorization is not evidence of eligibility and does not guarantee payment. The Contractor must inform providers to verify member eligibility prior to rendering the dental service. The member must have eligibility on the date of service or the authorization is invalidated. When someone loses eligibility, the continuation of any dental appointments and treatment shall be between the provider and the member. (Except for orthodontic authorizations where coverage outside of eligibility is described in Sections 4.1.4 and 4.5.1.)

#### Prepayment Review

The Contractor shall provide review prior to payment of CDT codes designated by SFC to assure appropriateness of care and proper payment. Prepayment review should not be confused with Service Authorization. Prepayment Review is a review process completed after the service is provided, but in advance of payment being made to assure appropriateness of care standards are met.

Dental codes requiring prepayment review are outlined in Exhibits A and B in the Office Reference Manual and are available at: [http://www.dmas.virginia.gov/dental-providers\\_home.htm](http://www.dmas.virginia.gov/dental-providers_home.htm). CDT codes subject to prepayment review may be changed by the Department at any time.

#### Post Payment Review

The Contractor shall provide a review of paid claims to assure appropriateness of care and proper payment on at least a monthly basis as part of its ongoing integrity program. The Contractor shall select claims through sampling methodology, through routine audits, and as directed by the Department. The Offeror shall submit its written post payment review program to the Department for approval. The program shall include a detailed written audit plan, a mechanism to report findings to the Department's Program Integrity Unit and Medicaid Fraud Control Unit, and provider termination activity.

#### 4.12.12 Prior Approval Request Tracking

Each prior approval request processed by the Contractor shall be assigned a unique number and be maintained in a database designed by the Contractor that will contain all pertinent information about the request and be available to Call Center staff. This information will include, but will not be limited to: provider name and DMAS provider ID number, member name and Medicaid/FAMIS Plus or FAMIS ID number, procedure code(s) requested, requested units/visits, requested begin and end dates, procedure code(s) authorized, authorized begin and end dates, and request disposition (approved, reduced or denied). The Contractor shall report to the Department a summary of all service authorization activity on a monthly basis.

Present service authorization volumes are as follows. Approximately 155,549 service authorization requests are processed annually for *Smiles For Children* (SFY 09 report) members. An additional 26,829 prep-payment review authorization were submitted for SFY 09)

#### 4.13 Claims Processing Requirements

The Contractor shall have in place an automated claims processing system capable of accepting and processing paper claims and claims submitted electronically. As part of their proposal submission, Offerors must describe its claim processes including the dental claim forms accepted from providers.

Final claim processing requirements must be approved by the Department prior to implementation and upon any revision.

The Contractor shall process, as described herein, the provider's claims for covered benefits provided to members consistent with the Department's applicable policies and procedures and the terms of this RFP. Contractor shall also participate in the Department's efforts to improve and standardize billing and payment procedures.

##### 4.13.1 Electronic Billing System

The Contractor shall maintain and promote an electronic data processing system for claims payment and processing and shall implement an electronic billing system for interested participating dental providers in HIPAA compliant formats. The Contractor must make available to providers an electronic means of submitting claims. In addition, the Contractor shall make every effort to assure at least ninety (90%) percent of claims received from providers are submitted electronically by 2014.

All participating dental providers should be strongly encouraged and provided the training necessary to submit their claims electronically and the Contractor shall submit strategy to increase use of electronic billing systems which rely on technology. The Contractor or any entities acting on behalf of the Contractor shall not charge providers for filing claims electronically. Providers may engage in electronic billing services from their Practice Management Service or through a Value Added Network (VAN) at their own cost. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable line fees and/or charges. The Contractor shall comply at all times with all recognized standardized paper billing forms/format including, but not limited to the Dental ADA Claim form.

The Contractor shall not revise or modify the standardized form or format itself. Further, the Contractor agrees to adopt national standards and standardized instructions and definitions that are consistent with

industry norms for the forms identified above when developed by the Department in conjunction with appropriate workgroups.

#### 4.13.2 HIPAA and Industry Recommendations

The Contractor shall comply with Health Insurance Portability and Accountability Act (HIPAA) requirements. Further, the Contractor agrees that the Department may present recommendations concerning claims billing and processing that are consistent with industry norms. The Contractor shall comply with said recommendations within sixty (60) calendar days from receipt of notice by the Department and at no additional charge to the Department.

#### 4.13.3 Timeliness and Accuracy of Payment

The Contractor agrees to comply with prompt pay claims processing requirements in accordance with 42 C.F.R. § 447.45. The Contractor shall ensure that ninety percent (90%) of clean claims for payment of services delivered to members (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of receipt of such claims. The Contractor shall process, and, if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered. "Pay" means that the Contractor shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to Contractor. "Process" means the Contractor must send the provider a written remittance advice or other appropriate written notice evidencing either that the claim has been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. With the implementation of HIPAA requirements, this process must be electronic. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written notice must specifically identify all such information and documentation. Resubmission of a denied claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing. If requested by the provider, the Contractor shall provide a status report indicating the disposition for every adjudicated claim for each claim type submitted by providers seeking payment. The status report shall contain appropriate explanatory remarks related to payment or denial of the claims. The Contractor shall have a mechanism in place to handle this type of request through its ad hoc reporting system, the internet, or other means. The Offeror must include a description of its provider payment status reporting options with its proposal.

The Contractor shall provide to the Department a detailed claim processing report in the format reflected in Attachment VIII, Dental Monthly Report. The report shall capture the Contractor's performance with timely claims processing requirements and claim adjudication status applied (paid, denied, etc.).

Failure to comply with the aforementioned claims processing requirements shall result in the Contractor being required to implement a corrective action plan and shall result in the application of liquidated damages and/or immediate sanctions as described in Attachment III of this RFP.

#### 4.13.4 Reimbursement Rate for Dental Services

When the Department has established eligibility and the member has incurred dental expenses that are covered benefits within the plan, the Contractor shall make reimbursement for the dental services at the Medicaid established fee-for-service rates. The DMAS Dental Fee File can be downloaded from the Department's web site at [http://www.dmas.virginia.gov/dental-providers\\_home.htm](http://www.dmas.virginia.gov/dental-providers_home.htm) under Current Dental Rates. The Contractor shall not use capitation payment reimbursement methods or any type of non fee-for-service reimbursement methodology for services provided under this RFP and resulting contract. The Contractor shall require the provider to be enrolled with Virginia Medicaid prior to rendering services. The Contractor shall require that participating providers hold the member harmless for covered services, including any costs above the fee-for-services rates. The Contractor shall require, as a condition of payment, that the service provider accept the amount paid by the Contractor as payment in full.

As part of their proposal submission, Offerors shall provide a description of their timely filing requirements as based upon business practices. The Contractor shall process claims received within no more than 180 calendar days of the date of service. Additionally, the Contractor shall process claims, including payments, voids, and adjustments, outside of timely filing requirements in cases of retroactive or delayed eligibility, accident cases, and as a result of delayed payment from the member's primary insurance payer, as detailed in Section 4 of the Office Reference Manual located at: [http://www.dmas.virginia.gov/dental-providers\\_home.htm](http://www.dmas.virginia.gov/dental-providers_home.htm). The Contractor shall maintain all claim record detail for at least 6 years from the claim adjudication date.

#### 4.13.5 Dental Service Payments

The Contractor is not at financial risk for the provision of covered benefits to members. The Contractor shall prepare checks for payment to providers on a weekly basis and shall notify the Department of the amount to be paid in accordance with the terms described in Section 6 of this RFP.

Claims paid through the Contractor's system will be based upon enrollment information downloaded from the 834 Benefit Enrollment and Maintenance transaction sent to the Contractor weekly. There could occur instances where the Contractor receives claims for eligible members, per the VAMMIS, but who were not included on the 834 Benefit Enrollment and Maintenance transaction sent by the Department to the Contractor. In these cases, the Contractor must pend the claim for the next 30 days following the weekly receipt of the updated 834 eligibility file and recycle such claims instead of denying them for eligibility/enrollment reasons.

### **4.14 Other Coverage**

#### 4.14.1 Other Insurance Coverage

The Contractor shall reject claims that should rightly be processed by a member's primary dental carrier. In addition, the system must allow for coordination of benefits in accordance with the Medicaid/FAMIS Plus and FAMIS "payer of last resort" rules. The Contractor is responsible for deductibles and coinsurance up to the maximum reimbursement amount that would have been paid in the absence of other primary insurance coverage for Medicaid/FAMIS Plus and FAMIS covered services.

#### 4.14.2 Withholding Payments

The Contractor shall not withhold payment for services provided to a member if third party liability or the amount of liability cannot be determined, or third party liability payment will not be available within a reasonable time.

#### 4.14.3 Recovery of Funds

All funds recovered from third parties shall be reported to the Department and treated as offsets to claims payments.

### **4.15 Subrogation Recoveries**

The Department retains the responsibility to pursue, collect, and retain all non-health insurance resources such as casualty, liability, estates, child support, and personal injury claims. The Contractor is not permitted to seek recovery of any non-health insurance funds.

The Contractor shall notify the Department on a monthly basis of any members identified during that past month who are discovered to have any coverage not previously reported to the Contractor by the Department, including members identified as having trauma injuries. (Reference Attachment VI) for the suggested format to use when reporting potential coverage secondary to an accident.) The Contractor shall provide all claims data associated with care given to members in relation to accidents/traumas, and other coverage not reflected in the Department's enrollment information.

### **4.16 IRS Form 1099**

The Contractor shall prepare and mail Internal Revenue Service ("IRS") Form 1099 to the IRS on behalf of providers who receive payments under this RFP. The Contractor shall provide a hard copy and, if requested, a magnetic tape transfer of form 1099 information to the providers for subsequent reporting of Form 1099 information to the IRS. In addition, the Contractor shall provide a hard copy, and if requested, a magnetic tape transfer of the 1099 information to the Department.

### **4.17 Interfaces, Supporting Files, and VAMMIS Access Requirements**

In response to this RFP, the Offeror shall receive member eligibility data from the Virginia Medicaid Management Information System (VAMMIS), send encounter data, and provide supporting payment documentation of claims data, along with other information as required by the Department used for program monitoring and analysis as described in Section 4.17 and 4.18 of this RFP. The contractor must also be able to access VAMMIS via the internet.

#### Interface File Transfer Requirements

This contract requires that the Contractor establish connectivity with the Commonwealth's fiscal agent to exchange data files.

Currently, the fiscal agent allows the following connectivity option for file data exchange. All files must be exchanged through a secure, encrypted FTP site maintained by the fiscal agent. During the requirements phase of this project it will be determined if these files will be pushed or pulled from the fiscal agent FTP site. The Contractor may access this site with an FTP client or through use of a web browser.

## **Connectivity Options**

SFTP over SSH

SFTP over TLS-P

SFTP over TLS-Implicit

SFTP over SSL

### 4.17.2 Member Eligibility (834)

The Contractor will receive a weekly HIPAA compliant 834 Benefit Enrollment and Maintenance version 5010 transaction from the fiscal agent's secure FTP server. The contractor is responsible for completion of all data mapping necessary to update the contractor's system with eligibility information to provide services to the covered members and support the reporting needs of the Commonwealth at no additional cost to the Department. The Contractor must have staff available to make mapping and system changes during the contract term. The current 834 version 4010 Companion Guide can be found in Appendix XV. Due to the timing of this contract and the mandated implementation of the X12 version 5010, the dental contractor selected will be required to process a 834 version 5010 at the start of this contract.

### 4.17.3 Encounter Data (837D)

The Contractor shall send a weekly HIPAA compliant 837D Health Care Claim: Dental version 5010 transaction to the Commonwealth's fiscal agent's secure FTP server on a schedule set by DMAS. The current 837 version 4010 Companion Guide can be found in Appendix XVI. Due to the timing of this contract and the mandated implementation of the X12 version 5010, the dental contractor selected will be required to process a 837 version 5010 at the start of this contract.

### 4.17.4 Supporting Claim File Documentation

In addition to the encounter data, the Department requires that the contractor submit a weekly Excel spreadsheet summarizing claim payment information, which supports the funding of the contractor's claims payment account. In addition, the contractor must submit a weekly

Excel spreadsheet containing claim detail information coinciding with the funding spreadsheet. The Excel version currently used is 2003. The contractor must use an Excel version compatible with what is used by the Commonwealth. These spreadsheets must be emailed to the Contract Monitor by 5:00 PM EST on Wednesday or as requested.

Claims Detail information shall be verified by the Department before funding is released. The Department reserves the right to modify this process at a future time.

### Connectivity to the Virginia Medicaid Management Information System (VAMMIS)

The Contractor's staff will be granted access to VAMMIS through the web portal (<https://www.viriniamedicaid.dmas.virginia.gov>) with an ACF2 secure sign on. This will enable the Contractor to view eligibility and other pertinent MMIS data as deemed necessary by DMAS. The Contractor's Help Desk employees supporting this contract must have access to the Internet. The Department will ensure the Contractor and their staff members receive VAMMIS training.

#### 4.17.5 Contractor Database and Processing System

In order to meet information system requirements and to support the timely provision of Departmental services, the Contractor shall operate a database maintained with the highest level of privacy and security as defined in HIPAA regulations. The database shall be capable of maintaining and recording participant protected health information (PHI) for the Department's Dental Program. Data stored in the database shall be kept current, based on updates received from the Department's fiscal agent and the Contractor's claims processing system.

The Contractor's database and processing system shall ensure the timeliness and accuracy of data used in the business processes for final claims payment determination based on the Department's rules and regulations. This system shall be capable of allowing for future growth and flexibility in dental coverage at no additional cost to DMAS.

Although the Contractor will maintain the database and processing system at their facility, DMAS and DMAS authorized agents must have access to the Contractor's database to support the Virginia Medicaid dental program. DMAS requires 8 access/licenses to the database and the various applications used by the Contractor at no additional cost to the Department. All data and other information used to maintain the Virginia Medicaid dental program is the property of the Department.

The Offeror shall describe the approach to convert and transfer approximately 2,930,000 historical claims records (covering a period of four years) and supporting records and documentation from the current contractor's system to include any work currently in process. In addition, the Offeror shall describe any foreseeable obstacles or constraints impeding this process. A description of any proposed document management solutions should be included.

#### 4.17.6 Data Validation Edits and Audits

The Contractor's claims processing system shall perform the following validation edits and audits at a minimum but may not be limited to the following:

- i. Prior Approval/Pre-Payment Approval - The system must determine whether a covered service requires prior approval, and if so, whether the Contractor granted approval.
- ii. Valid Dates of Service - The system must assure that dates of services are valid dates  
and not in the future.
- iii. Duplicate Claims - The system must automatically inform the provider that the current claim is an exact or possible duplicate and deny that claim as appropriate and have override capability.
- iv. Covered Service - The system must verify that a service is a valid covered service and is eligible for payment under the Department's dental benefit for that eligibility group.
- v. Provider Validation - The system must approve for payment only those claims received from providers that would have been paid in the absence of other primary insurance coverage for Medicaid/FAMIS plus and FAMIS covered services.
- vi. Eligibility Validation - The system must confirm the member for whom a service was provided was eligible on the date the service was incurred.
- vii. Quantity of Service - The system must validate claims to assure that the quantity of services is consistent with Department rules and policy.
- viii. Rejected Claims - The system must determine whether a claim is acceptable for adjudication and reject claims that are not.

- ix. Managed Care Organizations - The system must reject claims that should rightly be processed and paid by a member's MCO for any and all physical health treatments.
- x. Other Insurance Coverage – The system must reject claims that should rightly be processed by a member's primary dental carrier. In addition, the system must allow for coordination of benefits in accordance with the Medicaid/FAMIS Plus “payer of last resort” rules. The Contractor is responsible for paying deductibles and coinsurance up to the maximum reimbursement amount that would have been paid in the absence of other primary insurance coverage for Medicaid/FAMIS plus and FAMIS covered services.
- xi. Service Limits – The system must verify that a service is not covered outside of the Department's established service limits, including but not limited to once in a lifetime procedures.
- xii. Correct Payment Amounts – The system must pay the claim at the lesser of the billed amount or the Department's allowable amount, other third party payer coverage, etc. as described in the Office Reference Manual referenced in Attachment 1 of this RFP.

Claims History - The Contractor shall accept 24 months of paid dental claims history in an agreeable format to be used for duplicate claims payment verification purposes.

#### 4.17.7 System Flexibility

The Contractor's claims process system shall be table driven with the capability to handle eligibility and procedure coverage changes and edit and audit changes immediately upon notification by DMAS at no additional charge.

#### 4.17.8 Systems Readiness Review and Access to Contractor's system

The Contractor will work with the Department to ensure that the Contractor's processing system satisfies the functional and informational requirements of Virginia's Dental program requirements. The Contractor shall assist the Department in the analysis and testing of information systems, claims processing and reporting requirements. DMAS expects to test and validate the system through user acceptance testing with ample time prior to production. The Contractor must provide and maintain a test environment and provide 8 access/licenses to Department staff allowing access to test the Contractor's system from DMAS user workstations. DMAS users must be able to access the Contractor's test and production environments through the life of the contract. The Contractor will provide any software or additional communications network required or special equipment and training for access at the Contractor's expense. The Contractor shall notify DMAS of available hours and any scheduled downtime prior to its occurrence. When on Contractor's site, DMAS users must be granted access to system applications when auditing Contractor's work. The Contractor agrees to actively send and receive test data transmissions prior to implementation until approved and throughout the contract as changes are deemed necessary by Federal, State, or DMAS policy.

#### 4.17.10 Secure Email

The Contractor shall provide SSL secure email access over the Internet between DMAS and the Contractor and any other entity where PHI is communicated. No direct connection of VPNs to DMAS will be used for this purpose nor will DMAS use individual email certificates for its staff. Such secure email will only require DMAS staff to use a 128-bit SSL enabled web browser to access the contractor or send email to the contractor. DMAS will provide no special application server(s) for this purpose. Routing of emails over point-to-point telecommunications circuits between DMAS and the Contractor

supports Secure SMTP over Transport Layer Security (TLS) RFC 3207 over the internet. The solution must include a method for secured industry standard email using strong encryption keys (greater than 128 bit) between DMAS and the Contractor throughout the contract term. Bidirectional TLS email encryption must be tested and documented between DMAS and the contractor's SMTP server. Otherwise, the contractor will use the DMAS secure email server encrypted at 128-bits for secure email. DMAS uses Tumbleweed secure email server. DMAS additionally has implemented the new Symantec Mail Security appliances that do point-to-point TLS email encryption.

#### 4.17.11 Risk Management and Security

The Contractor, at a minimum shall meet VITA standards, which may be found on the VITA website at <http://www.vita.virginia.gov> DMAS requires the Contractor to conduct a security risk analysis and to communicate the results in a Risk Management and Security Plan that is compliant with the most stringent requirements from the standards listed below:

- Section 1902 (a) (7) of the Social Security Act (SSA);
- HIPAA Security Rule, 45 CFR Parts 160, 162, and 164 Health and Insurance Reform; Security Standards: Final Rule (latest version);
- COV ITRM Policy SEC500-02 dates (latest version);
- COV ITRM Standard SEC501-01 (latest version); and
- DMAS policies specifically identified.

The following specific security measures shall be included in a section of the Risk Management and Security Plan:

- Computer hardware controls that ensure acceptance of data from authorized networks only;
- At the Contractor's central facility, placement of software controls that establish separate files for lists of authorized user access and identification codes;
- Manual procedures that provide secure access to the system with minimal risk.
- Multilevel passwords, identification codes or other security procedures that must be used by State agency or Contractor personnel;
- All Contractor database software changes related to the PA program may be subject to the Department's approval prior to implementation; and
- System operation functions must be segregated from systems development duties.

The Risk Management and Security Plan document must be delivered to the Department 30 days before implementation. The Plan will also be made available to appropriate State and Federal agencies as deemed necessary by DMAS.

#### 4.17.12 Disaster Preparedness and Recovery at the Service Authorization Processing Site

The Contractor shall submit a Business Continuity/Disaster Recovery Plan for its processing system prior to implementation. If requested, test results of the plan must be made available to the Department. The plan must be tested before the effective date of the contract and must meet the requirements of any applicable state and federal regulations, and of the Department. The Contractor's Business Continuity/Disaster Recovery Plan must include sufficient information to show that it meets the following requirements:

- Documentation of emergency procedures that include steps to take in the event of a natural disaster by fire, water damage, sabotage, mob action, bomb threats, etc. This documentation must be in the form of a formal Disaster Recovery Plan. The Contractor will apply recognized industry standards governing Disaster Preparedness and Recovery including the ability to continue receiving calls, processing prior authorizations, and other functions required in this RFP in the event that the central site is rendered inoperable. Additionally, the Contractor's disaster plan must include provisions in relation to the processing center telephone number(s);
- Employees at the site must be familiar with the emergency procedures;
- Smoking must be prohibited at the site;
- Heat and smoke detectors must be installed at the site both in the ceiling and under raised floors (if applicable). These devices must alert the local fire department as well as internal personnel;
- Portable fire extinguishers must be located in strategic and accessible areas of the site. They must be vividly marked and periodically tested;
- The site must be protected by an automatic fire suppression system;
- The site must be backed up by an uninterruptible power source system; and
- The system at the disaster recovery site must be tested and verified in accordance with VITA standards.

The Business Continuity/Disaster Recovery Plan document must be delivered to the Department 30 days before implementation.

#### 4.17.13 Continuity of Operations

The Contractor shall be required to provide a Continuity of Operations Plan (COOP) that relates to the services or functions provided by them under this contract. Key information to be included in the contractor's COOP and used as an example can be found on the VITA website at <http://www.vita.virginia.gov>

The Continuity of Operations Plan document shall be delivered to the Department 30 days before implementation.

#### 4.17.14 Security Training

The Contractor shall be required to provide a Security Training Plan that relates to the services or functions provided by them under this contract.

The Security Training Plan document shall be delivered to the Department 30 days before implementation.

### **4.18 Electronic Data Submission Including Encounter Claims**

The Contractor shall not transmit protected health information (PHI) over the Internet or any other insecure or open communication channel unless such information is encrypted or otherwise safeguarded using procedures no less stringent than those described in 45 CFR § 142.308(d).

If the Contractor stores or maintains PHI in encrypted form, the Contractor shall, promptly at the Department's request, provide the Department with the software keys to unlock such information.

#### 4.18.1 Electronic Data Interchange (EDI)

The Contractor shall transmit documents directly or through a third party value added network. Either party may select, or modify a selection of, a Value-Added Network (VAN) with thirty (30) calendar days written notice.

The Contractor shall be solely responsible for the costs of any VAN with which it contracts. The Contractor will be liable to the other for the acts or omissions of its VAN while transmitting, receiving, storing or handling documents. The Contractor is solely responsible for complying with the subscription terms and conditions of the VAN he or she selects, and for any and all financial liabilities resulting from that subscription agreement.

#### 4.18.2 Test Data Transmission

The Contractor agrees to actively send and receive test data transmissions prior to implementation until approved. The Contractor agrees to receive redundant transmission (e.g. faxed copy and electronic), if required by the Department, for up to thirty (30) calendar days after a successful EDI link is established.

#### 4.18.3 Garbled Transmissions

If the Contractor receives an unintelligible document/file, the Contractor will promptly notify the sending party (if identifiable from the received document/file). If the sending party is identifiable from the document, but the receiving party failed to give notice that the document is unintelligible, the records of the sending party will govern. If the sending party is not identifiable from the document, the records of the party receiving the unintelligible document will govern.

#### 4.18.4 Certification

Any payment information from the Contractor that is used for rate setting purposes (e.g. any encounter data) or any payment related data required by the state must be certified by the Contractor's Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer of the Contractor. The Contractor shall be responsible for validating submissions from providers and subcontractors.

The Contractor shall use Attachment IV, Certification of Encounter Data, on a monthly basis reflecting prior submissions of encounters; and, Attachment V, Certification of Data, for certification of non-encounter payment related data submissions within one (1) week of the date of submission. Any data not certified within the specified time frames will not be considered as part of the rate setting processes.

#### 4.18.5 Enforceability and Admissibility

Any document properly transmitted pursuant to this Contract shall be deemed for all purposes (1) to be "a writing" or "in writing," and (2) to constitute an "original" when printed from electronic records established and maintained in the ordinary course of business. Any document which is transmitted pursuant to the EDI terms of this Agreement will be as legally sufficient as a written, signed, paper document exchanged between the parties, notwithstanding any legal requirement that the document be in writing or signed. Documents introduced as evidence in any judicial, arbitration, mediation or administrative proceeding will be admissible to the same extent as business records maintained in written form.

#### 4.18.6 Timeliness, Accuracy, and Completeness of Data

The Contractor shall ensure that all electronic data submitted to the Department are timely, accurate and complete. At a minimum, encounter data and provider network reports will be submitted via electronic media in accordance with Department criteria.

In the event that electronic data files are returned to the Contractor due to errors, the Contractor agrees to process incorrect data and resubmit within thirty (30) calendar days. The Contractor agrees to correct encounter claims where appropriate and resubmit corrected encounter claims in accordance with the specifications set forth in this RFP.

The Contractor shall evaluate the completeness of the data from providers on a periodic basis. The Contractor must report the plan/strategy used by the Contractor, including completeness at start up, when revised, and upon request. Any deficiencies found through the review process must be reported to the Department within 60 calendar day. A corrective action plan to address any deficiencies found must be provided to the Department within 30 calendar days after notification of any deficiencies.

#### 4.18.7 Encounter Claims Data Submission

Approved and denied encounters shall be submitted following the guidelines established by the Encounter Data Submission Manual, including the format, data elements, and data values specified. All encounters must be submitted via Virginia's Medicaid EDI Bulletin Board as described in that guide. The standard for accepting a transmission in its entirety is no more than a five percent (5%) fatal error rate. Fatal errors, when applicable, should be corrected and the encounter adjusted within thirty (30) days of receipt of the propriety error and/or electronic error reports. If the Contractor loses its production privilege due to a high volume of fatal errors, then the Contractor must actively test with DMAS and regain approval for production submissions within thirty (30) days.

All encounters shall be submitted weekly using the nationally recognized formats defined below:

- Dental Claims – Submit using the American National Standards Institute (ANSI) 837, version 40.10 with addenda including all required data elements.

All encounters shall be submitted to the Virginia Medicaid Management Information System (VAMMIS) Gateway System to interface with the ACS File Transfer Protocol (FTP) Server.

Submissions shall be made at least weekly and may be made more frequently with the approval of the Department. Files with HIPAA defined level 1 or level 2 errors in the ISA, GS, GE, or ISE records will be rejected and a negative 997 sent back to the submitter. The entire file must be resubmitted after the problem is fixed. Files with HIPAA defined level 1 or level 2 errors inside a ST-SE loop will have that ST-SE loop rejected and a negative 997 will be sent back to the submitter identifying the loop. Any other ST-SE loops, which do not have level 1 or level 2 errors, will be processed. Only the rejected ST-SE loops should be resubmitted after fixing the problem. Errors on rejected files or ST-SE loops must be corrected and resubmitted within thirty (30) calendar days of the date of rejection.

For the purposes of this Contract, an encounter is any service received by the member and processed by the Contractor. The Contractor shall submit encounters/claims for all claims it receives, with the exception of claims the Contractor has determined to be a duplicate of a previously processed claim/encounter and other exceptions as noted in the Encounter Data Submission Manual. The

Contractor is responsible for submission of data from all of its subcontractors to the State or its agent in the specified format that meets all specifications required by the Department and matches the requirements placed on the Contractor by the Department for encounters. This data shall be submitted and on a timely basis.

At the end of each calendar year, the Department will prepare an Encounter Submission Calendar. The purpose of this calendar is to schedule receipt of encounter records from the Contractor. The Contractor shall adhere to the Department's submission schedule. Files submitted on the scheduled date should only include the normal submission, no backlog, unless agreed to in advance by the Department. Any changes to the submission dates require re-scheduling with the Department. If unable to submit the encounters on the scheduled date, notify the Department within three business days of an alternate submission date.

Except for encounters involving appeals, the Contractor shall submit to the Department ALL electronic encounter claims within thirty (30) calendar days of receipt. Late data will be accepted, but the Department reserves the right to set and adjust timeliness standards as required in order to comply with State and Federal reporting requirements. The Contractor is strongly encouraged to submit encounter data as received and discouraged from waiting the full time allotted before submitting the encounter data to the Department. The Department reserves the right to require written explanations of all appeals. The Department reserves the right to require more frequent submissions, based on file size/volume and to require more frequent submissions, based on file size/volume.

The Contractor shall be required to pass a testing phase before production encounter data will be accepted. The Contractor shall pass the testing phase within twelve calendar weeks from the effective date of the change.

The Contractor shall submit the test encounter data to the Department's fiscal agent electronically according to the specifications of the HIPAA Implementation and Companion Guidelines.

The Contractor shall be responsible for passing a phased-in test process prior to submitting production encounter data. The Contractor shall utilize production encounter data, systems, tables, and programs when processing encounter test files.

Any additional costs incurred by the Department resulting from the Contractor not submitting encounters within thirty (30) calendar days of receipt will be passed on to the Contractor.

The Department reserves the right to reimburse the Contractor for paid claim dollars based on the encounter claims data submissions. Should the Department opt for this or a similar alternative payment process, the Department shall consider the impact of payments to providers. The Department shall consider offering an advancement of funds to the Contractor to compensate for the time period between the claims being processed for payment and the encounter approval.

#### 4.18.8 Encounter Data Reconciliation

The Contractor shall fully cooperate with all the Department's efforts to monitor the Contractor's compliance with the requirements of encounter data submission including encounter data accuracy, completeness, and timeliness of submission to the Department's Fiscal Agent. The Contractor may comply with all requests related to encounter data monitoring efforts in a timely manner.

#### 4.18.9 Provider Identification Data

Contractor shall maintain a dental provider database. The Department also maintains a copy of this provider file on our own MMIS in order to support encounter processing. The Contractor will submit a weekly Excel file to designated DMAS staff via secure email with new and/or updated provider information. In the event no changes to provider information are needed for the month, the Contractor will inform the Department via email notification. The file layout is defined below:

- a) NPI
- b) Provider Type
- c) Last Name
- d) First Name
- e) Middle Initial
- f) Suffix
- g) Title
- h) Address
- i) City
- j) State
- k) Zip(5+4)
- l) Contact Name
- m) Phone(including area code)
- n) Tax ID Number
- o) Provider Begin Date
- p) License Number
- q) License Begin Date
- r) License End Date
- s) Specialty
- t) Languages

The Contractor is responsible to ensure that all encounter claims are identified with an active National Provider Identification (NPI) number and the correct provider identification numbers are associated with the appropriate claims and service dates. As of the effective date of mandatory compliance with the CMS NPI Rule, no encounter record will be accepted by DMAS unless the provider has an active NPI record.

#### **4.19 Transition Upon Termination Requirements**

At the expiration of this Contract, or if at any time the Department desires a transition of all or any part of the duties and obligations of Contractor to the Department or to another vendor after termination or expiration of the Contract, the Department shall notify the Contractor of the need for transition. Such notice shall be provided at least sixty (60) calendar days prior to the date the Contract will expire, or at the time the Department provides notice of termination to Contractor, as the case may be. The transition process will commence immediately upon such notification and shall, at no additional cost to the

Department, continue past the date of contract termination or expiration if, due to the actions or inactions of Contractor, the transition process is not completed before that date.

If delays in the transition process are due to the actions or inactions of the Department or the Department's newly designated vendor, the Department and Contractor will negotiate in good faith a contract for the conduct of and compensation for transition activities after the termination or expiration of the Contract. In the event that a subsequent Contractor is unable to assume operations on the planned date

for transfer, the Contractor will continue to perform MIS operations on a month-to-month basis for up to six months beyond the planned transfer date. The Department will withhold final payment to the Contractor until transition to the new Contractor is complete.

#### 4.19.1 Close Out and Transition Procedures:

- 4.19.1.a Within ten (10) business days after receipt of written notifications by the Department of the initiation of the transition, Contractor shall provide to the Department a detailed electronic document, containing the following:
- i. The number of dental claims approved, denied or pending at the time of transition, including the following information: the Participant's name and identification number, the Participating Dental Provider's name and provider number, and the type of service;
  - ii. Information on any pending grievances, including Department appeals hearings; and
  - iii. The number of service authorizations in process, including the following information: the Participant's name and identification number, the Participating dental provider name and provider number and type of dental service.
- 4.19.1.b Within ten (10) business days after receipt of the detailed document, the Department will provide Contractor with written instructions, which shall include, but not be limited to, the following:
- i. The packaging, documentation, delivery location, and delivery date of all records, data and review information to be transferred. The delivery period shall not exceed thirty (30) calendar days from the date the instructions are issued by the Department.
  - ii. The date, time and location of any transition meeting to be held among the Department, Contractor and any incoming Contractor. Contractor shall provide a minimum of two (2) individuals to attend the transition meeting and those individuals shall be proficient in and knowledgeable about the materials to be transferred.
- 4.19.1.c Within five (5) business days after receipt of the materials from Contractor, the Department shall submit to Contractor in writing any questions the Department has with regard to the materials transferred by Contractor. Within five (5) business days after receipt of the questions, Contractor shall provide written answers to the Department.
- 4.19.1.d All copyright and patent rights to all papers, reports, forms, materials, creations, or inventions created or developed in the performance of this contract shall become the sole property of the Department. On request, the Contractor shall promptly provide an acknowledgment or assignment in a tangible form satisfactory to the Department to evidence the Department's sole ownership of specifically identified intellectual property created or developed in the

performance of the contract. This includes but is not limited to the call center telephone number established for Medicaid/FAMIS Plus/FAMIS.

- 4.19.1e The Contractor shall be liable for all dental claims incurred up to the date of termination.

#### **4.20 Reporting Requirements**

The Contractor shall submit the reports described within this section in a format approved by the Department.

##### **4.20.1 Data Base Requirements**

In order to meet information system requirements and to support the timely provision of ad hoc report requests that may be made by the Department, Contractor shall maintain a current database, in a format acceptable to the Department, capable of retrieving data on short notice. At a minimum, the database shall include the following data:

- Member Name;
- Medicaid/FAMIS Plus or FAMIS ID #;
- Member Social Security Number (SSN);
- Member MCO (if applicable);
- Dates of Service;
- Specific service provided by procedure ADA Code;
- Servicing Provider Number (Medicaid #);
- Participating Dental Provider Name;
- Payment Status;
- Billed Charge Amount;
- Allowed Amount;
- Payment Amount;
- Received Date;
- Payment Date; and
- Any other data element required by common dental practice, ADA Guidelines, federal or state law.

Data stored in the database shall be current through the prior week.

##### **4.20.2 Claim Activity Reporting Requirements**

The Contractor shall provide to the Department a Monthly Dental Report, as reflected in Attachment VIII, a Detailed Claim Processing and Reconciliation Report as described in Section 6 of this RFP, a Monthly Batch Claim Operations Report, an Encounter Data Report, and a Claims Lag Triangle Report including the data elements and in the format and medium (including electronic) requested by the Department. Record layout and other information about report submission are available through the Department.

The Contractor shall provide an **annual version** of the Monthly Summary Report (shown in Attachment VIII) that captures totals for the contract year, within ninety (90) calendar days of the effective contract date and effective contract renewal date.

#### 4.20.3 Appointment Assistance/Care Coordination Report

The Contractor shall submit a monthly report on the number of requests for assistance to obtain an appointment as specified in Section 4.7.2, and shall include a summary of the coordination of care assistance provided as described in Sections 4.7.4 and 4.7.5. The first report under this RFP, covering the month of June 2011, shall be due on July 15, 2011. Thereafter, reports shall be due fifteen (15) days after the end of each calendar month. The report shall provide sufficient information to allow the Department to determine the number of requests by city/county, % of requests per city/county, referral source, outcomes, and the time required to locate a participating dental provider willing to serve the member who is seeking an appointment for covered services.

#### 4.20.3a Request a Dentist Report

The Contractor shall submit a monthly report as outlined in 4.3.1 identifying the names and addresses of members who contacted the dental benefit administrator to find a dentist. The submitted report should reflect the total number of callers and average turnaround time from call date to resolution date.

#### 4.20.4 Financial Reporting Requirements

##### 4.20.4a Monthly Full Reconciliation Report

The Contractor shall provide to the Department a monthly cumulative account of the financial transactions reconciling the provider claims to the SFC checking account. Should the contractor stop payment or void any check and not reissue a replacement check, the funds are to be refunded to the Department and the associated claims must be voided in the claims system.

##### 4.20.4b Monthly Bank Statement

The Contractor shall provide to the Department a copy of monthly bank statements with supporting documentation sufficient to verify account credit and debit adjustments. At a minimum, the monthly bank statement should clearly indicate the date of the statement, bank account name and account numbers to verify transfer of funds.

##### 4.20.4c Stale Dated Check Report

The contractor shall provide to the Department a monthly Stale Dated Check report that includes checks outstanding or uncashed after the 150-day mark for review and potential follow up with the providers. Checks that remain uncashed after 180-days of the issue date are deemed "stale dated" and are to be voided and the funds refunded to the Department on a quarterly basis. All claims associated with the voided 180-day checks are to be voided in the claims system.

##### 4.20.4d Negative Balance Report

The contractor shall provide to the Department a monthly Negative Balance report that lists providers who have outstanding debts with the contractor. The report should also list the claims and/or transactions that generated the negative balance as well as the date the overpayment associated with the negative balance occurred.

##### 4.20.4e Accrued Interest report

The contractor shall provide to the Department a monthly accrued interest report associated with the SFC bank account. The Contractor should reimburse the Department quarterly for interest accrued on this account. Interest should accrue based on the daily balance of funds remaining in the SFC account. The Contractor must notify DMAS via email when the transfer has occurred.

#### 4.20.4f Audited Financial Statements and Income Statements

The contractor shall provide to the Department copies of its annual audited financial statements no later than ninety (90) calendar days after the end of the calendar year and Quarterly Income Statements no later than thirty (30) calendar days after the end of each calendar quarter.

#### 4.20.5 Outreach Reports

The Contractor shall provide an annual Outreach Report that describes the dental related outreach activities completed in the preceding year and results of those activities.

#### 4.20.6 Call Center Response Time Reports

The Contractor shall maintain records and report to the Department on Call Center Response times weekly for the first 3 months and monthly thereafter. The call center reports are identified in Section 4.3 of the RFP. Monthly reports will be due fifteen (15) calendar days after the end of the calendar month being reported.

#### 4.20.7 Meeting Reports

The Contractor shall submit the minutes of its Utilization Review Committee meetings, and Quality Assurance Committee meetings on a calendar quarter basis, due thirty (30) days after the end of each quarter. If no meetings occurred during the quarter, that fact shall be reported. Peer Review Committee shall be scheduled twice a year and held more frequently if additional case reviews are necessary. The Contractor shall submit the minutes of its Peer Review Committee meetings to the Department within (30) days after the meetings occur.

#### 4.20.8 Satisfaction Surveys

The Contractor shall conduct, at a minimum, a semi-annual Member Satisfaction Survey and a semi-annual Provider Satisfaction Survey. The survey questions and methodology shall be approved by the Department prior to conducting the survey. The Contractor shall submit a report identifying key findings to the Department annually.

#### 4.20.9 Public Filings

The Contractor shall promptly furnish the Department with copies of all public filings, including correspondence, documents and all attachments on any matter arising out of this RFP.

#### 4.20.10 Comprehensive Network Analysis Report

The Contractor shall provide a Comprehensive Network Analysis Report, monthly and annually, as described in Section 4.8.4 that provides a detailed analysis of provider recruitment activities and that tracks provider network changes, and when possible, captures reasons for provider disenrollment.

#### 4.20.11 Grievance and Appeals Reports

The Contractor shall provide grievance and appeal logs and summary reports as described in Sections 4.8.14 and 4.9 of this RFP.

4.20.12 Semi-Annual and Annual Report

The Contractor shall provide and develop in conjunction with the Department a semi annual and an annual report that provide a report card summary for all of the following activities: Claims Activity, Service authorization Activity, Network Recruitment, Member Outreach, Call Center, Grievances and Appeals, Member Utilization, and Quality Improvement. The Offeror shall submit sample “annual report card” reports with their RFP Proposal. The Department shall approve the final reporting format. The Contractor must modify the final report to the agreed upon specifications at no cost to the Department.

4.20.13 Dental Utilization Tracking System

The Contractor shall develop and maintain a tracking system with the capability to identify and report the member’s current dental utilization status, pending preventive services, and preventive treatment due dates, referrals for corrective treatment, whether corrective treatment was provided, and dates of service for corrective treatment for each member.

4.20.14 Projected Participation and Utilization Goals Report

Using the Department’s base-line benchmarks as described in this RFP, the Offeror shall include with its proposal projections for the next four years for provider participation and increased pediatric (all children under age 21) utilization.

	<b>SFY 2009</b>	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Year 4</b>
<b>Provider Participation</b>	1387 number				
<b>Pediatric Utilization Ages 3-20yrs</b>	48.52%				

In addition the Offeror shall report in detail the implementation strategy it will utilize to achieve the projected provider participation and pediatric utilization goals. The Offeror’s proposed strategy shall sufficiently describe the basis for the Offeror’s administrative services organization (ASO) per member per month (PMPM) cost proposal. The Contractor shall update the projections on an annual basis.

4.20.15 Other Reporting Requirements

The Contractor shall also provide such additional monthly and ad hoc reports in relation to the RFP (and resulting contract) requirements in a format as agreed upon by the Department and the Contractor. The Contractor shall assure compliance with future reporting requirements of federal initiatives such as H.R. 2; the Children’s Health Insurance Program Reauthorization Act of 2009, or CHIPRA and/or other federal/state health care reform activity as determined by the Department. The Department shall incur no expense in the generation of such reports. Additionally, the Contractor shall make revisions in the data elements or format of the reports required in this RFP and resulting contract upon request of the Department and without additional charge to the Department. The Department shall provide written notice of such requested revisions of format changes in a notice of required report revisions. The Contractor will respond to all routine inquires/requests from the Department within two business days either acknowledging receipt of the Department’s request or providing a date that the Contractor will respond. Contractor shall maintain a data gathering and storage system sufficient to meet the requirements of this RFP. The Department may impose liquidated damages or monetary sanctions under Attachment III of the RFP based upon Contractor's failure to timely submit Standard Reports in the required format and medium.

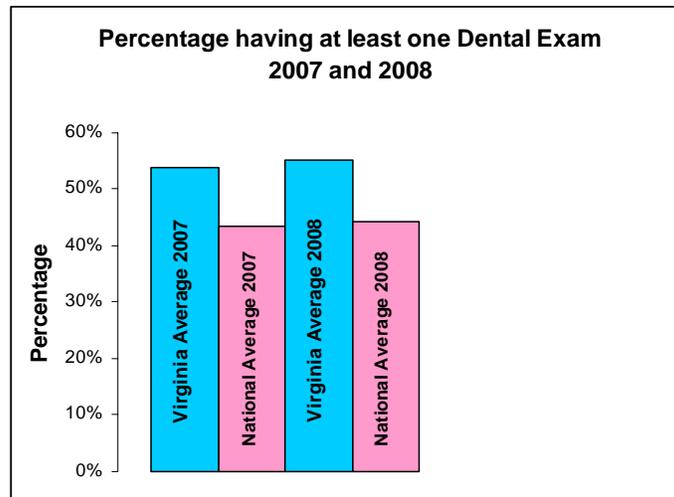
#### 4.20.16 Healthcare Effectiveness Data and Information (HEDIS) Annual Dental Visit Report

The Contractor shall submit an Annual Dental Visit Report to the Department using the criteria specified in the most current years HEDIS Technical Specifications per National Committee for Quality Assurance (NCQA). The current version of HEDIS (2010) measures the percentage of members 2-21 years of age who had at least one (1) dental visit during the measurement year. Data elements required in the report are outlined in Attachment XII. The Contractor shall submit this report to the Department annually. The contractor should be aware of any changes that NCQA makes to the HEDIS technical specifications for the relevant dental measure and change their methods accordingly. The Department anticipates that the Contractor shall meet and exceed the National Medicaid average annually.

Adhering to the HEDIS Technical Specification, the Offeror shall submit its plan explaining how it will continue to meet or exceed the National Medicaid average for percentage having at least one dental exam.

#### **Baseline Data**

During calendar years 2007 and 2008 the *Smiles For Children* used HEDIS Technical Specification to develop and Annual Dental Visit Report. During both calendar years, over 50% of the *Smile For Children* members had at least one dental visit. During both years *Smiles For Children* was well above the National Medicaid average and utilization was between the 75<sup>th</sup> and 90<sup>th</sup> percentile of the National data. (see chart)



\* **Data Sources and Limitations:** Virginia Medicaid and CHIP Average was provided by DMAS for calendar year 2007 and 2008 using HEDIS Technical Specifications. National Averages were collected from Quality Compass. While DMAS used HEDIS Technical Specifications to calculate the scores, final score is not audited by HEDIS. It is based on HEDIS calculation.

## **4.21 Virginia Bureau of Insurance Requirements**

The Contractor shall demonstrate evidence of its compliance with applicable Virginia Bureau of Insurance requirements. All financial reports filed with the Department by the Contractor shall demonstrate evidence of compliance with Virginia Bureau of Insurance financial requirements.

## **4.22 Fraud and Abuse**

### **4.22.1 Prevention/Detection of Provider Fraud and Abuse**

The Contractor shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected instances of fraud and abuse. Such policies and procedures must be in accordance with Federal regulations described in 42 CFR Parts 455 and 456, and as described in the Department's Dental Manual, Chapter VI. The Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential instances of fraud and abuse.

### **4.22.2 Fraud and Abuse Compliance Plan**

- a. The Contractor shall have a written Fraud and Abuse compliance plan. The Contractor's specific internal controls, policies and procedures shall be described in a comprehensive written plan and be maintained on file with the Contractor for review and approval by the Department and as an annual Contract submission. The Plan must define how the Contractor shall identify and report suspected fraud and abuse by members, by network providers, by subcontractors and by the Contractor. The Plan must be submitted annually and must discuss the monitoring tools and controls used to protect against theft, embezzlement, fraudulent marketing practices, or other types of fraud and program abuse. The Plan must additionally describe the type and frequency of training provided to prepare staff to detect fraud. All fraudulent activities or other program abuses shall be handled subject to the laws and regulations of the Commonwealth of Virginia and/or Federal law and regulation.

The Department shall provide notice of approval, denial, or modification to the Contractor within thirty (30) calendar days of annual submission. The Contractor shall make any requested updates or modifications available for review after modifications are completed as requested by the Department within thirty (30) calendar days of a request. At a minimum the written plan shall:

- i. Ensure that all officers, directors, managers and employees know and understand the provisions of the Contractor's fraud and abuse compliance plan;
- ii. Contain procedures designed to prevent and detect potential or suspected abuse and fraud in the administration and delivery of services under this contract;
- iii. Include a description of the specific controls in place for prevention and detection of potential or suspected abuse and fraud, such as:
  - a. Claims edits;
  - b. Post-payment and prepayment review of claims;
  - c. Provider profiling and credentialing;

- d. Service authorization;
  - e. Utilization management;
  - f. Relevant subcontractor and provider agreement provisions;
  - g. Written provider and member material regarding fraud and abuse referrals.
- iv. Contain provisions for the confidential reporting by members, network providers and subcontractors of plan violations to the designated person as described in item b. below;
  - v. Contain provisions for the investigation and follow-up of any compliance plan reports;
  - vi. Ensure that the identities of individuals reporting violations of the plan are protected;
  - vii. Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations;
    - viii. Require any confirmed or suspected provider or member fraud and abuse under state or federal law to be reported to the Department;
    - ix. Ensure that no individual who reports plan violations or suspected fraud and abuse is subjected to retaliation.
- b. The Contractor shall designate an officer or director in its organization who has responsibility and authority for carrying out the provisions of the fraud and abuse compliance plan.
  - c. The Contractor shall report incidents of potential or actual fraud and abuse to the Department within two (2) business days of initiation of any investigative action by the Contractor or within two (2) business days of Contractor notification that another entity is conducting such an investigation of the Contractor, its network providers, or its members. All reports shall be sent to the Department in writing and shall include a detailed account of the incident, including names, dates, places, and suspected fraudulent activities. In addition, the Contractor shall provide a comprehensive annual report to the Department of all incidents of potential or actual fraudulent activity and results.
  - d. The Contractor shall cooperate with all fraud and abuse investigation efforts by the Department and other State and Federal entities.
  - e. All cases where fraud is suspected or detected shall be referred to the Department for referral to Medicaid Fraud Control Unit (MFCU) prior to the initiation of any actions or recoupment efforts. The Contractor shall provide support to the MFCU on matters relating to specific cases involving detected or suspected fraud.
  - f. The Contractor shall notify the Department for approval of provider recoupment amounts exceeding \$2,000. For recoupment amounts under \$2,000 the Contractor will notify the Department if a problem is identified with the recoupment.

#### **4.23 Readiness for Implementation**

No later than April 1, 2011 the Contractor shall demonstrate, to the Department's satisfaction, that Contractor is fully capable of performing all duties under this Contract, including demonstration of the following:

- Contractor's provider network is adequate in all regions of the Commonwealth to assure that there will be minimal disruptions in service to members and that the Contractor has instructed members and participating dental providers in the basic operation of the Dental Program;
- Contractor has thoroughly trained its staff on the specifics of Dental Program policies, and that Contractor's staff has sufficient medical and dental knowledge to make determinations of dental services needs;
- Contractor has trained its staff to handle telephone requests from members, dentists and participating dental providers, and has provided to the Department copies of training materials and described the methods used for training and outreach;
- Contractor has the ability to accept, process service authorization and accept, process and pay dental claims from participating dental providers for the provision of covered and dental services;
- Contractor's MIS has successfully completed the requirements listed in Section 4 including that the Contractor has the ability to transmit utilization data to the Department that are accurate and timely and consistent with HIPAA standards;
- Contractor has demonstrated the ability to submit and accept to the Department's satisfaction all required documentation with respect to payments from the Department to the Contractor as described in Section 6; and
- Contractor's QI, member services, and other pertinent components are in place in accordance with requirements described in this RFP;
- Contractor shall test all interfaces with the Department prior to implementation;
- Contractor has submitted an Operational Readiness Plan demonstrating compliance with the terms of the RFP.

The Contractor's inability to demonstrate, to the Department's satisfaction and as provided in this Section, that Contractor is fully capable of performing all duties under this contract no later than April 1, 2011 shall be grounds for the immediate termination of the Contract by the Department pursuant to the Department Special Terms and Conditions, 10.7 Cancellation of Contract rights.

#### **4.24 Implementation**

Administration of the Dental Program by Contractor shall begin on July 1, 2011 ("Implementation"). Payment to Contractor as provided in Section 6 (Payments to the Contractor) of this Contract shall begin upon implementation. Contractor shall not be compensated for any expenses incurred prior to the implementation date.

The Commonwealth may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the services and the Offeror shall furnish to the Commonwealth all such information and data for this purpose as may be requested. The Commonwealth reserves the right to inspect Offeror's physical facilities, including any located outside of Richmond, prior to award to satisfy questions regarding the Offeror's capabilities. The Commonwealth further reserves the right to reject any proposal if the evidence submitted by, or investigations of, such Offeror fails to satisfy the Commonwealth that such Offeror is properly qualified to carry out the obligations of the contract and to provide the services contemplated therein.

#### **4.25 Internet Site**

The Contractor agrees to host and maintain an Internet site that is owned by DMAS on the Contractor's server. The Contractor, at a minimum will meet VITA standards, which may be found on the VITA website at <http://www.vita.virginia.gov> . The web site will contain information devoted to members and providers. At a minimum, the site shall contain the following.

- i. a link to the Contractor's current provider directory, with provider contact information, and with the capability to locate providers by geographic locations, type of practice, and panel restrictions (i.e., accepting or not accepting new patients)
- ii. an outline of coverage
- iii. other information about the plan
- iv. Contractor contact names, telephone numbers, and addresses for individuals to contact with respect to services covered in this RFP
- v. how to obtain program information in non-English languages
- vi. information regarding how to submit grievances and or appeals to the Contractor
- vii. information to assist providers with billing and or prior authorization issues, access to the provider manual, frequently asked questions, etc.

The contractor shall maintain the capability to provide totals of daily, weekly, and monthly numbers of site visits and page views for the month, with information detailing the most viewed page(s).

#### **4.26 Dental Services Consultation and Support**

The Contractor shall consult the Department regarding changes and trends in the dental industry having the potential to impact the Virginia Medicaid program. The Contractor shall support the Department in responses to stakeholders. The Contractor may also include in this section ideas for innovative improvements to the Medicaid program.

The Contractor shall:

- a. Provide quarterly updates on national, federal and state policy changes and provide recommendations to the Department regarding these changes;
- b. Keep the Department abreast of industry and other similar state Medicaid program trends and changes and provide recommendations to the Department regarding these changes;
- c. Identify new applications in the dental industry;
- d. Make recommendations to the Department as appropriate on cost savings and quality improvement initiatives and assist with the development of such initiatives;
- e. Be responsive to the Department when it receives requests from the General Assembly and other stakeholders on dental-related issues;

- f. Be responsive to the Department during its development and revisions to Medicaid Memos, Manuals, and other official agency documents, as may be applicable;
- g. Support the Department with other dental-related inquiries as requested;
- h. Inform the Department on a quarterly basis, or sooner, if there is a significant benefit to the program, about Federal or State policy or legislative changes, actual or proposed, and new cost savings initiatives or industry trends that could potentially impact the *Smiles For Children* program; and
- i. Submit a quarterly report that identifies additional dental service costs savings initiatives for the Department to consider. The report shall provide a summary of each initiative proposed, current and projected utilization data to support proposed savings, and pros and cons of each proposed initiative (e.g. policy, administrative barriers). The report shall contain a brief timeline for implementation.
- j. Acknowledge all routine requests for assistance from the Department within two business days and each acknowledgement must include a planned resolution date. Urgent or emergent issues/requests from the Department will stipulate a specific response due date;
- k. Provide a point of contact when Virginia staff are out of the office or are not available.
- l. Assure that monthly quarterly semi annual and annual reports are submitted timely and contain accurate information which reflects the current reporting period. Submissions should include an overall analysis of trends and changes in the data.

## **5. DMAS RESPONSIBILITIES**

DMAS will oversee the dental program, including overall program management, determination of policy and monitoring of service. DMAS will work in partnership with the Contractor and dental providers to develop a quality program. Following are the primary responsibilities of DMAS:

- a) Policy interpretation – DMAS will make the final decision regarding all policy issues;
- b) On-going project oversight and management (to include announced and unannounced site visits to the Contractor) to ensure regulatory compliance. If any aspect of the contractor’s operation is conducted outside of the Commonwealth of Virginia, the contractor will pay for air travel and lodging (to include meals) for two DMAS staff to conduct site visits annually;
- c) Provide Contractor with all up to date member eligibility information;
- d) Field observations of operations and the call center;
- e) Monitor staffing levels; outreach to members, provider network adequacy, pediatric dental utilization and other monitoring;
- f) Review and approve any Contractor written policies, subcontracts and or procedural communications to members, providers and others prior to release; and
- g) Attend/observe QI/QA peer review activities;
- h) Media contact-DMAS is the key representative of the dental program with regard to the media. All questions or other contact from the media must be referred directly to the designated DMAS representative.

## **6. PAYMENTS TO THE CONTRACTOR**

Payment processes described in this Section shall be tested as part of the readiness for implementation review described in Section 4.23. Any changes required to the Contractor’s processes as identified through readiness review activities shall be made by the Contractor prior to implementation. Costs associated with these changes shall be borne by the Contractor.

## 6.1 Annual Review of Controls

The Contractor shall provide to the Department and the State Treasurer a statement from its external auditor that a review of the Company's internal accounting controls reveals no condition believed to be a material weakness in the proper administration of the Department's Dental Program in accordance with sound business principles. The written statement shall be provided annually each June 15 for the preceding calendar year.

## 6.2 Payment Methodology

### 6.2.1 Administrative Services Organization (ASO) Payments

The Contractor shall be compensated for ASO responsibilities based on a fixed fee per member per month (PMPM) as determined by the RFP negotiations and subsequent contract award. Each monthly payment to the Contractor shall be equal to the number of members certified by the Department multiplied by the administrative fee for the appropriate member-funding category. Member funding categories shall include Medicaid Children under age 21, Medicaid Expansion (member aid category 94), FAMIS members, and Medicaid adults age 21 and over. Eligible Medicaid Children, Medicaid Expansion, and FAMIS children categories make up the pediatric PMPM rate category and shall be reimbursed at the pediatric dental PMPM rate of reimbursement. However, for Federal funding, reporting, and tracking purposes the payments must be reported separately, as shown in the table below.

The Contractor's payment shall be based on enrollment reported by the Department to the Contractor in the 834 enrollment report effective the first day of each month of the contract period. Monthly compensation will not be adjusted upward or downward during the month based on fluctuating eligibility. The Department shall arrange for payment each month at an agreed upon time by the State Treasurer's office for administrative payments as described herein.

SFY	Medicaid/Medicaid Expansion/FAMIS Children	Medicaid Adults
July 1, 2008 – June 30, 2009	496,386	243,650
July 1, 2009 – June 30, 2010	555,562	258,479

\*PMPM: Per Member Per Month

### 6.2.2 Detailed Claim Processing and Reconciliation Reports

The Contractor shall pay claims only for persons determined to be eligible by the Department. The Contractor shall provide to the Department a weekly electronic Detailed Claim Processing Report. This report must provide detailed data on all claims processed, including any voids or adjustments. As part of the RFP response, the Offeror must provide sample detailed claim-processing reports currently being utilized and the specific data elements captured. The Department must approve the final Detailed Claim Processing Report format. The Contractor must modify the final report to the agreed upon specifications at no cost to the Department.

The final report shall be sorted by member funding category (Medicaid, Medicaid Expansion, or FAMIS), and sorted by age category (Under 21, 21 and Over). The report will reflect a subtotal of claims processed by age category for each program category. (In the event the Governor and the General Assembly approve dental coverage for pregnant women, the report must also separately identify

the claims for the pregnant women over age 21 member funding category.) The report must also reflect a grand total paid for all member categories. The grand total must reconcile to the amount of reimbursement requested by the Contractor. The report must reflect claim data by individual. Individuals must be identified by name, Medicaid/FAMIS Plus or FAMIS ID number, and aid category. All payment related reports shall be submitted using the appropriate Data Certification form as shown in Attachments IV and V in accordance with requirements listed in Section 4.18.4.

The Contractor shall reconcile the net totals on the Detailed Claim Processing Report to the check register and EFT register monthly. A full bank reconciliation report shall be provided to the Department monthly by the 20<sup>th</sup> of the next month, including monthly bank statements and a list of outstanding checks. A cumulative account of funds is required and the account balance must be carried month to month in the ledger to identify check dates and the length of time checks have been outstanding. Any interest accrued in the SFC bank account should be returned to the Department through an established process approved by the Department.

### 6.2.3 Pass-Through Payment to the Contractor for Claims Paid on Behalf of the Department

The Contractor shall provide to the Department a weekly request for reimbursement with the Detailed Claim Processing Report (where the total monies requested matches the total claim monies paid) in the agreed upon format, by member funding category by 5:00PM EST on Wednesday prior to the Friday evening VAMMIS payment processing cycle. The Contractor shall ensure that its requests for reimbursement from the Department are made timely, such that claims are paid in accordance with prompt-pay requirements, as described in Section 4.13.3 of this RFP. The Contractor shall be reimbursed by the VAMMIS either by check or electronic funds transfer(s), as agreed to by the Contractor. For submissions received prior to the Friday VAMMIS payment processing cycle, reimbursement by check would reflect the date of the Friday occurring one week after the Friday VAMMIS payment processing cycle. Reimbursement by electronic funds transfer payment would reflect the date of the Monday occurring one week after the Friday VAMMIS payment processing cycle. For reconciliation purposes, the Contractor's payment to the provider should be dated/handled such that the funding by the Department, the Contractor's dental encounter data, remittance advice records and checks issued would consistently represent payments processed during the same week and month.

Pass-through payment funds shall be maintained in a separate account, referred to herein as the *Virginia* SFC claim payment account, from the Contractor's ASO payment funds. The Contractor shall list the Department on the bank signature card. Funds in the *Smiles For Children* claims payment account can only be used for paying claims under this Contract pursuant to Section 4.13, and cannot be pledged by Contractor or used to secure a loan, guaranty, debt or other obligation of the Contractor. The Department shall not be liable for over-draft charges or any other banking related charges assessed on the *Virginia* SFC claim payment account. Contractor shall be responsible for submitting claims information to the Department within the time frame necessary to meet its obligations to pay provider claims within the prompt-pay claims processing requirements described in Section 4.13.3. Additionally, any monetary charges for claims not paid by the Contractor within prompt-pay claims processing requirements, as described in Section 4.13.3 of this RFP, shall be borne by and the sole obligation of the Contractor and at no expense to the Department.

#### 6.2.3a. Pass through Payment to the Contractor for Interpreter Services paid on behalf of the Department to the Contractor

Upon receipt of appropriate documentation from dental providers, the Contractor agrees to reimburse dental providers who have paid for interpreter services necessary for treatment of *Smiles For Children*

members. As required by the Department, dental providers must submit an invoice to the Contractor from the interpreter service vendor that includes the following information:

#### Dental Provider Invoice

- Dental provider information and treatment rendered, amount paid to vendor, *Smiles For Children* member name, ID number and date of service.
- Interpreter Service Vendor's name, address and telephone number.

Should the Department deem necessary, documentation requested from dental providers for interpreter reimbursement may change. The Contractor will inform dental providers 30 days in advance of any change in the reimbursement process.

Within 30 days of the receipt of invoice, the Contractor will reimburse the dental provider. The Contractor will invoice the Department weekly and will be reimbursed by the Department through the add/pay process currently in place for reimbursement of claims. The Department has designated a separate transaction code to be used to reimburse the Contractor for interpreter services.

#### 6.2.4 Encounter Claims Submission and Reconciliation

The Contractor's encounter data shall be in the X12-410A format for dental services (reference Section 4.18). Encounters received shall reflect all adjudicated claims (i.e., claims paid, denied, voids, adjustments, etc.). Encounters must be submitted to the fiscal agent within ninety (90) days of claims processing. All fatal errors must be corrected within thirty (30) days of receipt of the error report and the Contractor must notify the Department of the resubmissions. The Contractor shall submit the Data Certification form shown in Attachment IV within one month of the date of the encounter submission.

The encounter data shall reconcile to the Detailed Claim Processing Report within six (6) months of receipt of the Detailed Claim Processing Report. Any claim reflected on the Detailed Claim Processing Report but is not validated by an encounter submission must be refunded to the Department. The Department will advise the Contractor of any discrepancies. The Contractor shall have thirty (30) days to justify and correct the discrepancy or reimburse the Department of any overpayments, if any.

#### 6.2.5 Interest Monies

Interest monies generated from the deposit of funds into the *SFC* claim payment account shall be the property of the Department. The Contractor shall report on a monthly basis any interest earned on provider payment funds to the Department. The Contractor shall refund interest payments to the Department quarterly, through a repayment method to be agreed upon prior to implementation.

#### 6.2.6 Stale Dated Checks

If a check written from the SFC bank account has not been cashed after 180 days, the funds shall be returned to the Department. All claims associated with stale dated checks are to be voided in the claims system. The Contractor shall return funds to the Department through a repayment method to be agreed upon prior to implementation.

#### 6.2.7 Deductions

The Department reserves the right to deduct from amounts which are or shall become due and payable to the Contractor under this or any contract between the Contractor and the Commonwealth of Virginia,

including but not limited to interest earned on provider payments, claims not validated in encounter submissions (as described in Section 6.2.4) and liquidated damages assessed as described in Attachment III to this RFP.

### **6.3 Travel Compensation**

The Contractor shall not be compensated or reimbursed for travel, meals, or lodging.

### **6.4 Payment of Invoice**

The payment of the invoice by the Department shall not prejudice the Department's right to object to or question any invoice or matter in relation thereto. Such payment by the Department shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any of the amounts invoiced therein.

### **6.5 Invoice Reductions**

The Contractor's invoice shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the Department, on the basis of audits conducted in accordance with the terms of this contract, not to constitute proper remuneration for compensable services.

## **7. PROPOSAL PREPARATION AND SUBMISSION REQUIREMENTS**

Each Offeror shall submit a separate Technical Proposal and a Cost Proposal in relation to the requirements described in this RFP. The following describes the general requirements for each proposal and the specific requirements for the Technical Proposal and the Cost Proposal.

### **General Requirements for Technical Proposals and Cost Proposals**

#### **7.1. Overview**

Both the Technical Proposal and the Cost Proposal shall be developed and submitted in accordance with the instructions outlined in this section. The Offeror's proposals shall be prepared simply and economically, and they shall include a straightforward, concise description of the Offeror's capabilities that satisfy the requirements of the RFP. Although concise, the proposals should be thorough and detailed so that DMAS may properly evaluate the Offeror's capacity to provide the required services. All descriptions of services should include an explanation of proposed methodology, where applicable. The proposals may include additional information that the Contractor considers relevant to this RFP.

The proposals shall be organized in the order specified in this RFP. A proposal that is not organized in this manner risks elimination from consideration if the evaluators, at their sole discretion, are unable to find where the RFP requirements are specifically addressed. Failure to provide information required by this RFP may result in rejection of the proposal.

#### **7.1.1 Critical Elements of the Technical Proposal**

**The Offeror must cross reference its Technical proposal with each requirement listed in Section 4 of this RFP. In addition, the Offeror must assure that the following documentation is included in the proposal:**

**Implementation Plan:** Submit a detailed implementation plan demonstrating the Offeror's proposed schedule to implement the dental program no later than July 1, 2011.

**Implementation Schedule:** The Contractor shall implement the dental program described in this RFP no later than July 1, 2011. The Contractor shall provide a detailed implementation work plan, including deliverables and timelines, as part of the proposal. A comprehensive report on the status of each subtask, tasks, and deliverables in the work plan will be provided to the Department by the Contractor every week during implementation. The Contractor shall submit, no later than 30 days after the award of the contract, a detailed implementation plan demonstrating the Contractor's proposed schedule to implement the dental benefits program no later than July 1, 2011. The plan must include a pre-testing of all programs. A comprehensive report on the status of each subtask, tasks, and deliverables, in the work plan will be provided to the Department every week during the implementation. The implementation shall be prepared in Microsoft MS Project and shall delineate each task, with milestones, and dates through the end of the first contract year. The Contractor and the State will work together during the initial contract start-up to establish a schedule for key activities and define expectations for the content and format of Contract Deliverable for at least the first fiscal year. The Department may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the services and the Offeror shall furnish to the Department all such information and data for this purpose as may be requested. The Department reserves the right to inspect Offeror's physical facilities, including any located outside of Richmond, prior to award to satisfy questions regarding the Offeror's capabilities. The Department further reserves the right to reject any proposal if the evidence submitted by, or investigations of, such Offeror fails to satisfy the Department that such Offeror is properly qualified to carry out the obligations of the contract and to provide the services contemplated therein.

**Plan for Outreach and Increased Pediatric Dental Utilization:** Submit a detailed description of the manner in which Offeror proposes to perform the responsibilities detailed in Section 4.7. The plan must include a step-by-step description of the procedures by which each requirement will be met.

**Network Development and Maintenance:** Submit a detailed description with complete information on the Contractor's dental access capacity (number and types of providers in each city or county) as of the date of submission of this RFP, and the planned capacity as of the anticipated start date of the contract with DMAS. The Offeror may submit Letters of Intent (LOIs) and contracts from dental providers with whom the Contractor intends to negotiate a contract for dental services prior to implementation of this RFP. In lieu of LOIs the Offeror can provide a detailed strategy describing its provider recruitment and development activities. The Contractor's strategy should include a quantitative analysis of the planned activities and expected results based upon the Offeror's prior experience or related research analysis. Thirty days prior to the program implementation date, Contractor shall supply the Department with a final provider network for evaluation and analysis and must include requirements for transition of the current network while maintaining high provider satisfaction ratings. The Contractor shall assure that its submitted network includes providers currently credentialed in the SFC program.

**Education:** Submit a detailed description of the Offeror's plan to educate Virginia Medicaid/FAMIS Plus/FAMIS members, providers, and others with an interest in the dental program. The Offeror should recommend education and notification processes and methods to the Department to increase compliance rates and minimize transition disruptions. The plan must include education activities prior to and after implementation.

**Service Authorization Process:** Submit a detailed description of any proposed service authorization approval and appeals process for dental services authorizations. The Offeror must address how it will use automation, and what specific steps will be taken to make the service authorization process consumer/provider friendly.

**Claims Processing:** Submit a detailed description of the Offeror's claim processing policies, procedures, and systems. Contractors must include documentation describing their performance track record in relation to claim processing time frames.

**Call Center:** Submit a detailed description of how the Offeror will staff and operate a toll-free Call Center. The plan must describe the information and assistance that will be provided by Call Center Representatives.

**Utilization Review Process:** Submit a detailed description of any proposed utilization review process. The Offeror must address how it will use automation, and what specific steps will be taken to make the utilization review process consumer/provider friendly.

**Staffing:** The Offeror must submit a detailed description of the staffing plan, which describes the types of personnel who shall be hired, how staff shall be compensated (hourly, wage, temporary), and how the staff shall be supervised. This section shall also include a description of the Offeror's plan for staff training, including components and length of training curriculum, a plan for on-going training, and a proposal of a Training Guide or Procedures Manual.

**Auditing:** Submit a description of how all activities will be audited and how processing center responses will be monitored to ensure accuracy of information provided to callers. This section must also describe a plan to ensure confidentiality of records.

**Transition of Care:** Submit a detailed description of how the Offeror will minimize disruption to members and providers particularly in relation to start-up transition of care issues as described in Section 4. The transition plan shall include at a minimum the following: Within ten (10) days from the award of contract, the Contractor shall schedule and attend a meeting (entrance conference) at DMAS to discuss all pertinent items relative to the contract. The Contractor will work closely with DMAS to define project management, status reporting standards, and communication protocols. DMAS shall:

- Coordinate communications and act as a liaison between the new Contractor and the incumbent Contractor;
- Coordinate the transfer of files and applications from the incumbent Contractor to the new Contractor on a schedule outlined in the approved work plan;
- Provide all available relevant documentation on operations currently performed by the incumbent Contractor and DMAS;
- Establish protocols for problem reporting and controls for the transfer of data or information from the incumbent Contractor to the new Contractor;
- Work with the Contractor to review and finalize the project work plan for the Transition Phase;
- Assign a DMAS' liaison to participate in Contractor work groups;
- Review and approve procedure and protocols defined by the work groups; and
- Monitor progress through periodic status reports, weekly meetings, and work plan updates.

The new Contractor shall:

- Finalize the implementation plan, including the Transition Phase activities and submit it to DMAS for approval;
  
- Work with DMAS to establish communication protocols between the new Contractor and DMAS;

- Weekly meetings will be held throughout the Transition Phase to discuss and resolve transition issues, establish procedures and protocols to support operations, and promote communications among all parties;
- Work with DMAS to establish project management and reporting standards;
- Submit periodic written status reports on the progress of tasks against the approved work plan; and
- Conduct periodic status meetings with DMAS. The new Contractor is responsible for preparing the agenda for the meetings and preparing and distributing minutes, to include action items, from each meeting

**Quality Management:** The Contractor must submit a detailed description of the process and program, including submission of standard and proposed reporting packages.

## **7.2 Binding of Proposal**

The Technical Proposal shall be clearly labeled “RFP 2011-03 Technical Proposal” on the front cover. The Cost Proposal shall be clearly labeled “RFP 2011-03 Cost Proposal” on the front cover. The legal name of the organization submitting the proposal shall also appear on the covers of both the Technical Proposal and the Cost Proposal.

The proposals shall be typed, bound, page-numbered, single-spaced with a 12-point font on 8 1/2” x 11” paper with 1” margins and printed on one side only. Each copy of the Technical Proposal and each copy of the Cost Proposal and all documentation submitted shall be contained in single three-ring binder volumes where practical. A tab sheet keyed to the Table of Contents shall separate each major section. The title of each major section shall appear on the tab sheet.

The Offeror shall submit an original and five (5) copies of the Technical Proposal and one original of the Cost Proposal by the response date and time specified in this RFP. Each copy of the proposal shall be bound separately. This submission shall be in a sealed envelope or sealed box clearly marked “RFP 2011-03 Technical Proposal”. In addition, the original of the Cost Proposal shall be sealed separately and clearly marked “RFP 2011-03 Cost Proposal” and submitted by the response date and time specified in this RFP. The Cost Proposal forms in Attachment X shall be used. The Offeror shall also submit one electronic copy (compact disc preferred) of their Technical Proposal in MS Word format (Microsoft Word 2003 or compatible format) and of their Cost Proposal in MS Excel format (Microsoft Word 2003 or compatible format). In addition, the Offeror shall submit a redacted (proprietary and confidential information removed) electronic copy in PDF format of their Technical Proposal and their Cost Proposal.

## **7.3 Table of Contents**

The proposals shall contain a Table of Contents that cross-references the RFP submittal requirements in Section 4: “Technical Proposal Requirements.” Each section of the Technical Proposal shall be cross-referenced to the appropriate section of the RFP that is being addressed. This will assist DMAS in determining uniform compliance with specific RFP requirements.

## **7.4 Submission Requirements**

All information requested in this RFP shall be submitted in the Offeror's proposals. A Technical Proposal shall be submitted and a Cost Proposal shall be submitted in the Offeror's collective response. The proposals will be evaluated separately. By submitting a proposal in response to this RFP, the Offeror certifies that all of the information provided is true and accurate.

All data, materials and documentation originated and prepared for the Commonwealth pursuant to this RFP belong exclusively to the Commonwealth and shall be subject to public inspection in accordance with the Virginia Freedom of Information Act. Confidential information shall be clearly marked in the proposal and reasons the information should be confidential shall be clearly stated.

Trade secrets or proprietary information submitted by an Offeror are not subject to public disclosure under the Virginia Freedom of Information Act; however, the Offeror shall invoke the protections of §2.2-4342(F) of the Code of Virginia, in writing, either before or at the time the data is submitted. The written notice shall specifically identify the data or materials to be protected and state the reasons why protection is necessary.

The proprietary or trade secret materials submitted shall be identified by some distinct method such as highlighting or underlining and shall indicate only the specific words, figures, or paragraphs that constitute trade secret or proprietary information. The classification of an entire proposal document, line item prices and/or total proposal prices as proprietary or trade secrets is not acceptable and, in the sole discretion of DMAS, may result in rejection and return of the proposal.

All information requested by this RFP on ownership, utilization and planned involvement of small businesses, women-owned businesses and minority-owned business (Attachment XI) shall be submitted with the Offeror's Cost Proposal.

## **7.5 Transmittal Letter**

The transmittal letter shall be on official organization letterhead and signed by the individual authorized to legally bind the Offeror to contract agreements and the terms and conditions contained in this RFP. The organization official who signs the proposal transmittal letter shall be the same person who signs the cover page of the RFP and Addenda (if issued).

At a minimum, the transmittal letter shall contain the following:

1. A statement that the Offeror meets the required conditions to be an eligible candidate for the contract award including:
  - a) The Offeror must identify any contracts or agreements they have with any state or local government entity that is a Medicaid and/or Title XXI State Child Health Insurance Program provider or Contractor and the general circumstances of the contract or agreement. This information will be reviewed by DMAS to ensure there are no potential conflicts of interest;
  - b) Offeror must be able to present sufficient assurances to the state that the award of the contract to the Contractor will not create a conflict of interest between the Contractor, the Department, and its subcontractors; and
  - c) The Offeror must be licensed to conduct business in the state of Virginia.
2. A statement that the Offeror has read, understands and agrees to perform all of the Contractor responsibilities and comply with all of the requirements and terms set forth in this RFP, any modifications of this RFP, the Contract and Addenda;
3. The Offeror's general information, including the address, telephone number, and facsimile

transmission number;

4. Designation of an individual, to include their e-mail and telephone number, as the authorized representative of the organization who will interact with DMAS on any matters pertaining to this RFP and the resultant Contract; and
5. A statement agreeing that the Offeror's proposal shall be valid for a minimum of 180 days from its submission to DMAS.

#### **7.6 Signed Cover Page of the RFP and Addenda**

To attest to all RFP terms and conditions, the authorized representative of the Offeror shall sign the cover page of this RFP, as well as the cover page of the Addenda, if issued, to the RFP, and submit them along with its technical proposal.

#### **7.7 Procurement Contact**

The principal point of contact for this procurement in DMAS shall be:

Daniel Plain  
Health Care Services Division  
Department of Medical Assistance Services  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219  
Email: [RFP2011-03@dmas.virginia.gov](mailto:RFP2011-03@dmas.virginia.gov)

All communications with DMAS regarding this RFP should be directed to the principal point of contact. All RFP content-related questions shall be in writing to the principal point of contact or the DMAS Contract Management Officer. An Offeror who communicates with any other employees or Contractors of DMAS concerning this RFP after issuance of the RFP may be disqualified from this procurement.

#### **7.8 Submission and Acceptance of Proposals**

The proposals, whether mailed or hand delivered, shall arrive at DMAS no later than January 14, 2011. DMAS shall be the sole determining party in establishing the time of arrival of proposals. Late proposals shall not be accepted and shall be automatically rejected from further consideration. The address for delivery is:

**Proposals may be sent by US mail, Federal Express, UPS, etc. to:**  
Attention: William D. Sydnor  
Department of Medical Assistance Services  
600 East Broad Street, Suite 1300  
Richmond, VA 23219

**Hand Delivery or Courier to:**

Attention: William D. Sydnor  
Department of Medical Assistance Services  
7th Floor DMAS Receptionist  
600 East Broad Street  
Richmond, VA 23219

If DMAS does not receive at least one responsive proposal as a result of this RFP, DMAS reserves the right to select a Contractor that best meets its needs. DMAS management shall select this Contractor. DMAS also reserves the right to reject all proposals. DMAS reserves the right to delay implementation of the RFP if a satisfactory Contractor is not identified or if DMAS determines a delay is necessary to ensure implementation goes smoothly without service interruption. Information will be posted on the DMAS web site, [http://dmasva.dmas.virginia.gov/Content\\_pgs/rfp-home.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/rfp-home.aspx) and the eVA Web-site at <http://www.eVA.virginia.gov>

### **7.9 Oral Presentation and Site Visit**

At any point in the evaluation process, DMAS may employ any or all of the following means of evaluation:

- Reviewing Industry Research
- Offeror Presentations
- Site Visits
- Contacting Offerors References
- Product Demonstrations/Pilot Tests
- Requesting Offeror to elaborate on or clarify specific portions of their proposals.

No Offeror is guaranteed an opportunity to explain, supplement or amend its initial proposal. Offeror must not submit a proposal assuming that there will be an opportunity to negotiate, amend or clarify any aspect of their submitted proposals. Therefore, each Offeror is encouraged to ensure that its initial proposal contains and represents its best offering.

Offerors should be prepared to conduct product demonstrations, pilot tests, presentations or site visits at the time, date and location of DMAS' choice, should DMAS so request.

DMAS may make one or more on-site visits to see the Offeror's operation of another contract. DMAS shall be solely responsible for its own expenses for travel, food and lodging.

### **7.10 Technical Proposal**

The following describes the required format, content and sequence of presentations for the Technical Proposal:

#### **7.10.1 Chapter One: Executive Summary**

The Executive Summary Chapter shall highlight the Offeror's:

1. Understanding of the project requirements.
2. Qualifications to serve as the DMAS Contractor for the project.
3. Overall Approach to the project and a summary of the contents of the proposal.

#### **7.10.2 Chapter Two: Corporate Qualifications and Experience**

Chapter Two shall present the Offeror's qualifications and experience to serve as the Contractor. Specifically, the Offeror shall describe its:

1. Organization Status:

- a) Name of Project Director for this Contract;
- b) Name, address, telephone number, fax number, and e-mail address of the legal entity with whom the contract is to be written;
- c) Federal employer ID number;
- d) Name, address, telephone numbers of principal officers (president, vice-president, treasurer, chair of the board of directors, and other executive officers);
- e) Name of the parent organization and major subsidiaries;
- f) Major business services;
- g) Legal status and whether it is a for-profit or a not-for-profit company;
- h) A list of board members and their organizational affiliations;
- i) Current organization chart; and
- j) Any specific licenses and accreditation held by the Offeror.

2. Corporate Experience:

- a) Offeror's overall qualifications to carry out a project of this nature and scope.
- b) The Offeror shall describe the background and success of the Offeror's organization and experience in performing service authorization services and utilization review, specifically implementing state, local or regional programs.
- c) The Offeror's knowledge of the Medicaid/FAMIS Plus and/or FAMIS member populations and the communities.
- d) For each experience with operating, managing, or contracting for the provision of service authorization services or other human services, the Offeror shall indicate the contract or project title, dates of performance, scope and complexity of contract, and customer references (see below).
- e) Any other related experience the Offeror feels is relevant shall be included.
- f) The Offeror shall indicate whether the Offeror has had a contract terminated for any reason within the last five years.
- g) The Offeror also shall indicate if a claim was made on a payment or performance bond. If so, the Offeror shall submit full details of the termination and the bonds including the other party's name, address, and telephone number.

3. References:

- a) Two customers or participants who will substantiate the Offeror's qualifications and capabilities to perform the services required by the RFP.
- b) Two customers or participants who can attest to the Offeror's experience with interface files for data loads.
- c) Contact information for all service authorization contracts for Medicaid/FAMIS Plus or FAMIS products and any Virginia based non-Medicaid groups the Contractor chooses to include, held by the Offeror at any time since January 1, 2004.

The Offeror shall complete the Reference Form in Attachment IX for each reference and contract, which includes the contract name, address, telephone number, contact person, and periods of work performance.

4. Financial Stability:

The Offeror shall submit evidence of financial stability. The Offeror should submit one of the following financial reports:

- a) For a publicly held corporation, a copy of the most recent three years of audited financial reports and financial statements with the name, address, and telephone number of a responsible person in the Offeror's principal financial or banking organization, or
- b) For a privately held corporation, proprietorship, or partnership, financial information for the past three years, similar to that included in an annual report, to include, at a minimum, an income statement, a statement of cash flows, a balance sheet, and number of years in business, as well as the name, address, and telephone number of a contact in the Offeror's principal financial or banking organization and its auditor.

#### 7.10.3 Chapter Three: Tasks and Technical Approach

The Offeror shall fully describe how it intends to meet all of the tasks required in Section 3 of the RFP and technical proposal requirements listed in Section 4 of this RFP. DMAS does not want a "re-write" of the RFP requirements. Specifically, the Offeror shall describe in detail its proposed approach for each of the required tasks listed in Section 3 and technical proposal requirements in Section 4 including any staff, systems, procedures, or materials that will be used to perform these tasks. This includes how each task will be performed, what problems need to be overcome, what functions the staff will perform, and what assistance will be needed from DMAS, if any.

**Note:** DMAS welcomes new and innovative approaches to dental services. While fully addressing the dental objectives in Sections 3 and 4 of this RFP, the Offeror may also include alternate approaches for DMAS consideration. Additional services can be addressed as long as a separate line item for the associated costs is submitted with the proposal. (refer to Attachment X – Enhanced Benefits)

#### 7.10.4 Chapter Four: Staffing

The proposal shall describe the following:

1. Staffing Plan: The Offeror shall provide a functional organizational chart of the proposed project structure and organization, indicating the lines of authority for proposed staff directly involved in performance of this contract and relationships of the staff to each function of the organization. The staffing plan shall indicate the number of proposed FTEs by position and an estimate of hours to be committed to the project by each staff position. The plan shall also show the number of staff to be employed by the Contractor and staff to be obtained through subcontracting arrangements. Contact information must be provided for all key staff involved in the implementation and ongoing management of the program.

Offerors must submit 2 references for each proposed key staff member, showing work for previous participants who have received similar services to those proposed by the Offeror for this contract. Each reference must include the name of the contact person, address, telephone number and description of services provided.

2. Staff Qualifications and Resumes: Job descriptions for all key staff on the project including qualifications, experience and/or expertise required should be included. Resumes limited to two pages must be included for key staff. The resumes of personnel proposed must include qualifications, experience, and relevant education, professional certifications and training for the position they will fill.

3. Office Location: A description of the geographical location of the central business office, the billing office, the processing center and satellite offices, if applicable, shall be included. In addition, the hours of operation should be noted for each office as applicable to this contract.

#### 7.10.5 Chapter Five: Project Work Plan

The proposal shall describe the following:

Work Plan and Project Management: The proposal shall include a work plan (Microsoft Project 2003 or compatible version) detailing the sequence of events and the time required to implement this project no later than July 1, 2011. The relationship between key staff and the specific tasks and assignments proposed to accomplish the scope of work shall also be included. A PERT, Gantt, or Bar Chart that clearly outlines the project timetable from beginning to end shall be included in the proposal. Key dates and key events relative to the project shall be clearly described on the chart including critical path of tasks. The Offeror shall describe its management approach and how its proposed work plan will be executed.

Progress Reports: Upon award of a contract, the Contractor must prepare a written progress report, as well as telephonic meetings, every week or more frequently as necessary and present this report to the Director, Division of Health Care Services or his designee. The report must include:

1. Status of major activities and tasks in relation to the Contractor's work plan, including specific tasks completed for each part of the project.
2. Target dates for completion of remaining or upcoming tasks/activities.
3. Any potential delays or problems anticipated or encountered in reaching target dates and the reason for such delays.
4. Any revisions to the overall work schedule.

#### 7.10.6 Chapter Six: Required Forms:

This chapter shall contain the signatory documents as outlined in the RFP. These include the following:

1. RFP Cover Sheet
2. RFP Addenda (if issued).
3. Offerors Transmittal Letter
4. Certification of Compliance with Prohibition of Political Contributions and Gifts During the Procurement Process" (Attachment XX)

## **8. PROPOSAL EVALUATIONS**

DMAS will conduct a comprehensive, fair, and impartial evaluation of the Technical and Cost Proposals received in response to this RFP. The Evaluation Team will be responsible for the review and scoring of all proposals. This group will be responsible for the recommendation to the DMAS Director.

### **8.1 Evaluation of Minimum Requirements**

DMAS will initially determine if each proposal addresses the minimum RFP requirements to permit a complete evaluation of the Technical and Cost Proposals. Proposals shall comply with the instructions to Offerors contained throughout this RFP. Failure to comply with the instructions shall deem the proposal non-responsive and subject to disqualification without further consideration. DMAS reserves the right to waive minor irregularities.

The minimum requirements for a proposal to be given consideration are:

**RFP Cover Sheet, Addenda (if issued), Transmittal Letter and Certification of Compliance with Prohibition of Political Contributions and Gifts During the Procurement Process” (Attachment XX):** These shall be completed and properly signed by the authorized representative of the organization.

**Closing Date:** The proposal shall have been received, as provided in Section 7.8, before the closing of acceptance of proposals in the number of copies specified.

**Compliance:** The proposal shall comply with the entire format requirements described in Section 4 and the Technical Proposal and Cost Proposal requirements described in Section 7.

**Mandatory Conditions:** All mandatory General and Specific Terms and Conditions contained in Sections 9 and 10 shall be accepted.

**Small Business Subcontracting Plan** – Summarize the planned utilization of DMBE certified small businesses and small businesses owned by women and minorities under the contract to be awarded as a result of this solicitation. (Attachment XI) This shall be submitted with the Offerors cost proposal.

## **8.2 Proposal Evaluation Criteria**

The broad criteria for evaluating proposals include, but are not limited to, the elements below:

<b>Criteria</b>	<b>Weights</b>
<b>1. Experience of the Offeror in performing dental benefits administration services in rural and urban areas.</b>	<b>15%</b>
a) Experience of the Offeror in working with indigent populations, particularly Medicaid/FAMIS Plus and FAMIS populations.	
b) Experience in managing a diverse provider network.	
c) Experience of the Offeror in developing productive relationships with public, private and not-for-profit community organizations regarding common dental issues.	
<b>2. Technical Proposal - Demonstration in the written proposal of the Offeror's ability, facilities and capacity to provide all required services in a timely, efficient and professional manner.</b>	<b>30%</b>
a) Clarity and thoroughness of the Offeror's proposal in addressing the components of the RFP and implementing them as described and on schedule.	
b) Proposed project management of the resources available to the Offeror for meeting the requirements of the RFP.	
<b>3. Staffing - Experience and expertise of specific staff assigned to the contract.</b>	<b>10%</b>
a) Prior experience of staff with similar projects.	
b) Qualifications of staff.	
c) Appropriateness of the relationship between staff qualifications and assigned responsibilities.	
<b>4. Quality of References</b>	<b>5%</b>
a) References who clearly address the nature of the work performed by the Offeror.	
b) References who exhibit satisfaction with the work performed by the Offeror.	
c) Contacts for other contracts who exhibit satisfaction with the work performed by the Offeror.	
<b>5. Small Business Subcontracting Plan (Attachment XI)</b>	<b>20%</b>
<b>6. Cost Proposal</b>	<b>20%</b>
a) The PMPM cost proposal – see Attachment X. For purposes of evaluation, each Offeror's PMPM cost by member program category shall be multiplied by the average monthly enrollment for each eligibility category (pediatric dental, adult dental and pregnant women). The Offeror with the lowest cost proposal shall be identified, and all other Offeror costs shall be evaluated in comparison to this price bid.	

The cost proposal shall be evaluated and weighted but is not the sole deciding factor for the RFP. The lowest cost proposal shall be scored the maximum number of evaluation points for cost. All other cost proposals shall be evaluated and assigned points for cost in relation to the lowest cost proposal. Although cost proposals are evaluated and weighted, they are not the sole deciding factor for the RFP.

## **9. GENERAL TERMS AND CONDITIONS**

## **9.1 Vendors Manual**

This solicitation is subject to the provisions of the Commonwealth of Virginia *Vendors Manual* and any changes or revisions thereto, which are hereby incorporated into this contract in their entirety. The procedure for filing contractual claims is in section 7.19 of the *Vendors Manual*. A copy of the manual is normally available for review at the purchasing office and is accessible on the Internet at <http://www.eva.virginia.gov/learn-about-eva/vendors-manual.htm> .

## **9.2 Applicable Laws and Courts**

This solicitation and any resulting contract shall be governed in all respects by the laws of the Commonwealth of Virginia and any litigation with respect thereto shall be brought in the courts of the Commonwealth. The agency and the Contractor are encouraged to resolve any issues in controversy arising from the award of the contract or any contractual dispute using Alternative Dispute Resolution (ADR) procedures (*Code of Virginia*, §2.2-4366). ADR procedures are described in Chapter 9 of the *Vendors Manual*. The Contractor shall comply with all applicable federal, state and local laws, rules and regulations.

## **9.3 Anti-Discrimination**

By submitting their proposals, Offerors certify to the Commonwealth that they will conform to the provisions of the Federal Civil Rights Act of 1964, as amended, as well as the Virginia Fair Employment Contracting Act of 1975, as amended, where applicable, the Virginians With Disabilities Act, the Americans With Disabilities Act and §2.2-4311 of the Virginia Public Procurement Act (VPPA), and any other applicable laws. If the award is made to a faith-based organization, the organization shall not discriminate against any member of goods, services, or disbursements made pursuant to the contract on the basis of the member's religion, religious belief, refusal to participate in a religious practice, or on the basis of race, age, color, gender or national origin and shall be subject to the same rules as other organizations that contract with public bodies to account for the use of the funds provided; however, if the faith-based organization segregates public funds into separate accounts, only the accounts and programs funded with public funds shall be subject to audit by the public body. (*Code of Virginia*, § 2.2-4343.1 E).

In every contract over \$10,000, the provisions in Sections 9.3.1 and 9.3.2. below apply:

9.3.1. During the performance of this contract, the Contractor agrees as follows:

- a) The Contractor will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment, except where there is a bona fide occupational qualification reasonably necessary to the normal operation of the Contractor. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.
- b) The Contractor, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, will state that such Contractor is an equal opportunity employer.
- c) Notices, advertisements and solicitations placed in accordance with federal law, rule or

regulation shall be deemed sufficient for the purpose of meeting these requirements.

9.3.2. The Contractor will include the provisions of 9.3.1 above in every subcontract or purchase order over \$10,000, so that the provisions will be binding upon each subcontractor or vendor.

#### **9.4 Ethics in Public Contracting**

By submitting their proposals, Offerors certify that their proposals are made without collusion or fraud and that they have not offered or received any kickbacks or inducements from any other Offeror, supplier, manufacturer or subcontractor in connection with their proposal, and that they have not conferred on any public employee having official responsibility for this procurement transaction any payment, loan, subscription, advance, deposit of money, services or anything of more than nominal value, present or promised, unless consideration of substantially equal or greater value was exchanged.

#### **9.5 Immigration Reform and Control Act Of 1986**

By entering into a written contract with the Commonwealth of Virginia (COV), the Contractor certifies that the Contractor does not, and shall not during the performance of the contract for goods and services in the Commonwealth, knowingly employ an unauthorized alien as defined in the federal Immigration Reform and Control Act of 1986.

#### **9.6 Debarment Status**

By submitting their proposals, Offerors certify that they are not currently debarred by the Commonwealth of Virginia or any other federal, state or local government from submitting bids or proposals on any type of contract, nor are they an agent of any person or entity that is currently so debarred.

#### **9.7 Antitrust**

By entering into a contract, the Contractor conveys, sells, assigns, and transfers to the Commonwealth of Virginia all rights, title and interest in and to all causes of action it may now have or hereafter acquire under the antitrust laws of the United States and the Commonwealth of Virginia, relating to the particular goods or services purchased or acquired by the Commonwealth of Virginia under said contract.

#### **9.8 Mandatory Use of State Form and Terms and Conditions**

Failure to submit a proposal on the official State form, in this case the completed and signed RFP Cover Sheet, may be a cause for rejection of the proposal. Modification of or additions to the General Terms and Conditions of the solicitation may be cause for rejection of the proposal; however, the Commonwealth reserves the right to decide, on a case by case basis, in its sole discretion, whether to reject such a proposal.

#### **9.9 Clarification of Terms**

If any prospective Offeror has questions about the specifications or other solicitation documents, the prospective Offeror should contact Daniel Plain ([RFP2011-03@dmas.virginia.gov](mailto:RFP2011-03@dmas.virginia.gov)) no later than December 6, 2010. Any revisions to the solicitation will be made only by addendum issued by the buyer.

#### **9.10 Payment**

1. To Prime Contractor:

- a. Invoices for items ordered, delivered and accepted shall be submitted by the Contractor directly to the payment address shown on the purchase order/contract. All invoices shall show the state contract number and/or purchase order number; social security number (for individual contractors) or the federal employer identification number (for proprietorships, partnerships, and corporations).
- b. Any payment terms requiring payment in less than 30 days will be regarded as requiring payment 30 days after invoice or delivery, whichever occurs last. This shall not affect offers of discounts for payment in less than 30 days, however.
- c. All goods or services provided under this contract or purchase order, that are to be paid for with public funds, shall be billed by the Contractor at the contract price, regardless of which public agency is being billed.
- d. The following shall be deemed to be the date of payment: the date of postmark in all cases where payment is made by mail, or the date of offset when offset proceedings have been instituted as authorized under the Virginia Debt Collection Act.
- e. Unreasonable Charges: Under certain emergency procurements and for most time and material purchases, final job costs cannot be accurately determined at the time orders are placed. In such cases, Contractors should be put on notice that final payment in full is contingent on a determination of reasonableness with respect to all invoiced charges. Charges that appear to be unreasonable will be researched and challenged, and that portion of the invoice held in abeyance until a settlement can be reached. Upon determining that invoiced charges are not reasonable, the Commonwealth shall promptly notify the Contractor, in writing, as to those charges which it considers unreasonable and the basis for the determination. A Contractor may not institute legal action unless a settlement cannot be reached within thirty (30) days of notification. The provisions of this section do not relieve an agency of its prompt payment obligations with respect to those charges that are not in dispute (*Code of Virginia*, § 2.2-4363).

2. To Subcontractors:

- a. A Contractor awarded a contract under this solicitation is hereby obligated:
  - (1) To pay the subcontractor(s) within seven (7) days of the Contractor's receipt of payment from the Commonwealth for the proportionate share of the payment received for work performed by the subcontractor(s) under the contract; or
  - (2) To notify the agency and the subcontractor(s), in writing, of the Contractor's intention to withhold payment and the reason.
- b. The Contractor is obligated to pay the subcontractor(s) interest at the rate of one percent per month (unless otherwise provided under the terms of the contract) on all amounts owed by the Contractor that remain unpaid seven (7) days following receipt of payment from the Commonwealth, except for amounts withheld as stated in (2) above. The date of mailing of any payment by U. S. Mail is deemed to be payment to the addressee. These provisions apply to each sub-tier Contractor performing under the primary contract. A Contractor's obligation to pay an interest charge to a subcontractor may not be construed to be an obligation of the Commonwealth.

3. Each prime Contractor who wins an award in which provision of a SWAM procurement plan is a condition to the award, shall deliver to the contracting agency or institution, on or before request for final payment, evidence and certification of compliance (subject only to insubstantial shortfalls and to shortfalls arising from subcontractor default) with the SWAM procurement plan. Final payment under the contract in question may be withheld until such certification is delivered and, if necessary, confirmed by the agency or institution, or other appropriate penalties may be assessed in lieu of withholding such payment.
4. The COV encourages Contractors and subcontractors to accept electronic and credit card payments.

#### **9.11 Precedence of Terms**

The following General Terms and Conditions: *VENDORS MANUAL*, APPLICABLE LAWS AND COURTS, ANTI-DISCRIMINATION, ETHICS IN PUBLIC CONTRACTING, IMMIGRATION REFORM AND CONTROL ACT OF 1986, DEBARMENT STATUS, ANTITRUST, MANDATORY USE OF STATE FORM AND TERMS AND CONDITIONS, CLARIFICATION OF TERMS, PAYMENT shall apply in all instances. In the event there is a conflict between any of the other General Terms and Conditions and any Special Terms and Conditions in this solicitation, the Special Terms and Conditions shall apply.

#### **9.12 Qualifications of Offerors**

The Commonwealth may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the services/furnish the goods and the Offeror shall furnish to the Commonwealth all such information and data for this purpose as may be requested. The Commonwealth reserves the right to inspect Offeror's physical facilities prior to award to satisfy questions regarding the Offeror's capabilities. The Commonwealth further reserves the right to reject any proposal if the evidence submitted by, or investigations of, such Offeror fails to satisfy the Commonwealth that such Offeror is properly qualified to carry out the obligations of the Contract and to provide the services and/or furnish the goods contemplated therein.

#### **9.13 Testing And Inspection**

The Commonwealth reserves the right to conduct any test/inspection it may deem advisable to ensure goods and services conform to the specifications.

#### **9.14 Assignment of Contract**

A contract shall not be assignable by the Contractor in whole or in part without the written consent of the Commonwealth. Any assignment made in violation of this section will be void.

#### **9.15 Changes To The Contract**

Changes can be made to the contract in any of the following ways:

1. The parties may agree in writing to modify the scope of the contract. An increase or decrease in the price of the contract resulting from such modification shall be agreed to by the parties as a part of their written agreement to modify the scope of the contract. **In any such change to the resulting contract, no increase to the contract price shall be permitted without**

**adequate consideration, and no waiver of any contract requirement that results in savings to the Contractor shall be permitted without adequate consideration. Pursuant to Virginia Code § 2.2-4309, the value of any fixed-price contract shall not be increased via modification by more than 25% without the prior approval of the Division of Purchases and Supply of the Virginia Department of General Services.**

2. The Department may order changes within the general scope of the contract at any time by written notice to the Contractor. Changes within the scope of the contract include, but are not limited to, things such as services to be performed or changes in programs, policies, legislation or operations. The Contractor shall comply with the notice upon receipt. The Contractor shall be compensated for any additional costs incurred as the result of such order and shall give the Department a credit for any savings. Said compensation shall be determined by one of the following methods:
  - a. By mutual agreement between the parties in writing; or
  - b. By agreeing upon a unit price or using a unit price set forth in the contract, if the work to be done can be expressed in units, and the Contractor accounts for the number of units of work performed, subject to the Department's right to audit the Contractor's records and/or to determine the correct number of units independently; or
  - c. By ordering the Contractor to proceed with the work and keep a record of all costs incurred and savings realized. A markup for overhead and profit may be allowed if provided by the contract. The same markup shall be used for determining a decrease in price as the result of savings realized. The Contractor shall present the Department with all vouchers and records of expenses incurred and savings realized. The Department shall have the right to audit the records of the Contractor as it deems necessary to determine costs or savings. Any claim for an adjustment in price under this provision must be asserted by written notice to the Department within thirty (30) days from the date of receipt of the written order from the Department. If the parties fail to agree on an amount of adjustment, the question of an increase or decrease in the contract price or time for performance shall be resolved in accordance with the procedures for resolving disputes provided by the Disputes Clause of this contract or, if there is none, in accordance with the disputes provisions of the Commonwealth of Virginia *Vendors Manual*. Neither the existence of a claim nor a dispute resolution process, litigation or any other provision of this contract shall excuse the Contractor from promptly complying with the changes ordered by the Department or with the performance of the contract generally.

#### **9.16 Default**

In case of failure to deliver goods or services in accordance with the contract terms and conditions, the Commonwealth, after due oral or written notice, may procure them from other sources and hold the Contractor responsible for any resulting additional purchase and administrative costs. This remedy shall be in addition to any other remedies, which the Commonwealth may have.

#### **9.17 Insurance**

By signing and submitting a bid or proposal under this solicitation, the Offeror certifies that if awarded the contract, it will have the following insurance coverage at the time the contract is awarded. For

construction contracts, if any subcontractors are involved, the subcontractor will have workers' compensation insurance in accordance with §§ 2.2-4332 and 65.2-800 et seq. of the *Code of Virginia*. The Offeror further certifies that the Contractor and any subcontractors will maintain this insurance coverage during the entire term of the contract and that all insurance coverage will be provided by insurance companies authorized to sell insurance in Virginia by the Virginia State Corporation Commission.

#### MINIMUM INSURANCE COVERAGES AND LIMITS REQUIRED FOR MOST CONTRACTS:

1. Workers' Compensation: Statutory requirements and benefits: Coverage is compulsory for employers of three or more employees, to include the employer. Contractors who fail to notify the Commonwealth of increases in the number of employees that change their workers' compensation requirements under the *Code of Virginia* during the course of the contract shall be in noncompliance with the contract.
2. Employer's Liability: \$100,000.
3. Commercial General Liability: \$1,000,000 per occurrence. Commercial General Liability is to include bodily injury and property damage, personal injury and advertising injury, products and completed operations coverage. The Commonwealth of Virginia must be named as an additional insured and so endorsed on the policy.
4. Automobile Liability: \$1,000,000 per occurrence. (Only used if motor vehicle is to be used in the contract.)

#### **9.18 Announcement Of Award**

Upon the award or the announcement of the decision to award a contract over \$50,000, as a result of this solicitation, the Department will publicly post such notice on the DGS/DPS eVA web site located at [www.eva.virginia.gov](http://www.eva.virginia.gov) for a minimum of 10 days.

#### **9.19 Drug-Free Workplace**

During the performance of this contract, the Contractor agrees to:

1. Provide a drug-free workplace for the Contractor's employees;
2. Post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition;
3. State in all solicitations or advertisements for employees placed by or on behalf of the Contractor that the Contractor maintains a drug-free workplace; and
4. Include the provisions of the foregoing clauses in every subcontract or purchase order of over \$10,000, so that the provisions will be binding upon each subcontractor or vendor.

For the purposes of this section, "*drug-free workplace*" means a site for the performance of work done in connection with a specific contract awarded to a Contractor, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

## 9.20 Nondiscrimination of Contractors

A Bidder, Offeror, or Contractor shall not be discriminated against in the solicitation or award of this contract because of race, religion, color, sex, national origin, age, disability, faith-based organizational status, any other basis prohibited by state law relating to discrimination in employment or because the bidder or Offeror employs ex-offenders unless the state agency, department or institution has made a written determination that employing ex-offenders on the specific contract is not in its best interest. If the award of this contract is made to a faith-based organization and an individual, who applies for or receives goods, services, or disbursements provided pursuant to this contract objects to the religious character of the faith-based organization from which the individual receives or would receive the goods, services, or disbursements, the public body shall offer the individual, within a reasonable period of time after the date of his objection, access to equivalent goods, services, or disbursements from an alternative provider.

## 9.21 eVA Business-To-Government Vendor Registration

The eVA Internet electronic procurement solution, Web-site portal [www.eva.virginia.gov](http://www.eva.virginia.gov), streamlines and automates government purchasing activities in the Commonwealth. The eVA portal is the gateway for vendors to conduct business with state agencies and public bodies. All vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-procurement solution either through the eVA Basic Vendor Registration Service or eVA Premium Vendor Registration Service. All Offerors must register in eVA; failure to register shall result in the proposal being rejected.

- a. eVA Basic Vendor Registration Service: \$25 Annual Registration Fee plus the appropriate order Transaction Fee specified below. eVA Basic Vendor Registration Service includes electronic order receipt, vendor catalog posting, on-line registration, electronic bidding, and the ability to research historical procurement data available in the eVA purchase transaction data warehouse.
- b. eVA Premium Vendor Registration Service: \$25 Annual Registration Fee plus the appropriate order Transaction Fee specified below. eVA Premium Vendor Registration Service includes all benefits of the eVA Basic Vendor Registration Service plus automatic email or fax notification of solicitations and amendments.
- c. For orders issued prior to August 16, 2006, the Vendor Transaction Fee is 1%, capped at a maximum of \$500 per order.
- d. For orders issued August 16, 2006 and after, the Vendor Transaction Fee is:
  - (i) DMBE-certified Small Businesses: 1%, capped at \$500 per order.
  - (ii) Businesses that are not DMBE-certified Small Businesses: 1%, capped at \$1,500 per order.

## 9.22 Availability of Funds

It is understood and agreed between the parties herein that the agency shall be bound hereunder only to the extent of the funds available or which may hereafter become available for the purpose of this agreement.

## 9.23 Set-Asides

This solicitation is set-aside for DMBE-certified small business participation only when designated "SET-ASIDE FOR SMALL BUSINESSES" in the solicitation. DMBE-certified small businesses are those businesses that hold current small business certification from the Virginia Department of Minority Business

Enterprise. This shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received the DMBE small business certification. For purposes of award, Offerors shall be deemed small businesses if and only if they are certified as such by DMBE on the due date for receipt of proposals.

#### **9.24 Bid Price Currency**

Unless stated otherwise in the solicitation, Offerors shall state offer prices in US dollars.

#### **9.25 Authorization To Conduct Business In the Commonwealth**

The Contractor as a stock or non-stock corporation, limited liability company, business trust, or limited partnership or registered as a registered limited liability partnership shall be authorized to transact business in the Commonwealth as a domestic or foreign business entity if so required by Title 13.1 or Title 50 of the *Code of Virginia* or as otherwise required by law. Any business entity described above that enters into a contract with a public body pursuant to the *Virginia Public Procurement Act* shall not allow its existence to lapse or its certificate of authority or registration to transact business in the Commonwealth, if so required under Title 13.1 or Title 50, to be revoked or cancelled at any time during the term of the contract. A public body may void any contract with a business entity if the business entity fails to remain in compliance with the provisions of this section

### **10. SPECIAL TERMS AND CONDITIONS**

#### **10.1 Access To Premises**

The Contractor shall allow duly authorized agents or representatives of the State or Federal Government, during normal business hours, access to Contractor's and subcontractors' premises, to inspect, audit, monitor or otherwise evaluate the performance of the Contractor's and subcontractor's contractual activities and shall forthwith produce all records requested as part of such review or audit. In the event right of access is requested under this section, the Contractor and subcontractor shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Contractor or subcontractor's activities. The Contractor will be given thirty (30) calendar days to respond to any preliminary findings of an audit before the Department shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

The Department, the Office of the Attorney General of the Commonwealth of Virginia, the federal Department of Health and Human Services, and/or their duly authorized representatives shall be allowed access to evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under this Contract.

#### **10.2 Access To and Retention of Records**

In addition to the requirements outlined below, the Contractor must comply, and must require compliance by its subcontractors with the security and confidentiality of records standards.

### 10.2.1 Access to Records

The Department, the Centers for Medicare and Medicaid Services, State and Federal auditors, or any of their duly authorized representatives shall have access to any books, fee schedules, documents, papers, and records of the Contractor and any of its subcontractors.

The Department, the Centers for Medicare and Medicaid Services, State and Federal auditors, or any of their duly authorized representatives, shall be allowed to inspect, copy, and audit any of the above documents, including, medical and/or financial records of the Contractor and its subcontractors.

### 10.2.2 Retention of Records

The Contractor shall retain all records and reports relating to this Contract for a period of six (6) years after final payment is made under this Contract or in the event that this Contract is renewed six (6) years after the renewal date. When an audit, litigation, or other action involving records is initiated prior to the end of said period, however, records shall be maintained for a period of six (6) years following resolution of such action or longer if such action is still ongoing. Copies on microfilm or other appropriate media of the documents contemplated herein may be substituted for the originals provided that the microfilming or other duplicating procedures are reliable and are supported by an effective retrieval system which meets legal requirements to support litigation, and to be admissible into evidence in any court of law.

### 10.2.3 Confidentiality Of Personally Identifiable Information

The Contractor assures that information and data obtained as to personal facts and circumstances related to patients or members will be collected and held confidential, during and following the term of this agreement, and will not be divulged without the individual's and the agency's written consent and only in accordance with federal law or the Code of Virginia. Contractors who utilize, access, or store personally identifiable information as part of the performance of a contract are required to safeguard this information and immediately notify the agency of any breach or suspected breach in the security of such information. Contractors shall allow the agency to both participate in the investigation of incidents and exercise control over decisions regarding external reporting. Contractors and their employees working on this project may be required to sign a confidentiality statement. The Contractor shall maintain the confidentiality of Medicaid client information. The Contractor shall ensure that access to this information will be limited to the Contractor. The Contractor shall take measures to prudently safeguard and protect unauthorized disclosure of the Medicaid client information in its possession. The Contractor shall establish internal policies to ensure compliance with Federal and State laws and regulations regarding confidentiality including, but not limited to, 42 CFR § 431, Subpart F, and Virginia Code § 2.2-3800, et. seq. In no event may the Contractor provide, grant, allow, or otherwise give, access to Medicaid client information to anyone without the express written permission of DMAS. The Contractor shall assume all liabilities under both State and Federal law in the event that the information is disclosed in any manner. Upon the Contractor's receiving any requests for Medicaid client information from any individual, entity, corporation, partnership or otherwise, the Contractor shall notify DMAS within twenty-four (24) hours or on the next business day. In cases where the information requested by outside sources is releasable under the Freedom of Information Act (FOIA), as determined by DMAS, the Contractor shall provide support for copying and invoicing such documents at the Contractor's expense.

## Protected Health Information (PHI)

The Contractor shall comply with all federal and state laws and regulations with regard to handling, processing, and using health care data. The Contractor must keep abreast of the regulations and be able to reach full compliance within the specified timeframes. Since HIPAA is federal law and its enacting regulations apply to all health care information, the Contractor must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations at no additional cost to DMAS. The DMAS and the Contractor, as defined in section 160.103 of the Final HIPAA Privacy Rule, will enter into this Business Associate Agreement to comply with the HIPAA Privacy regulation requirements.

- a. The Contractor shall not use Protected Health Information (PHI) otherwise than as expressly permitted, or as required by law.
- b. The Contractor shall ensure that any agents and subcontractors to whom it provides PHI received from DMAS agree in writing to the same restrictions, terms, and conditions relating to PHI that apply to the Contractor.
- c. The Contractor shall report to DMAS within thirty (30) days of discovery, any use or disclosure of PHI made in violation of agreement or any law. The Contractor shall implement and maintain sanctions for any employee, subcontractor, or agent who violates the requirements of agreement or the HIPAA privacy regulations.
- d. The Contractor shall make an individual's PHI available to DMAS within thirty (30) days of an individual's request for such information as notified by DMAS.
- e. The Contractor shall make PHI available for amendment and correction and shall incorporate any amendments or corrections to PHI within thirty (30) days of notification by DMAS.
- f. DMAS may immediately terminate a Business Associate agreement with the Contractor if DMAS determines that the Contractor has violated a material term of the agreement.
- g. The Contractor shall develop a written Business Associate Data Security Plan, that shall be available upon request, within thirty (30) days of the execution of a Business Associate Agreement. The Business Associate Data Security Plan shall describe the manner in which the Contractor will use DMAS' data and the procedures the Contractor will employ to secure the data.

### **10.3 Advertising**

In the event a contract is awarded for services resulting from this proposal, no indication of such sales or services to DMAS will be used in product literature or advertising without prior written permission from DMAS. The Contractor shall not state in any of its advertising or product literature that the Commonwealth of Virginia or any agency or institution of the Commonwealth has purchased or uses its products or services without prior written permission from DMAS. DMAS must approve any advertising, marketing or press release connected with this contract.

#### **10.4 Audit**

The Contractor shall retain all books, records, and other documents relative to this contract for six (6) years after final payment, or longer if audited by the Commonwealth of Virginia, whichever is sooner. The agency, its authorized agents (to include the Office of Comprehensive Services), and/or state auditors shall have full access to and the right to examine any of said materials during said period.

#### **10.5 Award**

Selection shall be made of two or more Offerors deemed to be fully qualified and best suited among those *submitting proposals on the* basis of the evaluation factors included in the Request for Proposals, including price, if so stated in the Request for Proposals. Negotiations shall be conducted with the Offeror(s) so selected. Price shall be considered, but need not be the sole determining factor. After negotiations have been conducted with each Offeror so selected, the agency shall select the Offeror which, in its opinion, has made the best proposal, and shall award the contract to that Offeror. The Commonwealth may cancel this Request for Proposals or reject proposals at any time prior to an award, and is not required to furnish a statement of the reasons why a particular proposal was not deemed to be the most advantageous (*Code of Virginia, § 2.2-4359D*). Should the Commonwealth determine in writing and in its sole discretion that only one Offeror is fully qualified, or that one Offeror is clearly more highly qualified than the others under consideration, a contract may be negotiated and awarded to that Offeror. The award document will be a contract incorporating by reference all the requirements, terms and conditions of the solicitation and the Contractor's proposal as negotiated.

#### **10.6 Cancellation of Contract**

The Department reserves the right to cancel and terminate any resulting contract, in part or in whole, without penalty, upon 90 days written notice to the Contractor. Any contract cancellation notice shall not relieve the Contractor of the obligation to deliver and/or perform on all outstanding services issued prior to the effective date of cancellation.

#### **10.7 Termination**

This Contract may be terminated in whole or in part:

- a. By the Department, for convenience, with not less than ninety (90) days prior written notice, which notice shall specify the effective date of the termination,
- b. By the Department, in whole or in part, if funding from Federal, State, or other sources is withdrawn, reduced, or limited;
- c. By the Department if the Department determines that the instability of the Contractor's financial condition threatens delivery of services and continued performance of the Contractor's responsibilities; or
- d. By the Department if the Department determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities.

The Contractor shall not terminate this contract in part.

Each of these conditions for contract termination is described in the following paragraphs.

#### 10.7.a Termination for Convenience

- a. The Department may terminate this contract at any time without cause, in whole or in part, upon giving the contractor notice of such termination. Upon such termination, the contractor shall immediately cease work and remove from the project site all of its labor forces and such of its materials as owner elects not to purchase or to assume in the manner hereinafter provided. Upon such termination, the contractor shall take such steps as owner may require to assign to the owner the contractor's interest in all subcontracts and purchase orders designated by owner. After all such steps have been taken to owner's satisfaction; the contractor shall receive as full compensation for termination and assignment the following:
  - (1) All amounts then otherwise due under the terms of this contract,
  - (2) Amounts due for work performed subsequent to the latest Request for Payment through the date of termination,
  - (3) Reasonable compensation for the actual cost of demobilization incurred by the contractor as a direct result of such termination. The contractor shall not be entitled to any compensation for lost profits or for any other type of contractual compensation or damage other than those provided by the preceding sentence. Upon payment of the forgoing, owner shall have no further obligations to the contractor of any nature.
- b. In no event shall termination for the convenience of the owner terminate the obligations of the contractor's surety on its payment and performance bonds.

#### 10.7.b Termination for Unavailable Funds

The Contractor understands and agrees that the Department shall be bound only to the extent of the funds available or which may become available for the purpose of this resulting Contract. When the Department makes a written determination that funds are not adequately appropriated or otherwise unavailable to support continuance of performance of this Contract, the Department shall, in whole or in part, cancel or terminate this Contract.

The Department's payment of funds for purposes of this Contract is subject to and conditioned upon the availability of funds for such purposes, whether Federal and/or State funds. The Department may terminate this Contract upon written notice to the Contractor at any time prior to the completion of this Contract, if, in the sole opinion of the Department, funding becomes unavailable for these services or such funds are restricted or reduced. In the event that funds are restricted or reduced, it is agreed by both parties that, at the sole discretion of the Department, this Contract may be amended. If the Contractor shall be unable or unwilling to provide covered services at reduced rates, the Contract shall be terminated.

No damages, losses, or expenses may be sought by the Contractor against the Department, if, in the sole determination of the Department, funds become unavailable before or after this Contract between the parties is executed. A determination by the Department that funds are not appropriated or are otherwise inadequate or unavailable to support the continuance of this Contract shall be final and conclusive.

#### 10.7.c Termination Because of Financial Instability

If DMAS determines that there are verifiable indicators that the Contractor will become financially unstable to the point of threatening the ability of the Department to obtain the services provided for under the Contract, DMAS will require verification of the Contractor's financial situation. If from the information DMAS determines the Contractor will inevitably become financially unstable, DMAS may terminate the contract before this occurs. If the Contractor ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a

receiver for its business or assets, DMAS may, at its option, immediately terminate this Contract effective at the close of business on a date specified by the Department. In the event the Department elects to terminate the Contract under this provision, the Contractor shall be notified in writing, by either certified or registered mail, specifying the date of termination. The Contractor shall submit a written waiver of the licensee's rights under the Federal bankruptcy laws.

In the event of the filing of a petition in bankruptcy by a principal network provider or subcontractor, the Contractor shall immediately so advise the Department. The Contractor shall ensure that all tasks that have been delegated to its subcontractor(s) are performed in accordance with the terms of this Contract.

#### 10.7.d Termination for Default

The Department may terminate the Contract, in whole or in part, if the Department determines that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract and is unable to cure such failure within a reasonable period of time as specified in writing by the Department, taking into consideration the gravity and nature of the default. Such termination shall be referred to herein as "Termination for Default."

Upon determination by the Department that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract, the Contractor shall be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to cure such failure. If the Contractor is unable to cure the failure within the specified time period, the Department can notify the Contractor in writing within thirty (30) calendar days of the last day of the specified time period that the Contract, has been terminated in full or in part, for default. This written notice will identify all of the Contractor's responsibilities in the case of the termination, including responsibilities related to member notification, network provider notification, refunds of advance payments, return or destruction of Department data and liability for medical claims.

In the event that DMAS determines that the Contractor's failure to perform its duties and responsibilities under this contract results in a substantial risk to the health and safety of Medicaid/FAMIS Plus or FAMIS members, DMAS may terminate this contract immediately without notice.

If, after notice of termination for default, it is determined by the Department or by a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control of and without error or negligence on the part of the Contractor or any of its subcontractors, the notice of termination shall be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties shall be governed accordingly.

In the event of termination for default, in full or in part, as provided for under this clause, the Department may procure or contract from other sources, upon such terms and in such manner as is deemed appropriate by the Department, supplies or services similar to those terminated, and the Contractor shall be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Contractor shall be liable to the Department for administrative costs incurred to procure such similar supplies or services as are needed to continue operations. In the event of a termination for default prior to the start of operations, any claim the Contractor may assert shall be governed by the procedures defined by the Department for handling contract termination. Nothing herein shall be construed as limiting any other remedies that may be available to the Department.

In the event of a termination for default during ongoing operations, the Contractor shall be paid for any outstanding payments due less any assessed damages.

## **10.8 Remedies for Violation, Breach, or Non-Performance of Contract**

Upon receipt by the Department of evidence of substantial non-compliance by the Contractor with any of the provisions of this Contract or with State or federal laws or regulations the following remedies may be imposed.

### **10.8.1 Procedure for Contractor Noncompliance Notification**

In the event that the Department identifies or learns of noncompliance with the terms of this contract, the Department will notify the Contractor in writing of the nature of the noncompliance. The Contractor must remedy the noncompliance within a time period established by the Department and the Department will designate a period of time, not less than ten (10) calendar days, in which the Contractor must provide a written response to the notification. The Department may develop or may require the Contractor to develop procedures with which the Contractor must comply to eliminate or prevent the imposition of specific remedies.

### **10.8.2 Remedies Available To the Department**

The Department reserves the right to employ, at the Department's sole discretion, any and all remedies available at law or equity including but not limited to, payment withholds and/or termination of the contract.

## **10.9 Performance and Payment Bonds**

The Contractor shall deliver to the Department purchasing office an executed performance bond, in a form acceptable to the Department, in the amount of one month of the estimated annual administrative (PMPM) contract amount, with the Department as obliged. In addition, the Contractor shall deliver to the Department purchasing office and executed payment bond, in a form acceptable to the Department, in the amount of one month of the estimated annual dental services payments amount, with the Department as obliged. The surety shall be a surety company or companies approved by the State Corporation Commission to transact business in the Commonwealth of Virginia. No payment shall be due and payable to the Contractor, even if the contract has been performed in whole or in part, until the bonds have been delivered to and approved by the Department.

## **10.10 Payment**

The Contractor shall be prepared to provide the full range of services requested under this RFP and resultant contract, on site and operationally ready to begin work by the implementation date established by DMAS. DMAS will provide adequate prior notice of at least 120 days of the implementation date. Upon approval of the Contractor's operational readiness and a determined start date, DMAS shall make payments as described in Section 6.

Each invoice submitted by the Contractor shall be subject to DMAS approval based on satisfactory performance of contracted services and compliance with all contract terms. The invoice shall contain the Federal tax identification number, the contract number and any other information subsequently required by DMAS.

### 10.11 Identification of Proposal Envelope

If a special envelope is not furnished, or if return in the special envelope is not possible, the signed bid/proposal should be returned in a separate envelope or package, sealed and identified as follows:

From: _____ Name of Contractor	_____ Due Date /Time
_____ Street or Box Number	_____ City, State, Zip Code
_____ RFP Number	

Name of Contract/Purchase Officer:

The envelope should be addressed as directed on Page 1 of the solicitation.

If a proposal not contained in the special envelope is mailed, the Offeror takes the risk that the envelope, even if marked as described above, may be inadvertently opened and the information compromised which may cause the proposal to be disqualified. Proposals may be hand delivered to the designated location in the office issuing the solicitation. No other correspondence or other proposals should be placed in the envelope.

### 10.12 Indemnification

Contractor agrees to indemnify, defend and hold harmless the Commonwealth of Virginia, its officers, agents, and employees from any claims, damages and actions of any kind or nature, whether at law or in equity, arising from or caused by the use of any materials, goods, or equipment of any kind or nature furnished by the Contractor/any services of any kind or nature furnished by the Contractor, provided that such liability is not attributable to the sole negligence of the using agency or to failure of the using agency to use the materials, goods, or equipment in the manner already and permanently described by the Contractor on the materials, goods or equipment delivered.

### 10.13 SMALL Businesses Subcontracting and Evidence of Compliance

- A. It is the goal of the Commonwealth that 40% of its purchases be made from small businesses. This includes discretionary spending in prime contracts and subcontracts. All potential Offerors are required to submit a Small Business Subcontracting Plan. Unless the Offeror is registered as a DMBE-certified small business and where it is practicable for any portion of the awarded contract to be subcontracted to other suppliers, the contractor is encouraged to offer such subcontracting opportunities to DMBE-certified small businesses. This shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received DMBE small business certification. No Offeror or subcontractor shall be considered a Small Business, a Women-Owned Business or a Minority-Owned Business unless certified as such by the Department of Minority Business Enterprise (DMBE) by the due date for receipt of proposals. If small business subcontractors are used, the prime contractor agrees to report the use of small business subcontractors by providing the purchasing office at a minimum the following information: name of small business with the DMBE certification number, phone number, total dollar amount

subcontracted, category type (small, women-owned, or minority-owned), and type of product/service provided.

- B. Each prime contractor who wins an award in which provision of a small business subcontracting plan is a condition of the award, shall deliver to the contracting agency or institution on a quarterly basis, evidence of compliance (subject only to insubstantial shortfalls and to shortfalls arising from subcontractor default) with the small business subcontracting plan. When such business has been subcontracted to these firms and upon completion of the contract, the contractor agrees to furnish the purchasing office at a minimum the following information: name of firm with the DMBE certification number, phone number, total dollar amount subcontracted, category type (small, women-owned, or minority-owned), and type of product or service provided. Payment(s) may be withheld until compliance with the plan is received and confirmed by the agency or institution. The agency or institution reserves the right to pursue other appropriate remedies to include, but not be limited to, termination for default.
- C. Each prime contractor who wins an award valued over \$200,000 shall deliver to the contracting agency or institution on a quarterly basis, information on use of subcontractors that are not DMBE-certified small businesses. When such business has been subcontracted to these firms and upon completion of the contract, the contractor agrees to furnish the purchasing office at a minimum the following information: name of firm, phone number, total dollar amount subcontracted, and type of product or service provided.

#### **10.14 Prime Contractor Responsibilities**

The Contractor shall be responsible for completely supervising and directing the work under this contract and all subcontractors that it may utilize, using its best skill and attention. Subcontractors who perform work under this contract shall be responsible to the prime Contractor. The Contractor agrees that it is as fully responsible for the acts and omissions of its subcontractors and of persons employed by it as it is for the acts and omissions of its own employees.

#### **10.15 Renewal of Contract**

This contract may be renewed by the Commonwealth for four successive one year periods under the terms and conditions of the original contract except as stated in 1. and 2. below. Price increases may be negotiated only at the time of renewal. Written notice of the Commonwealth's intention to renew shall be given approximately 90 days prior to the expiration date of each contract period.

1. If the Commonwealth elects to exercise the option to renew the contract for an additional one-year period, the contract price(s) for the additional one year shall not exceed the contract price(s) of the original contract, **in addition to any modifications**, increased/decreased by more than the percentage increase/decrease of the All Urban Consumers category of the CPI-W section of the Consumer Price Index of the United States Bureau of Labor Statistics for the latest twelve months for which statistics are available.
2. If during any subsequent renewal periods, the Commonwealth elects to exercise the option to renew the contract, the contract price(s) for the subsequent renewal period shall not exceed the contract price(s) of the previous renewal periods, in addition to any modifications, increased/decreased by more than the percentage increase/decrease of the All Urban Consumers category of the CPI-W section of the Consumer Price Index of the United States Bureau of Labor Statistics for the latest twelve months for which statistics are available.

#### **10.16 Confidentiality of Information**

By submitting a proposal, the Contractor agrees that information or data obtained by the Contractor from DMAS during the course of determining and/or preparing a response to this RFP may not be used for any other purpose than determining and/or preparing the Contractor's response. Such information or data may not be disseminated or discussed for any reasons not directly related to the determination or preparation of the Contractor's response to this RFP.

#### **10.17 HIPAA Compliance**

The Contractor shall comply, and shall ensure that any and all subcontractors comply, with all State and Federal laws and Regulations with regards to handling, processing, or using Health Care Data. This includes but is not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations as it pertains to this agreement, and the Contractor shall keep abreast of the regulations. Since this is a federal law and the regulations apply to all health care information, the Contractor shall comply with the HIPAA regulations at no additional cost to DMAS. The Contractor will also be required to enter into a DMAS-supplied HIPAA Business Associate Agreement with DMAS to comply with the regulations protecting Health Care Data. A template of this Agreement is available on the DMAS Internet Site at [http://dmasva.dmas.virginia.gov/Content\\_pgs/ab-ocs.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/ab-ocs.aspx)

#### **10.18 Obligation of Contractor**

By submitting a proposal, the Contractor covenants and agrees that it has satisfied itself of the conditions to be met, and fully understands its obligations, and that it will have no right to cancel its proposal or to relief of any other nature because of its misunderstanding or lack of information.

#### **10.19 Independent Contractor**

Any Contractor awarded a contract under this RFP will be considered an independent Contractor, and neither the Contractor, nor personnel employed by the Contractor, is to be considered an employee or agent of DMAS.

#### **10.20 Ownership of Intellectual Property**

All copyright and patent rights to all papers, reports, forms, materials, creations, or inventions created or developed in the performance specific to this contract shall become the sole property of the Commonwealth. DMAS shall have open access to the above. On request, the Contractor shall promptly provide an acknowledgement or assignment in a tangible form satisfactory to the Commonwealth to evidence the Commonwealth's sole ownership of specifically identified intellectual property created or developed in the performance of the contract.

#### **10.21 Subsidiary-Parent Relationship**

In the event the Offeror is a subsidiary or division of a parent organization, the Offeror must include in the proposal, a signed statement by the chief executive officer of the parent organization pledging the full resources of the parent organization to meet the responsibilities of the subsidiary organization under contract to the Department. DMAS must be notified within 10 days of any change in ownership as well as a letter explaining how the changes affect the Contractor's relationship with the Department. Any change in ownership will not relieve the original parent of its obligation of pledging its full resources to meet the obligations of the contract with DMAS without the expressed written consent of the DMAS Director.

## **10.22 Business Transactions Reporting**

The Contractor shall notify the Department within five (5) calendar days after any publicly announced acquisition agreement, pre-merger agreement, or pre-sale agreement impacting the Contractor's ownership. Business transactions to be disclosed include, but are not limited to:

- a. Any sale, exchange, or lease of any property between the Contractor and a Party in Interest;**
- b. Any lending of money or other extension of credit between the Contractor and a Party in Interest; and**
- c. Any furnishing for consideration of goods, services (including management services) or facilities between the Contractor and a Party in Interest. Business transactions for purposes of this section do not include salaries paid to employees for services provided in the normal course of employment by the Contractor.**

The Contractor shall advise the Department, in writing, within five (5) business days of any organizational change or major decision affecting its Medicaid business in Virginia or other states. This includes but is not limited to sale of existing business to other entities or a complete exit from the Medicaid market in another state or jurisdiction.

## **10.23 eVA Business-To-Government Contracts and Orders**

The solicitation/contract will result in 1 purchase order(s) with the eVA transaction fee specified below assessed for each order.

- a. For orders issued prior to August 16, 2006, the Vendor Transaction Fee is 1%, capped at a maximum of \$500 per order.
- b. For orders issued August 16, 2006 and after, the Vendor Transaction Fee is:
  - (i) DMBE-certified Small Businesses: 1%, Capped at \$500 per order.
  - (ii) Businesses that are not DMBE-certified Small Businesses: 1%, Capped at \$1,500 per order.

The eVA transaction fee will be assessed approximately 30 days after each purchase order is issued. Any adjustments (increases/decreases) will be handled through eVA change orders.

Internet electronic procurement solution, website portal [www.eVA.virginia.gov](http://www.eVA.virginia.gov), streamlines and automates government purchasing activities in the Commonwealth. The portal is the gateway for vendors to conduct business with state agencies and public bodies.

Vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-procurement solution and agree to comply with the following:

If this solicitation is for a term contract, failure to provide an electronic catalog (price list) or index page catalog for items awarded will be just cause for the Commonwealth to reject your bid/offer or terminate this contract for default. The format of this electronic catalog shall conform to the eVA Catalog Interchange Format (CIF) Specification that can be accessed and downloaded from [www.eVA.virginia.gov](http://www.eVA.virginia.gov). Contractors should email Catalog or Index Page information to [eVA-catalog-manager@dgs.virginia.gov](mailto:eVA-catalog-manager@dgs.virginia.gov).

#### **10.24 Compliance with Virginia Information Technology Accessibility Standard**

The Contractor shall comply with all State laws and Regulations with regards to accessibility to information technology equipment, software, networks, and web sites used by blind and visually impaired individuals. This accessibility standards are State law see § 2.2-3502 and § 2.2-3503 of The Code of Virginia. Since this is a State law and the regulations apply to accessibility to information technology equipment, software, networks, and web sites used by blind and visually impaired individuals, the Contractor shall comply with the Accessibility Standards at no additional cost to the Department. The Contractor must also keep abreast of any future changes to The Virginia Code as well as any subsequent revisions to the Virginia Information Technology Standards. The current Virginia Information Technology Accessibility Standards are published on the Internet at <http://www.vita.virginia.gov/library/default.aspx?id=663>

#### **10.25 Continuity of Services**

- a) The Contractor recognizes that the services under this contract are vital to the Agency and must be continued without interruption and that, upon contract expiration, a successor, either the Agency or another contractor, may continue them. The Contractor agrees:
  - (i.) To exercise its best efforts and cooperation to effect an orderly and efficient transition to a successor;
  - (ii.) To make all Agency owned facilities, equipment, and data available to any successor at an appropriate time prior to the expiration of the contract to facilitate transition to successor; and
  - (iii.) That the Agency Contracting Officer shall have final authority to resolve disputes related to the transition of the contract from the Contractor to its successor.
- b) The Contractor shall, upon written notice from the Contract Officer, furnish phase-in/phase-out services for up to ninety (90) days after this contract expires and shall negotiate in good faith a plan with the successor to execute the phase-in/phase-out services. This plan shall be subject to the Contract Officer's approval.
- c) The Contractor shall be reimbursed for all reasonable, pre-approved phase-in/phase-out costs (i.e., costs incurred within the agreed period after contract expiration that result from phase-in, phase-out operations) and a fee (profit) not to exceed a pro rata portion of the fee (profit) under this contract. All phase-in/phase-out work fees must be approved by the Contract Officer in writing prior to commencement of said work.

#### **10.26 STATE CORPORATION COMMISSION IDENTIFICATION NUMBER:**

Pursuant to Code of Virginia, §2.2-4311.2 subsection B, a bidder or Offeror organized or authorized to transact business in the Commonwealth pursuant to Title 13.1 or Title 50 is required to include in its bid or proposal the identification number issued to it by the State Corporation Commission (SCC). Any bidder or Offeror that is not required to be authorized to transact business in the Commonwealth as a foreign business entity under Title 13.1 or Title 50 or as otherwise required by law is required to include in its bid or proposal a statement describing why the bidder or Offeror is not required to be so authorized.

#### **10.27 Subcontracts**

No portion of the work shall be subcontracted without prior written consent of the purchasing agency. In the event that the contractor desires to subcontract some part of the work specified herein, the contractor

shall furnish the purchasing agency the names, qualifications and experience of their proposed subcontractors. The contractor shall, however, remain fully liable and responsible for the work to be done by its subcontractor(s) and shall assure compliance with all requirements of the contract.

#### **10.28 DMAS/CMS/ADA License Agreement for use of CDT**

The American Dental Association (ADA) holds all copyright, trademark and other rights related to the use of current dental terminology (CDT). The Contractor will assure that all forms of information containing CDT codes used for the *Smiles For Children* program are disseminated in accordance with all related copyright laws and regulations as well as the guidelines established by the ADA. Guidelines and be found in Attachment XIII.

## **ATTACHMENT I – DENTAL AND ORAL HEALTH SERVICES BENEFITS**

That Contractor shall accept, process and pay dental claims from participating dental providers for covered dental services referenced in the current Exhibits A and B of the Office Reference Manual and using the most current code on dental procedures and nomenclature. (See Exhibits A and B in the Office Reference Manual located at [http://www.dmas.virginia.gov/dental-providers\\_home.htm](http://www.dmas.virginia.gov/dental-providers_home.htm))

## ATTACHMENT II – EPSDT REQUIREMENTS

### MEDICAID and EPSDT

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at section 1905(a) of the Act be provided to an EPSDT member even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.

The EPSDT program consists of two mutually supportive, operational components:

*(1) assuring the availability and accessibility of required health care resources; and (2) helping Medicaid members and their parents or guardians effectively use these resources.*

These components enable Medicaid agencies to manage a comprehensive child health program of prevention and treatment, to seek out eligible members and inform them of the benefits of prevention and the health services and assistance available and to help them and their families use health resources, including their own talents and knowledge, effectively and efficiently. It also enables them to assess the child's health needs through initial and periodic examinations and evaluations, and also to assure that the health problems found are diagnosed and treated early, before they become more complex and their treatment more costly.

### Periodicity Schedule

Periodicity schedules for Periodic Screening, Vision, and Hearing services must be provided at intervals that meet reasonable standards of medical practice. States must consult with recognized medical organizations involved in child health care in developing reasonable standards.

Dental services must be provided at intervals determined to meet reasonable standards of dental practice. States must consult with recognized dental organizations involved in child health care to establish those intervals. A direct dental referral is required for every child in accordance with each state's periodicity schedule and at other intervals as medically necessary. The periodicity schedule for other EPSDT services may not govern the schedule for dental services. It is expected that older children may require dental services more frequently than physical examinations.

The EPSDT benefit, in accordance with section 1905(r) of the Act, must include the following services:

**Screening Services** -- Screening services shall include all of the following services:

- **Comprehensive health and developmental history** -- (including assessment of both physical and mental health development);
- **Comprehensive unclothed physical exam;**
- **Appropriate immunizations** -- (according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines);

- **Laboratory tests** -- Identify as statewide screening requirements the minimum laboratory tests or analyses to be performed by medical providers for particular age or population groups;

Lead Toxicity Screening - All children are considered at risk and must be screened for lead poisoning. CMS requires that all children receive a screening blood lead test at 12 months and 24 months of age. Children between the ages of 36 months and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test must be used when screening Medicaid-eligible children. A blood lead test result equal to or greater than 10 ug/dl obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample.

At this time, States may not adopt a statewide plan for screening children for lead poisoning that does not require lead screening for all Medicaid-eligible children.

- **Health Education** -- Health education is a required component of screening services and includes anticipatory guidance. At the outset, the physical and/or dental screening provides the initial context for providing health education. Health education and counseling to both parents (or guardians) and children is required and is designed to assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy lifestyles and practices as well as accident and disease prevention;
- **Vision Services** -- At a minimum, include diagnosis and treatment for defects in vision, including eyeglasses. Vision services must be provided according to a distinct periodicity schedule developed by the state and at other intervals as medically necessary;
- **Dental Services** -- At a minimum, include relief of pain and infections, restoration of teeth and maintenance of dental health. Dental services may not be limited to emergency services. Although an oral screening may be part of a physical examination, it does not substitute for examination through direct referral to a dentist. A direct dental referral is required for every child in accordance with the periodicity schedule developed by the state and at other intervals as medically necessary. The law as amended by OBRA 1989 requires that dental services (including initial direct referral to a dentist) conform to the state periodicity schedule which must be established after consultation with recognized dental organizations involved in child health care;

["The Guide to Children's Dental Care in Medicaid"](http://www.cms.gov/MedicaidEarlyPeriodicScrn/downloads/EPSTDDentalGuide.pdf) is now available through the CMS web site at:

<http://www.cms.gov/MedicaidEarlyPeriodicScrn/downloads/EPSTDDentalGuide.pdf>

- **Hearing Services** -- At a minimum, include diagnosis and treatment for defects in hearing, including hearing aids; and
- **Other Necessary Health Care** -- Provide other necessary health care, diagnosis services, treatment, and other measure described in section 1905(a) of the Act to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services.

**Diagnosis** -- When a screening examination indicates the need for further evaluation of an individual's health, provide diagnostic services. The referral should be made without delay and follow-up to make sure that the member receives a complete diagnostic evaluation. If the member is receiving care from a continuing care provider, diagnosis may be part of the screening and examination process. States should develop quality assurance procedures to assure comprehensive care for the individual.

**Treatment** -- Health care must be made available for treatment or other measures to correct or ameliorate defects and physical and mental illnesses or conditions discovered by the screening services.

**Lead Poisoning Prevention** -- Screening for lead poisoning is a required component of an EPSDT screen. Current CMS policy requires a screening blood lead test for all Medicaid-eligible children at 12- and 24-months of age. In addition, children over the age of 24 months, up to 72 months of age, should receive a screening blood lead test if there is no record of a previous test. Any additional diagnostic and treatment services determined to be medically necessary must also be provided to a child diagnosed with an elevated blood lead level.

**State Medicaid Agency required activities** --

- States must inform all Medicaid-eligible persons under age 21 that EPSDT services are available.
- States must set distinct periodicity schedules for screening, dental, vision, and hearing services.
- States must report EPSDT performance information annually (CMS Form-416). The authority for requiring states to submit the annual report is section 1902(a)(43) of the Social Security Act (the Act). Each state must report annually for each Federal fiscal year if they administer or supervise the administration of an approved plan for a Federally aided title XIX program. The statute requires that states provide us with the following: (1) the number of children provided child health screening services, (2) the number of children referred for corrective treatment, (3) the number of children receiving dental services, and (4) the state's results in attaining goals set for the state under section 1905(r) of the Act. The form CMS-416 was developed to collect this information.

**The annual EPSDT report (Form CMS-416)**

The CMS-416 report provides basic information on participation in the Medicaid child health program. The information is used to assess the effectiveness of State EPSDT programs in terms of the number of children (by age group and basis of Medicaid eligibility), who are provided child health screening services, are referred for corrective treatment, and the number receiving dental services. Child health screening services are defined for purposes of reporting on this form as initial or periodic screens required to be provided according to a state's screening periodicity schedule.

**Recommendations for Preventive Pediatric Dental Care**

Dental services shall be provided at intervals that meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care. Dental services shall be provided at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition. Dental services must at a minimum include relief of pain and infection, restoration of teeth, and maintenance of dental health.

Federal EPSDT regulations require that States establish distinct periodicity schedules for medical, vision, hearing and dental screenings. The PCP, other screening provider or Dental Contractor must refer children three (3) years of age and older for a complete dental evaluation by a Medicaid enrolled dentist.

**Referral to Dental Screening**

Members may access dental care without first obtaining a referral from their primary care provider or a physician screener. Federal EPSDT regulations require a direct referral to a dentist beginning at age three. An oral inspection must be performed by the EPSDT screening provider as part of each physical

examination for a child screened at any age. Tooth eruption, caries, bottle tooth decay, developmental anomalies, malocclusion, pathological conditions or dental injuries must be noted. The oral inspection is not a substitute for a complete dental evaluation provided through direct referral to a dentist.

The PCP or other screening provider must make an initial direct referral to a dentist when the child receives his or her three-year screening. The initial dental referral must be provided at the initial medical screening regardless of the periodicity schedule on any child age three or older unless it is known and documented that the child is already receiving regular dental care. The importance of regular dental care must be discussed with the family (and child as appropriate) on each screening visit for children three (3) years and older. When any screening, even as early as the neonatal examination, indicates a need for dental services at an earlier age, referral must be made for needed dental services.

### ATTACHMENT III - LIQUIDATED DAMAGES AND SANCTIONS

#### LIQUIDATED DAMAGES

The Department may impose any or all of the liquidated damages below upon reasonable determination that the Contractor fails to comply with any corrective action plan (CAP) or is otherwise deficient in the performance of its obligations under the RFP, provided, however, that the Department only imposes those damages it determines to be appropriate for the deficiencies identified. The Department may impose intermediate damages on the Contractor simultaneously with the development and implementation of a corrective action plan if the deficiencies are severe or numerous.

##### A Reports and Deliverables:

For each day that an agreed upon report or deliverable is late, incorrect, or deficient, the Contractor shall be liable to the Department for liquidated damages in the amount of \$100 per work day per report or deliverable, except that if the delivery be delayed by any act, negligence, or default on the part of the Commonwealth, public enemy, war, embargo, fire, or explosion not caused by the negligence or intentional act of the contractor or his supplier(s), or by riot, sabotage, or labor trouble that results from a cause or causes entirely beyond the control or fault of the contractor or his supplier(s), a reasonable extension of time as the procuring public body deems appropriate may be granted. Upon receipt of a written request and justification for any extension from the contractor, the purchasing office may extend the time for performance of the contract or delivery of goods herein specified, at the purchasing office's sole discretion, for good cause shown.

Liquidated damages for late reports shall begin on the first day the report is late. Liquidated damages for incorrect reports (except ad hoc or on-request reports), or deficient deliverables shall begin on the sixteenth day after notice is provided from the Department to the Contractor that the report remains incorrect or the deliverables remain deficient; provided, however, that it is reasonable to correct the report or deliverable within fifteen (15) calendar days. For the purposes of determining liquidated damages in accordance with this Section, reports or deliverables are due in accordance with the following schedule, unless otherwise specified elsewhere in this RFP:

<u>DELIVERABLES</u>	<u>DATE AGREED UPON BY THE PARTIES</u>
Monthly Reports	15th day of month for prior month reporting.
Quarterly Reports	30 calendar days after the end of each quarter.
Annual Reports	Within ninety (90) calendar days of the effective contract date. (contract date)
Ad Hoc	Within ten (10) working days from the date of the request, or agreed upon date, when reasonable unless otherwise specified by Department.

##### B Program Issues

Liquidated damages for failure to perform specific responsibilities as described in this RFP are shown below

	<u>PROGRAM ISSUES</u>	<u>DAMAGE</u>
1.	Failure to comply with Appeals notice requirements of the Department's rules and regulations or any subsequent amendments thereto and all court orders governing appeal procedures, as they become effective. This includes notice of the right to appeal, appeals summaries, and timeliness requirements.	\$500 per calendar day for each day beyond the required time frame that the appeal is unanswered in each and every aspect and/or each day the appeal is not handled according to the provisions set forth by this RFP or required by the Department
2.	Failure to forward an expedited appeal to the Department in twenty-four (24) hours or a standard appeal in five (5) days.	\$500 per calendar day.
3.	Failure to submit provider appeals summaries shall result in the Contractor being liable for any costs that DMAS incurs as a result of the contractor's noncompliance.	Costs that DMAS incurs as a result of the Contractor's noncompliance.
4.	Failure to attend or defend the Contractor's decisions at provider appeal hearings or conferences shall result in the Contractor being liable for any costs that DMAS incurs as a result of the contractor's noncompliance.	Costs that DMAS incurs as a result of the Contractor's noncompliance.
5.	Failure to submit enrollee appeals summaries shall result in the Contractor being liable for a liquidated damage of \$100 per calendar day for each day that the appeal summary is late.	\$100 per calendar day for each day that the appeal summary is late.
6.	Failure to attend or defend the Contractor's decisions at enrollee appeal hearings or conferences shall result in the Contractor being liable for a liquidated damage of \$100 per calendar day for each day that the hearing or conference is delayed as a result of the contractor's noncompliance.	\$100 per calendar day for each day that the hearing or conference is delayed as a result of the contractor's noncompliance.
7.	Failure to complete or comply with corrective action plans as required by the Department.	\$500 per calendar day for each day the corrective action is not completed or complied with as required.
8.	Employment of licensed personnel.	\$250 per calendar day for each day that personnel are not licensed as required by applicable state law, regulations, and/or this contract.
9.	Failure to comply in any way with	\$250 per calendar day.

	<u>PROGRAM ISSUES</u>	<u>DAMAGE</u>
	staffing requirements as described in this RFP.	
10.	Failure to comply in any way with Member Material and Communication Requirements in Section 4.2. Requirements include the design, production and distribution (including all distribution costs such as postage) of member materials, including but not limited to brochures, provider directories, fact sheets, notices, or any other material necessary to provide information to members.	\$250 per calendar day.
11.	Failure to comply in any way with Outreach Activities in Section 4.7. Outreach activities include activities to increase utilization, appointment assistance, correcting non-compliant members, coordination with public health and other community organizations and as determined by the Department.	\$250 per calendar day.
12.	Failure to comply in any way Notification of Subcontractor Terminations in Section 4.11.4. When a subcontract that relates to the provision of services to members or claims processing services is being terminated between the Contractor and a subcontractor, the Contractor shall give at least thirty (30) days prior written notice of the termination to the Department. Such notice shall include, at a minimum, a Contractor's intent to change to a new subcontractor for the provision of said services, an effective date for termination and/or change, as well as any other pertinent information that may be needed. In addition to prior written notice, the Contractor shall also provide the Department with a transition plan, when requested, which shall include, at a minimum, information regarding how service authorization requests will be handled during and after the transition, and how continuity of care will be	\$500 per calendar day.

	<u>PROGRAM ISSUES</u>	<u>DAMAGE</u>
	maintained for the members. The Contractor's transition plan shall also include provisions to notify impacted or potentially impacted providers and members of the change.	
13.	Failure to comply in any way with Deductions in Section 6.2.7. Deductions include adjustments for interest earned on provider payments, claims not validated in encounter submissions (as described in Section 6.2.4) and liquidated damages.	\$100 per calendar day.
14.	Failure to comply in any way with Timeliness and Accuracy of Payment in Section 4.13 and 42 CFR §447.45. Timeliness and accuracy of payment require that the Contractor shall have in place an automated claims processing system, an electronic data processing system, the ability to reimburse and Medicaid established rates, and HIPAA compliance. The Contractor shall ensure that ninety percent (90%) of clean claims for payment of services delivered to members (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of receipt of such claims. The Contractor shall process, and, if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered.	\$1000 per calendar day.
15.	Failure to comply in any way with Other Reporting Requirements in Section 4.20.15 or any other terms in this RFP. Reports include monthly and ad hoc reports requested by the Department. The Contractor will assure compliance with CHIPRA and state/federal health reform initiatives.	\$100 per calendar day.

C Payment of Liquidated Damages

It is further agreed by the Department and the Contractor that any liquidated damages assessed by the Department shall be due and payable to the Department within thirty (30) calendar days after Contractor's receipt of the notice of damages and if payment is not made by the due date, the amount of said liquidated damages may be withheld from future payments by the Department without further notice. It is agreed by the Department and the Contractor that the collection of liquidated damages by the Department shall be made without regard to any appeal rights the Contractor may have pursuant to this RFP; however, in the event an appeal by the Contractor results in a decision in favor of the Contractor, any such funds withheld by the Department will be immediately returned to the Contractor. The due dates mentioned above may be delayed if the Contractor can show good cause as to why a delay should be granted. The Department has sole discretion in determining whether good cause exists for delaying the due dates.

The Contractor shall be liable for all liquidated damages imposed by DMAS. Any dispute between the Contractor and any provider/subcontractor regarding responsibility for any events giving rise to the imposition of liquidated damages shall not relieve the Contractor of their liability for said damages.

All liquidated damages imposed pursuant to this RFP, whether paid or due, shall be paid by the Contractor out of administrative and management costs and profits.

**ATTACHMENT IV- CERTIFICATION OF ENCOUNTER DATA**

**CERTIFICATION**

Pursuant to the contract(s) between Virginia and the (enter name of business entity) managed care organization (MCO), the MCO certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the Virginia Medical Assistance Program as a MCO, (insert Plan identification number(s) here). The (enter name of business) MCO acknowledges that if payment is based on encounter data, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The MCO hereby requests payment from the Virginia Medical Assistance Program under contracts based on encounter data submitted and in so doing makes the following certification to Virginia as required by the Federal regulations at 42 CFR 438.600 (et. al.).

**The (enter name of business) MCO has reported to Virginia for the month of (indicate month and year) all new encounters (indicate type of data such as – Mental Health – Institutional, Mental Health – Professional, Medical – Institutional, Medical – Professional, Pharmacy, Transportation, Dental, Vision, Laboratory). The (enter name of business) MCO has reviewed the encounter data for the month of (indicate month and year) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to Virginia in this report is accurate, complete, and truthful.**

**NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM. I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO THE (Enter Name of Business) MCO. I UNDERSTAND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT.**

Furthermore, by signing below, the Managed Care Organization attests that the paid claim amount is a proprietary field to be held as such by the Department of Medical Assistance Services. The Managed Care Organization states the following as to why protection is necessary: \_\_\_\_\_  
\_\_\_\_\_. This information shall not be released, pursuant to the authority of the COV sec. 2.2-4342(F) 2.23705.6, except as required for purposes of the administration of the Title XIX State Plan for Medical Assistance.

\_\_\_\_\_  
**(INDICATE NAME AND TITLE (CFO, CEO, OR DELEGATE)  
on behalf of**

\_\_\_\_\_  
**(INDICATE NAME OF BUSINESS ENTITY)**

\_\_\_\_\_  
**DATE**

**ATTACHMENT V - CERTIFICATION OF DATA (NON-ENCOUNTER)**

**CERTIFICATION**

Pursuant to the contract(s) between Virginia and the (enter name of business entity) managed care organization (MCO), the MCO certifies that: the business entity named on this form is a qualified provider enrolled with and authorized to participate in the Virginia Medical Assistance Program as a MCO Plan, (insert Plan identification number(s) here). The (enter name of business) MCO acknowledges that if payment is based on any information required by the State and contained in contracts, proposals, and related documents, Federal regulations at 42 CFR 438.600 (et. al.) require that the data submitted must be certified by a Chief Financial Officer, Chief Executive Officer, or a person who reports directly to and who is authorized to sign for the Chief Financial Officer or Chief Executive Officer.

The MCO hereby requests payment from the Virginia Medical Assistance Program under contracts based on any information required by the State and contained in contracts, proposals, and related documents submitted and in so doing makes the following certification to Virginia as required by the Federal regulations at 42 CFR 438.600 (et. al.).

**The (enter name of business) MCO has reported to Virginia for the period of (indicate dates) all information required by the State and contained in contracts, proposals, and related documents submitted. The (enter name of business) MCO has reviewed the information submitted for the period of (indicate dates) and I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) attest that based on best knowledge, information, and belief as of the date indicated below, all information submitted to Virginia is accurate, complete, and truthful.**

**NO MATERIAL FACT HAS BEEN OMITTED FROM THIS FORM. I, (enter Name of Chief Financial Officer, Chief Executive Officer or Name of Person Who Reports Directly To And Who Is Authorized To Sign For Chief Financial Officer, Chief Executive Officer) ACKNOWLEDGE THAT THE INFORMATION DESCRIBED ABOVE MAY DIRECTLY AFFECT THE CALCULATION OF PAYMENTS TO THE (Enter Name of Business) MCO. I UNDERSTAND THAT I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT.**

Furthermore, by signing below, the Managed Care Organization attests that the paid claim amount is a proprietary field to be held as such by the Department of Medical Assistance Services. The Managed Care Organization states the following as to why protection is necessary:

\_\_\_\_\_. This information shall not be released, pursuant to the authority of the COV sec. 2.2-4342(F) and 2.2-3705.6, except as required for purposes of the administration of the Title XIX State Plan for Medical Assistance.

\_\_\_\_\_  
**(INDICATE NAME AND TITLE  
(CFO, CEO, OR DELEGATE)  
on behalf of**

\_\_\_\_\_  
**(INDICATE NAME OF BUSINESS)  
DATE**

**ATTACHMENT VI – ACCIDENT/TRAUMA, WORKERS COMPENSATION, AND TPL  
COVERAGE**

**EXCEL SPREADSHEET REPORTING FORMAT**

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**IDENTIFIED ACCIDENT / TRAUMA CLAIM INFORMATION**

MEMBER IDENTIFICATION NUMBER  
MEMBER NAME  
BIRTHDATE  
PROVIDER OF SERVICE NAME  
DIAGNOSIS CODE  
PROCEDURE CODE  
DATE OF ACCIDENT  
DATE OF SERVICE  
AMOUNT BILLED  
AMOUNT PAID

---

**IDENTIFIED WORKERS COMPENSATION CLAIM INFORMATION**

MEMBER IDENTIFICATION NUMBER  
MEMBER NAME  
BIRTHDATE  
PROVIDER OF SERVICE NAME  
WORK RELATED DIAGNOSIS  
PROCEDURE CODE  
DATE OF ACCIDENT  
DATE OF SERVICE  
AMOUNT BILLED  
AMOUNT PAID

---

**IDENTIFIED HEALTH INSURANCE INFORMATION**

<b>MEMBER ID</b>	<b>MEMBER NAME</b>	<b>BIRTHDATE</b>	<b>OTHER INSURER POLICY ID</b>	<b>OTHER INSURER NAME (OI)</b>	<b>(OI) ADDRESS1</b>	<b>(OI) ADDRESS2</b>	<b>(OI) CITY</b>	<b>(OI) ST</b>	<b>(OI) ZIP</b>	<b>(OI) ZIP+4</b>	<b>POLICY #</b>	<b>POLICY EFFECTIVE DATE</b>

## **ATTACHMENT VII - THE 2010 APPROPRIATIONS ACT**

### **2010 Acts of Assembly, Chapter 874**

#### Item 297(G)

The Department of Medical Assistance Services and the Virginia Department of Health shall work with representatives of the dental community: to expand the availability and delivery of dental services to pediatric Medicaid recipients; to streamline the administrative processes; and to remove impediments to the efficient delivery of dental services and reimbursement thereof. The Department of Medical Assistance Services shall report its efforts to expand dental services to the Chairmen of the House Appropriations and Senate Finance Committees and the Department of Planning and Budget by December 15 each year.

#### Item 297(J)

The Department of Medical Assistance Services shall not require dentists who agree to participate in the delivery of Medicaid pediatric dental care services, or services provided to enrollees in the Family Access to Medical Insurance Security (FAMIS) Plan or any variation of FAMIS, to also deliver services to subscribers enrolled in commercial plans of the managed care vendor, unless the dentist is a willing participant in the commercial managed care plan.

#### Item 297(DDDD.1-3)

1. Effective July 1, 2010, the Department of Medical Assistance Services shall reduce the rates for dental services by 3.0 percent.
2. Effective July 1, 2011, the Department of Medical Assistance Services shall reduce the rates for dental services by 4.0 percent below the rates in effect on June 30, 2010.
3. If there is an extension through June 30, 2011 of increased Federal Medical Assistance Percentage under the American Recovery and Reinvestment Act (P.L. 111-5), the reduction in this paragraph shall not become effective. This contingent appropriation is subject to the provisions of paragraph KKKK. in this Item.

**ATTACHMENT VIII - DENTAL MONTHLY SUMMARY REPORT (MM-CCYY)**

<b>ENROLLEES</b>	<b>NUMBER</b>	
NUMBER OF ACTIVE ENROLLEES FOR THE MONTH		
<b>CLAIMS VOLUME</b>	<b>NUMBER</b>	
MONTH BEGIN INVENTORY		
RECEIVED THIS MONTH		
PROCESSED THIS MONTH		
MONTH END INVENTORY		
<b>SERVICES PROCESSED FOR THE MONTH</b>	<b>NUMBER</b>	<b>PERCENT</b>
NUMBER PAID THIS MONTH		
NUMBER DENIED THIS MONTH		
NUMBER PENDED THIS MONTH		
<b>TOTAL:</b>		
<b>PROCESSING TIME FOR CLEAN CLAIMS</b>	<b>NUMBER</b>	<b>PERCENT</b>
PERCENT PROCESSED WITHIN 30 DAYS		
<b>TOTAL:</b>		
<b>DENTAL AUTHORIZATIONS</b>	<b>NUMBER</b>	<b>PERCENT</b>
<b>NUMBER OF PRIOR AUTHORIZATIONS</b>		
NUMBER APPROVED		
NUMBER ADMINISTRATIVE DENIALS		
NUMBER CLINICAL DENIALS		
PRIOR AUTHORIZATIONS - TURNAROUND TIME (DAYS)		
<b>NUMBER OF PRE-PAYMENT REVIEWS</b>		
NUMBER APPROVED		
NUMBER ADMINISTRATIVE DENIALS		
NUMBER CLINICAL DENIALS		
PRE-PAYMENT TURNAROUND TIME (DAYS)		
<b>DENTAL UTILIZATION</b>	<b>NUMBER</b>	<b>PERCENT</b>
MEDICAID/FAMIS PLUS CHILDREN UNDER AGE 21		
FAMIS CHILDREN		
ADULTS		
TOTAL ENROLLEES SERVED		
<b>DENTAL PROVIDERS</b>	<b>NUMBER</b>	<b>PERCENT</b>
NUMBER WITH OPEN PANELS		
NUMBER WITH RESTRICTED PANELS (EPO ONLY)		
TOTAL		
<b>MEMBER SERVICES</b>	<b>NUMBER</b>	
NUMBER OF MEMBER GRIEVANCES		
NUMBER OF PROVIDER GRIEVANCES		
NUMBER OF STATE GRIEVANCES		
NUMBER OF APPEALS		

**ATTACHMENT IX - REFERENCES**

RFP 2011-03

Reference Form:

Contract Name:	
Customer name and address:	
Customer contact and title:	
Contact Phone number:	
Scope of Services of Contract:	
Contract Type (fixed price, fee for service, capitation, etc)	
Contract Size (# of members eligible, # of members served, etc):	
Contract Period	
Number of Contractor staff assigned to contract:	
Annual Value of Contract:	

**ATTACHMENT X - COST PROPOSAL  
OFFEROR'S COST DETAILS FOR PRICING  
(Reference RFP Section 6.2 )  
Schedule A-1: Total Price**

Item	Subtotal	Price
Start-up/Implementation cost: For period between date of signing contract with DMAS and date of start of operations.		\$
Pediatric Dental Annual Cost (Average Annual Cost from Schedule B-1)	\$	
Pediatric Dental Total Price (Annual Cost times 4 years)		\$
Adult Dental Annual Cost (Average Annual Cost from Schedule B-1)	\$	
Adult Dental Total Price (Annual Cost times 4 years)		\$
Total Cost Proposal (Start-up/Implementation plus Pediatric and Adult Dental 4 year cost)		\$
<i>Note: The Total Cost Proposal dollar amount will also be used for RFP 2011-03 Small Business Subcontracting Plan Scoring purposes.</i>		

**Schedule B-1: PMPM Calculation Chart**

<u>PMPM Category</u>	<u>Per Member Per Month (PMPM) Cost</u>	<u>Average Monthly Enrollment Volumes<sup>1</sup></u>	<u>Average Monthly Cost</u> (PMPM x Avg. Monthly Enrollment)	<u>Average Annual Cost<sup>3</sup></u> (Average Monthly Cost x 12 months)
<b>Pediatric Dental PMPM<sup>2</sup></b>	\$	<b>525,974</b>	\$	\$
<b>Adult Dental PMPM</b>	\$	<b>251,064</b>	\$	\$
<p><b>Note 1:</b> Average Monthly Enrollment Volumes based on numbers provided in RFP section 6.2 and divided by 12 months.</p> <p><b>Note 2:</b> Pediatric Dental PMPM includes eligible members in the Medicaid Children, Medicaid Expansion, and FAMIS member categories. Reference RFP Section 6.2 for details.</p> <p><b>Note 3:</b> Average annual cost calculated by the Offeror in this table does not represent the actual amounts to be paid in the performance of the contract. Amount paid to the winning Offeror in the performance of the contract will be based on their proposed PMPM and the actual monthly enrollments for each category.</p>				

**Schedule C-1: Optional Enhanced Benefits**

<b><u>PMPM Category<sup>1</sup></u> <b><u>(Description of Services)</u></b></b>	<b><u>Additional Per Member Per Month (PMPM) Cost</u></b>	<b><u>Estimated Average Monthly Enrollment Volumes<sup>2</sup></u></b>	<b><u>Average Monthly Cost</u> <b><u>(PMPM x Avg. Monthly Enrollment)</u></b></b>	<b><u>Average Annual Cost</u> <b><u>(Average Monthly Cost x 12 months)</u></b></b>
	\$		\$	\$
	\$		\$	\$
<p><b>Note 1:</b> Optional PMPM Category/Enhanced Benefits must also be detailed in the Offeror's Technical Proposal</p> <p><b>Note 2:</b> Offeror shall also detail how estimated average monthly enrollment volumes were determined in their Technical Proposal.</p>				

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name & Title

\_\_\_\_\_  
Company

\_\_\_\_\_  
Date

**ATTACHMENT XI - SMALL BUSINESS AND SUBCONTRACTING PLAN**

**Small Business Subcontracting Plan**

**Definitions**

**Small Business:** "Small business " means an independently owned and operated business which, together with affiliates, has 250 or fewer employees, or average annual gross receipts of \$10 million or less averaged over the previous three years. Note: This shall not exclude DMBE-certified women- and minority-owned businesses when they have received DMBE small business certification.

**Women-Owned Business:** Women-owned business means a business concern that is at least 51% owned by one or more women who are citizens of the United States or non-citizens who are in full compliance with United States immigration law, or in the case of a corporation, partnership or limited liability company or other entity, at least 51% of the equity ownership interest is owned by one or more women who are citizens of the United States or non-citizens who are in full compliance with United States immigration law, and both the management and daily business operations are controlled by one or more women who are citizens of the United States or non-citizens who are in full compliance with the United States immigration law.

**Minority-Owned Business:** Minority-owned business means a business concern that is at least 51% owned by one or more minority individuals or in the case of a corporation, partnership or limited liability company or other entity, at least 51% of the equity ownership interest in the corporation, partnership, or limited liability company or other entity is owned by one or more minority individuals and both the management and daily business operations are controlled by one or more minority individuals.

**All small businesses must be certified by the Commonwealth of Virginia, Department of Minority Business Enterprise (DMBE) by the due date of the solicitation to participate in the SWAM program. Certification applications are available through DMBE online at [www.dmbv.org](http://www.dmbv.org) (Customer Service).**

**Offeror Name:** \_\_\_\_\_

**Preparer Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Instructions**

- A. If you are certified by the Department of Minority Business Enterprise (DMBE) as a small business, complete only Section A of this form. This shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received DMBE small business certification.
- B. If you are not a DMBE-certified small business, complete Section B of this form. For the Offeror to receive credit for the small business subcontracting plan evaluation criteria, the Offeror shall identify the portions of the contract that will be subcontracted to DMBE-certified small business in this section. Points will be assigned based on each Offeror proposed subcontracting expenditures with DMBE certified small businesses for the initial contract period as indicated in Section B in relation to the Offeror's total price.

**Section A**

If your firm is certified by the Department of Minority Business Enterprise (DMBE), are you certified as a (check only one below):

- Small Business
- Small and Women-owned Business
- Small and Minority-owned Business

Certification number: \_\_\_\_\_ Certification Date: \_\_\_\_\_

**Section B**

Populate the table below to show your firm's plans for utilization of DMBE-certified small businesses in the performance of this contract. This shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received the DMBE small business certification. Include plans to utilize small businesses as part of joint ventures, partnerships, subcontractors, suppliers, etc.

**B. Plans for Utilization of DMBE-Certified Small Businesses for this Procurement**

Small Business Name & Address  DMBE Certificate #	Status if Small Business is also: Women (W), Minority (M)	Contact Person, Telephone & Email	Type of Goods and/or Services	Planned Involvement During Initial Period of the Contract	Planned Contract Dollars During Initial Period of the Contract
<b>Totals \$</b>					

**ATTACHMENT XII – ANNUAL DENTAL VISIT (ADV)**

<b>Summary of Changes to HEDIS (report year)</b>		
No changes to this measure.		
<b>Description</b>		
The percentage of members 2-21 years of age who had at least one dental visit during the measurement year. The measure applies only if dental care is a covered benefit in the organization's Medicaid contract.		
<b>Eligible Population</b>		
Product Line	Medicaid	
Ages	2-21 years as of December 31 of the measurement year. Report six age stratifications and a total rate: 2-3 years, 4-6 years, 7-10 years, 11-14 years, 15-18 years, 19-21 years, Total	
Continuous enrollment	The measurement year.	
Allowable Gap	No more than one gap in the enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., member whose coverage lapses for 2 months (60 days) is not considered continuously enrolled)	
Anchor date	December 31 of the measurement year.	
Benefit	Dental.	
Event/Diagnosis	None	
<i>Note: Visits for many one-year-olds will be counted because the specification includes children whose second birthday occurs any time during the measurement year.</i>		
<b>Administrative Specification</b>		
Denominator	The eligible population for each age group and the combined total.	
Numerator	One or more dental visits with a dental practitioner during the measurement year. A member had a dental visit if a submitted claim/encounter contains any code in Table ADV-A.	
<b>Table ADV-A: Codes to Identify Annual Dental Visits</b>		
<b>CPT</b>	<b>HCPCS/CDT-5</b>	<b>ICD-9-CM Procedure</b>
70300, 70310, 70320, 70350, 70355	D0120-D0999, D1110-D2999, D3110-D3999, D4210-D4999, D5110-D5899, D6010-D6205, D7111-D7999, D8010-D8999, D9110-D9999	23,24,87.12, 89.31,93.55, 96.54, 97.22, 97.33 - 97.35, 99.97
<i>Note: Current Dental Terminology (CDT) is the equivalent dental version of the CPT physician procedural coding system.</i>		

<b>Data Elements for Reporting</b>
Organizations that submit HEDIS data to NCQA must provide the following data elements.

<b>Table ADV-1: Data Elements for the Annual Dental Visit</b>	
	<b>Administrative</b>
Measurement year	<b>x</b>
Data collection methodology (Administrative)	<b>x</b>
Eligibility population	<i>For each stratification and total</i>
Numerator events by administrative data	<i>For each stratification and total</i>
Reported rate	<i>For each stratification and total</i>
Lower 95% confidence interval	<i>For each stratification and total</i>
Upper 95% confidence interval	<i>For each stratification and total</i>

**ATTACHMENT XIII – DMAS/CMS/ADA LICENSE AGREEMENT FOR USE OF CDT CODES**

The DMAS/CMS/ADA License Agreement for the use of CDT Codes can be found on the DMAS website at the following location:

[http://dmasva.dmas.virginia.gov/Content\\_pgs/dnt-home.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/dnt-home.aspx)

**ATTACHMENT XIV – CALL CENTER RESPONSE REPORT FORMAT**

Monthly Provider Call Center Response Time	Month	Total of Hours of Daily Call Center Access Provided	Total Agents Available	Total Calls Received	Total Calls Answered	ASA	Total Number Abandoned	Rate	% Answered	Hours Downtime Experienced	Reason	Calls with Average Wait Time of 3 Minutes or Less	Calls with Average Wait Time of 3 Minutes or More	% of Calls with Average Wait Time of 3 Minutes or Less	Avg. Time Prior to Abandonment	Avg. Talk Time
Provider																
Provider																
Provider																
Provider																
Provider																
Provider																
Provider																
Provider																
Provider																
Provider																
Provider																
Provider																
		<b>Annual Total</b>		<b>Annual Total</b>	<b>Annual Total</b>		<b>Annual Total</b>	<b>Annual Average</b>	<b>Annual Average</b>	<b>Annual Total</b>		<b>Annual Total</b>	<b>Annual Average</b>	<b>Annual Average</b>	<b>Annual Average</b>	<b>Annual Average</b>

## **ATTACHMENT XV – 834 VERSION 4010 COMPANION GUIDE**

The 834 Companion Guide is posted on the DMAS website at the following location:

[http://dmasva.dmas.virginia.gov/Content\\_pgs/dnt-home.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/dnt-home.aspx)

**ATTACHMENT XVI – 837 VERSION 4010 COMPANION GUIDE**

The 837 Companion Guide is posted on the DMAS website at the following location:

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**ATTACHMENT XVII - CERTIFICATION OF COMPLIANCE  
WITH PROHIBITION OF POLITICAL CONTRIBUTIONS AND GIFTS DURING THE  
PROCUREMENT PROCESS**

For contracts with a stated or expected value of \$5 million or more except those awarded as the result of  
competitive sealed bidding

I, \_\_\_\_\_, a representative of \_\_\_\_\_,  
*Please Print Name* *Name of Bidder/Offeror*

am submitting a bid/proposal to \_\_\_\_\_ in response to  
*Name of Agency/Institution*

\_\_\_\_\_, a solicitation where stated or expected contract value is  
*Solicitation/Contract #*

\$5 million or more which is being solicited by a method of procurement other than competitive sealed  
bidding as defined in § 2.2-4301 of the *Code of Virginia*.

I hereby certify the following statements to be true with respect to the provisions of §2.2-4376.1 of the  
*Code of Virginia*. I further state that I have the authority to make the following representation on behalf of myself  
and the business entity:

1. The bidder/offeror shall not knowingly provide a contribution, gift, or other item with a value greater than \$50 or make an express or implied promise to make such a contribution or gift to the Governor, his political action committee, or the Governor's Secretaries, if the Secretary is responsible to the Governor for an agency with jurisdiction over the matters at issue, during the period between the submission of the bid/proposal and the award of the contract.
2. No individual who is an officer or director of the bidder/offeror, shall knowingly provide a contribution, gift, or other item with a value greater than \$50 or make an express or implied promise to make such a contribution or gift to the Governor, his political action committee, or the Governor's Secretaries, if the Secretary is responsible to the Governor for an agency with jurisdiction over the matters at issue, during the period between the submission of the bid/proposal and the award of the contract.
3. I understand that any person who violates § 2.2-4376.1 of the *Code of Virginia* shall be subject to a civil penalty of \$500 or up to two times the amount of the contribution or gift, whichever is greater.

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Title*

\_\_\_\_\_  
*Date*