

Exhibit A-Attachment II
Scope of Work – Operations

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Exhibit A, Attachment II
Scope of Work - Operations**A. OPERATIONS REQUIREMENTS****1. Overview**

The Operations period constitutes the Operations work activities required of the Administrative Services Organization (ASO) Contractor in this Contract. The activities described in this chapter shall commence with the startup of Treatment Authorization Request (TAR) processing which is scheduled to take place ten (10) months and fifteen (15) days after Contract Effective Date (CED), which coincides with Takeover (See Exhibit A, Attachment I, Takeover). Operation includes, but is not limited to, customer service Operations, beneficiary and provider outreach, and the adjudication of claims for payment.

2. Objectives

The ASO Contractor shall perform activities that constitute the administrative functions described throughout this Contract. These activities include numerous requirements to be performed by the ASO Contractor, who has the professional and administrative capabilities to facilitate the Medi-Cal Dental Program in bringing dental benefits to the Medi-Cal beneficiaries. Activities include, but are not limited to, the following:

- a. Provider Services and Enrollment;
- b. Beneficiary Services;
- c. Telephone Service Center (TSC);
- d. Processing of all claims/Notice Of Authorizations (NOAs), Claim Inquiry Form (CIF)s, and Treatment of Authorization Request (TARs);
- e. Provider and Beneficiary Outreach;
- f. Surveillance Utilization Reports Profiling; and
- g. Quality Management.

3. Assumptions and Constraints

The Medi-Cal Dental Fee-For-Service program consists of two separate Contracts - one pertaining to the Administrative Services Organization (ASO) Contractor and one pertaining to the Fiscal Intermediary (FI) Contractor. These two Contractors are expected to work in concert with each other to achieve their respective goals and responsibilities outlined in their Contracts to carry out the Operations and policies of the Department.

- a. The ASO Contractor is responsible for all administrative functions of the program, including but not limited to, provider services and enrollment, beneficiary services, TSC functions, and quality management. In addition, the ASO Contractor shall perform all manual TARs processing and all manual claims processing.

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- b. The FI Contractor is responsible for all Operations' functions of the program, including but not limited to, maintaining of all claims data and provider enrollment data; staffing, implementing, and operating an Enterprise Project Management Office (EPMO); ensuring that CD-MMIS accurately and timely auto-adjudicate claims; maintaining a repository for all correspondences between the Department and the ASO and FI Contractors; and quality management.

4. Definition of CD-MMIS

The acronym "CD-MMIS" stands for California Dental Medicaid Management Information System. CD-MMIS has been certified by the Centers for Medicare and Medicaid Services (CMS) as meeting the requirements of the Social Security Act, Title XIX, providing federal matching funds to states implementing a comprehensive dental care program. The current CD-MMIS encompasses all aspects of Operations and requirements operated by the current contractor for the Department. Throughout this Contract, the term "CD-MMIS" is used synonymously with the Denti-Cal Program and the Medi-Cal Dental Program.

CD-MMIS, which is maintained by the FI Contractor, consists of the processing of all dental claims, TARs, NOAs and related documents, and CIFs. CD-MMIS processes claims primarily for the Medi-Cal Dental program, but has been adapted to also process claims and report on encounter data for a number of other health care programs, including but not limited to, Genetically Handicapped Persons' Program (GHPP) and California Children's Services (CCS).

Throughout this Contract the term "claim" is used to refer to claims as well as to NOAs that are returned for processing as claims resulting from previously approved TARs.

CD-MMIS receives and processes approximately ninety-nine thousand (99,000) claims per week and six thousand (6,000) TAR services per week, for approximately five thousand (5,000) active billing providers.

a. CD-MMIS Subsystems

CD-MMIS is divided into the following inter-related subsystems (Refer to each subsystem's respective sections of the ASO and FI Contracts for further details.):

- 1) Recipient Subsystem;
- 2) Provider Services Subsystem;
- 3) Reference Subsystem;
- 4) Claims Processing Subsystem;
- 5) Payment Subsystem;
- 6) Management and Administrative Reporting Subsystem (MARS);
- 7) Surveillance and Utilization Review Subsystem (S/URS); and

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- 8) The CD-MMIS system is also comprised of several smaller non-mainframe systems.
- b. CD-MMIS has many manual and automated interfaces with state agencies, providers, and other entities, as well as many distinctive features.
 - 1) The major inputs for CD-MMIS which are to be managed by the ASO Contractor include, but are not limited to:
 - a) Provider Enrollment Applications;
 - b) Medi-Cal and other program policy updates from the Department;
 - c) Change Orders and Dental Operating Instruction Letters (DOILs) from the Department;
 - d) Claim Detail Report (CDR) requests from the Department and other authorized users;
 - e) S/URS parameters from the Department;
 - f) Radiographs supporting claims/TARs from providers;
 - g) Any correspondences to/from beneficiaries and providers;
 - h) State Hearing Requests/Decisions from the Department of Social Services (DSS);
 - i) Licensing information from the Department of Consumer Affairs (DCA); and
 - j) Supporting documentation from providers.
 - 2) The major outputs for CD-MMIS which are to be managed by the ASO Contractor, include but are not limited to:
 - a) Provider manuals, bulletins, claim forms, NOAs, and other documents distributed to beneficiaries, providers, provider associations, vendors, submitters, and stakeholders;
 - b) Resubmission Turnaround Documents (RTDs);
 - c) Claim inquiry responses;
 - d) Management reports;
 - e) S/URS reports;
 - f) CDRs;
 - g) Reviewed radiographs returned to providers;

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- h) State Hearing transmittal memoranda;
- i) Various Financial Reports;
- j) Manual (MN) Reports;
- k) Beneficiary Treatment Authorization Requests Notification Letters; and
- l) Updates and modifications to website content, also including, but not limited to, provider and/or beneficiary mass email.

More specific information regarding the FI and ASO Contractor responsibilities for each of these elements can be found in their respective portions of the Contracts.

5. Components**a. Provider Services**

The Contractor shall provide all provider services including, but not limited to, provider outreach to encourage increased provider participation and enrollment; provider education to ensure that providers are kept current on the most recent and applicable program information including billing procedures and Department policies via publications, mass email, etc.; and provider support services. (For further information, refer to the ASO Contract, Exhibit A, Attachment II, Provider Services and the ASO Contract, Exhibit A, Attachment II, Provider Outreach.)

b. Beneficiary Services

The Contractor shall provide all beneficiary services including, but not limited to, beneficiary education to ensure that beneficiaries are properly informed of their scope of benefits, best practices for good oral health, and overall program polices; beneficiary assistance services such as the warm transfer process to assist in the scheduling of dental appointments for timely access to care; and facilitating the process to avail beneficiaries of their right to a State Hearing. (For further information, refer to ASO Contract, Exhibit A, Attachment II, Beneficiary Services and ASO Contract, Exhibit A, Attachment II, Beneficiary Outreach.)

c. Recipient Eligibility

The Contractor shall utilize recipient eligibility provided through the Recipient Subsystem to establish, verify and update beneficiary eligibility at the document level to facilitate claims processing. The Recipient Subsystem provides centralized control of eligibility data for all Medi-Cal, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and Child Health and Disability Prevention (CHDP) Gateway beneficiaries. The Recipient Subsystem receives information maintained exclusively by the Department to identify those persons who are eligible for benefits. This eligibility data is provided to the Contractor for use with other subsystems and for on-line inquiries. (For further information, refer to the FI Contract, Exhibit A, Attachment II, Recipient Subsystem.)

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d. MARS

The Contractor shall utilize reports and information produced by the MARS. The MARS component of CD-MMIS provides timely and meaningful information necessary for effective program management. The MARS reports are the tools designed to verify the integrity of other CD-MMIS subsystems, aid in timely detection of problems, and provide comparisons between current and past CD-MMIS performance data. This information allows the Contractor to make informed program management decisions. (For further information, refer to FI Contract, Exhibit A, Attachment II, Management and Administrative Reporting Subsystem.)

e. TSC

The Contractor shall manage and maintain a TSC to assist in providing personalized service to both beneficiaries and providers. (For further information, refer to the ASO Contract, Exhibit A, Attachment II, Telephone Service Center.)

f. TARs and Claims Processing

The Contractor shall process TARs and claims received from Medi-Cal dental providers as well as dental providers of the CHDP Gateway, CCS, GHPP, and Regional Center Consumers pursuant to requirements of the Claims Processing Subsystem section of the Contract. (For further information, refer to ASO Contract, Exhibit A, Attachment II, Claims Processing Subsystem.)

g. S/URS Profiling

The Contractor shall provide a process of aggregating and presenting data from CD-MMIS to address the delivery and utilization of services by providers and beneficiaries, respectively, and guard against fraudulent and/or abusive use of services by providers and beneficiaries.

The Contractor shall review all provider and beneficiary utilization reports produced by the CD-MMIS, and maintain documentation of the entire utilization review process to form an audit trail of utilization review activity.

For additional information regarding Contractor responsibilities regarding beneficiary and provider profiling, refer to Exhibit A, Attachment II, Surveillance and Utilization Review Subsystem (S/URS).

h. Quality Management

The Contractor shall perform quality management review pursuant to the requirements of the Quality Management Operations section of the ASO Contract and report results of that review to the Department so that the Department can measure the quality of work being performed and facilitate recommendations for operational changes when necessary. (For further information, refer to ASO Contract, Exhibit A, Attachment II, Quality Management.)

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6. Hierarchy Used to Resolve Inconsistencies

The documentation and the automated systems are subject to change as enhancements and other updates are made by the FI Contractor at the instruction of the Department. In the event that there are inconsistencies among the computer programs and procedure manuals included in CD-MMIS, the supporting design documentation, and the Contract, the following hierarchy, in the order specified with "a." being the highest authority, shall be observed in resolving inconsistencies:

- a. Contract Requirements;
- b. Change Orders;
- c. DOILS;
- d. Systems Development Notices (SDNs);
- e. Miscellaneous Change Documents (MCDs);
- f. Problem Statements (PSs);
- g. CD-MMIS computer programs;
- h. CD-MMIS procedure manuals; and
- i. System design documentation.

7. Special Consideration

The ASO Contractor shall work in concert with the FI Contractor to contribute to the creation and updating of all manuals, particularly those which directly impact the Contractor's ability to perform contractual duties and responsibilities. One master edition of manuals/documentation will represent the implementation of the Medi-Cal Dental Program including CD-MMIS and related applications. All manuals will undergo final processing through the FI Contractor for the maintaining of format and content consistency and accessibility. Refer to CD-MMIS FI Contract, Exhibit A, Attachment II, Data Processing and Documentation.

The Department reserves the right to require the Contractor to contract with a Department-approved Project Estimation Contractor, and Independent Verification and Validation (IV&V), Independent Project Oversight (IPO), and/or Project Management (PM) contractor(s) at the discretion of the Contracting Officer. The Project Estimation Contractor, and IV&V, IPO, and/or PM contractor(s) shall be paid by the Contractor, and reimbursed by the Department according to the Cost Reimbursement provisions of this Contract. These contractors will report directly to the Department or other State entities, such as the California Technology Agency, as directed by the Department.

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Provider Services is an integral component of the Contractor's organization that serves as the primary hub of information and communication between Medi-Cal dental providers, prospective dental providers, dental provider office staff, billing intermediaries, the Contracting Officer and the Department of Health Care Services (DHCS).

Provider Services shall be responsible to perform the necessary functions in providing essential customer service to the provider and beneficiary community including but not limited to credentialing and enrollment of providers, electronic billing, claims payment, provider training and communications.

The Contractor shall work collaboratively with Fiscal Intermediary (FI) Contractor to ensure the quality and integrity of the CD-MMIS meets or exceeds the standards delineated in the sections below and specified in the FI Contract, Exhibit A, Attachment II, Provider Services.

2. Objectives

The Contractor shall:

- a. Ensure that all Provider Services functions and responsibilities are conducted in a manner that complies with the most current federal and State program laws, regulations, policies, and procedures related to dental services under the California Medi-Cal program;
- b. Operate under the most current federal Medicaid Management Information System (MMIS) requirements;
- c. Ensure that providers and billing intermediaries submitting claims through electronic media and/or by hardcopy comply with the laws and regulations related to electronic billing with the Medi-Cal Dental Program;
- d. Ensure the system of record, the Provider Master File (PMF), is maintained with current, accurate, and useful information for the objectives of this Contract;
- e. Ensure the execution of quality customer service for prospective and enrolled dental professionals, and provider office staff, through informative and helpful inquiry responses, provider training, provider on-site visits, the Telephone Service Center (TSC), and other correspondence;
- f. Develop and provide robust training material and provider seminar sessions to providers regarding program laws, regulations, policies, and procedures;
- g. Maintain regular communication through provider bulletin publications and mass e-mail communication with all interested parties including but not limited to enrolled and prospective dental professionals, stakeholders, and governmental representatives;

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- h. Develop proposals and recommendations to improve customer service for the provider community executed by the Medi-Cal Dental Program including but not limited to the use of the Denti-Cal website, modifications to policy, and revising internal processes;
- i. Collaborate with Contractor staff and the FI Contractor to maintain regular communication in troubleshooting barriers to timely, responsive, and reliable customer service;
- j. Support Claims Processing, Management Administrative Reporting Subsystem (MARS), and Surveillance and Utilization Review Subsystem (S/URS); and
- k. Maintain adequate staffing levels to successfully execute the requirements of this Contract.

3. Assumptions and Constraints

The Provider Services component of this Contract is subject to the following assumptions and constraints:

- a. The Contractor shall work collaboratively with the FI Contractor to resolve any system related issues;
- b. The Contractor shall work with the FI Contractor so it can meet all of the deliverable requirements as delineated in Exhibit A, Attachment II, Administration section of this Contract;
- c. An applicant/provider must obtain a National Provider Identifier (NPI) prior to submitting a new application, revalidation application, or a re-enrollment application package. The NPI is utilized as the provider's unique identification number;
- d. Prospective providers are responsible for initiating the application process and completing all required enrollment forms with the assistance of Contractor staff and informing material published on the Denti-Cal website;
- e. Group dental practices shall be responsible for ensuring rendering providers treating Medi-Cal Dental patients at their practice submit the required rendering provider application and supporting documentation to the Contractor;
- f. Prospective providers who prove to meet the requirements of participation in the Medi-Cal Dental Program shall have an effective date of receipt of the completed, non-deficient application package;
- g. Receipt of a signed provider application/agreement and all applicable change forms/agreements constitutes a contractual relationship between DHCS and the provider regarding the rendering of services;
- h. Once enrolled, the provider, by law, must notify the Contractor within thirty-five (35) business days of any changes that occur to their provider information;

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- i. Out-of-State providers who have a valid, unrestricted dental license with the State of California, located in border communities in adjacent states shall be considered in-state providers for the purposes of this Contract. Out-of-State providers with valid, unrestricted dental licenses, not located in designated border communities may, under specific circumstances, be enrolled as out-of-state providers upon approval by the Department;
- j. The Contractor is liable for any erroneous payments made to providers who have been suspended or deactivated from the Medi-Cal Dental Program or otherwise declared ineligible by the Department from participating in the Medi-Cal Dental Program and for loss or reduction of federal funds;
- k. Claims/Treatment Authorization Requests (TARs) will be submitted to the program with the proprietary form until the American Dental Association (ADA) claim form can be phased in as the primary form. The Contractor shall continue to supply the proprietary form until the necessary system modifications are completed. Proprietary dental claim forms will be phased out and providers will be given a grace period to use existing inventory of proprietary forms contingent on the timeline for the system modifications; and
- l. Provider Services staff shall only perform provider related activities as specified in this section and/or as authorized by the Contracting Officer.

4. General Responsibilities

The Contractor shall:

- a. Use critical thinking and problem solving skills to identify and resolve provider issues or complaints by utilizing all resources including but not limited to: manual, ad hoc, and system generated reports; manuals, claim inquiries, provider errors on documents, personal contacts with dental providers/associations and additional information provided by the Department;
- b. Thoroughly document all known problems experienced by enrolled and prospective providers, noting provider names, and the nature of the challenges encountered (i.e., billing issues, obstacles presented by departmental policies, etc.). The Contractor shall proceed to frequently propose solutions including, but not limited to, changes to procedures, recommendations for additional training, and/or system modifications. Documented provider cases shall be followed up with the appropriate action and resolution of the identified and documented issue;
- c. Produce timely and accurate reports related to the functions of the Provider Services as required by the Contract and the Department. Reports shall meet requirements set forth in the Exhibit A, Attachment II, General Reporting Requirement section, unless otherwise specified in this section;
- d. Respond to written requests and inquiries from the Department requesting information in a timely manner. Reports shall meet requirements set forth in the Exhibit A, Attachment II, General Reporting Requirement section, unless otherwise specified in this section;

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- e. Accept and process all requests from providers to enroll or update their information for electronic funds transfer (EFT) and process provider disenrollment from EFT;
- f. Ensure that program publications, informing material, and forms are available online to providers, billing agents, government, and private entities;
- g. Request written approval from the Department on any action(s) to be taken against a provider. The request shall be accompanied by supporting documentation. Actions are defined as special claims review, prior authorization review, suspension from the program, payment withhold, and levies. Upon approval of the Department, the Contractor shall place the appropriate indicator on the PMF in order to effect the action approved by the Department. Disenrollment of a provider may only occur when prior Department approval has been secured. When a provider is disenrolled, an indicator shall be placed on the PMF to reflect that the provider is no longer active. Any such restriction or indicator shall not be removed without the Department's explicit authorization; and
- h. Support and enable Administrative Services Organization (ASO) Operations including, but not limited to, updating manuals used and updated by the ASO Contractor, providing input on policies with potential system implications, and providing advice for the execution of system modifications for the purposes of improving customer service for the provider community.

5. Provider Master File (PMF)

The Contractor shall, in collaboration with the FI Contractor:

- a. Use the PMF as the system of record for all other systems utilizing provider information for processing all claim/TAR/Claim Inquiry Form (CIF) documents. The following are requirements of the PMF:
 - 1) An accurate system of provider status information shall be provided and maintained;
 - 2) Ensure that providers who appear as "active" on the PMF are eligible to participate in the Medi-Cal program;
 - 3) Determine whether provider status changes entered into the PMF have been properly authorized according to Department procedures and whether such changes are placed on file in a timely manner; and
 - 4) Ensure that a single, active provider does not have multiple, or duplicate, identification numbers.
- b. Enter transactions (e.g., additions, deletions, and changes) online to the PMF on a daily basis;
- c. Evaluate and verify the status after each PMF update. Transactions determined to be in error shall not be updated to the PMF and correct information shall be obtained;

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- d. Update changes to provider status (active vs. inactive) in the PMF as directed by the Department; and
- e. Process requests from those out-of-state providers who are not located in a designated border community for reimbursement of services provided to a Medi-Cal beneficiary in accordance with the most current federal, State, and Department policies and procedures. If the out-of-state provider is enrolled, the Contractor shall process the request for payment. If the out-of-state provider is not enrolled, the Contractor shall enroll the provider as directed by the Department in order to provide any payment for services within the guidelines of the most current federal, State, and Departmental policies.

6. Provider Enrollment

The Provider Enrollment function of the Provider Services component of the Contract serves an integral role in ensuring the eligibility of Medi-Cal Dental Providers. The Contractor's primary responsibility is to ensure the applicant/provider is qualified according to regulations to bill and/or render services under the Medi-Cal Dental Program, in accordance with the most current rules, regulations, and policies of the State of California, the federal government, and the Department.

The Contractor shall:

- a. Perform monthly verifications for providers with active status in the PMF against the list of Dental Board of California (DBC) licensed dental providers. Deactivate enrolled providers whose unrestricted license the Contractor is not able to verify. Upon deactivation, send notifications of the deactivation to service office locations associated with the enrolled rendering provider. The Department shall be notified via formal Contractor letter of all deactivations;
- b. Ensure all provider deactivations from the PMF are conducted in a manner that is consistent with the most current federal and State laws and the Medi-Cal Dental Program's policies and procedures related to provider deactivations. Providers requesting deactivation shall be granted such deactivation with an effective date the provider has requested. Provider deactivations requested by the Department shall have deactivation effective dates determined by the Department. When a provider is deactivated, an appropriate indicator shall be placed in the PMF with an effective date determined in the aforementioned methods. Any such restriction or indicator shall not be removed without the Department's explicit written authorization;
- c. Ensure that all provider enrollment applications and agreements are processed in accordance with the most current applicable federal and State laws, statutes, regulations, policies, and procedures as directed by the Department;
- d. Ensure prospective Medi-Cal Dental providers receive and have easy access to sufficient information to understand program requirements to enable an expeditious enrollment application processing experience;
- e. Conduct monthly enrollment outreach workshops and weekly provider enrollment assistance line events in accordance with departmental objectives to enroll providers consistent with the Provider Outreach plan. A schedule of these

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events shall be submitted to the Department for review and approval on a quarterly basis. Costs for these events shall be reimbursed in accordance with the cost reimbursement provisions of Exhibit B, Attachment I, Special Payment Provisions;

- f. Upon receipt of an enrollment application package, ensure the following:
- 1) Prospective provider has an active, unrestricted license by the State of California through the DBC to practice dentistry, and, if applicable, provide certification of specialty;
 - 2) Validate prospective billing and rendering providers against the Social Security Administrations Death Master File, National Plan and Provider Enumeration System (NPPES), List of Excluded Individuals/Entities (LEIE), Excluded Parties List System (EPLS), the Medi-Cal Suspended and Ineligible List, and any other such databases that may be required by federal and State agencies;
 - 3) Request written approval from the Department on any provider applicants who have/had actions with the Department, DBC, or the Office of the Inspector General (OIG);
 - 4) Prospective provider has completed and signed the appropriate provider application/agreement and disclosure statement with the Contractor to abide by the most current federal and State statutes, regulations, policies and procedures for the provision of dental services under the California Medi-Cal program;
 - 5) Prospective provider does not have an outstanding accounts receivable (AR) with the Department under another provider number. If an outstanding AR is found for the prospective provider, the Contractor shall notify and seek direction from the Department within one business day;
 - 6) Prospective provider has declared any significant beneficial interest in another current or potential Medi-Cal provider's practice;
 - 7) The provider's application is reviewed in its entirety to determine and identify all deficiencies prior to returning the provider's application within ten (10) business days;
 - 8) Ensure that all provider application packages are complete during the credentialing process. If application packages are found to be deficient in information, the following process applies:
 - a) Contact the applicant via telephone, electronic mail, or fax until the deficient information is obtained or until three attempts at contacting the provider have elapsed;
 - b) If the deficient information cannot be obtained by the Contractor, the entire application shall be returned to the prospective provider within ten (10) business days. The Contractor shall not hold the application

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- package pending additional or missing information beyond the ten (10) business day period;
- c) Return any enrollment packet as unprocessed if the enrollee's name is different from his/her legal name; and
 - d) Require that the prospective provider reapply with a new application package for each cancelled application.
- 9) Border dental providers and all other out-of-state providers shall have their application packages processed in accordance with the most current federal and State program laws, regulations, policies, and procedures related to enrollment; and
- 10) Request new enrollees using a fictitious name or "doing business as" (DBA) to submit a copy of the Fictitious Name Permit issued by the DBC when enrolling under any name other than their legal name.
- g. Upon completion of the enrollment process, ensure the following:
- 1) Providers enrolling in the following manners shall have the twelve (12) month provisional provider status applied:
 - a) New provider applying for the Medi-Cal Dental Program;
 - b) Request for change of location;
 - c) Adding an additional office; and
 - d) Sole proprietor changing to a group practice.
 - 2) Place providers enrolling with the standard method of enrollment on a twelve (12) month provisional status:
 - a) Only the NPI associated with the service office initiating the change shall be placed in provisional provider status, effective the date of enrollment, unless a S/URS review is being conducted;
 - b) Maintain the history of provisional status beginning and ending dates and the reason for the provisional status when a billing provider identification number has been placed on provisional status;
 - c) Provisional status notification letters will only be sent to the provider number that originated the provisional status; and
 - d) After six months of provisional provider status, an integrity review profile shall be created, and if the profile reflects questionable actions then the Contractor shall notify the Department within ten (10) calendar days;
 - 3) Send written notification to the provider confirming the provider's enrollment effective date within seven business days. Payment for services will not be

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made until the provider is actively enrolled in the Medi-Cal Dental Program;
and

- 4) Store hard copies of the application package and all provider correspondence regarding the enrollment of providers for the term of the Contract.
- h. Revalidate enrollment information for every billing and rendering provider every five years, or as directed by the Department, regardless of provider type, pursuant to the requirements under the most current federal and State statutes, regulations and policies;
- i. Provide support to the Contractor's Provider Outreach unit.

7. Preferred Provisional Provider Enrollment

Preferred Provisional Provider Status denotes an enrollment process in which the applicant must meet an additional set of statutory criteria and if the statutory criteria are met, the applicant receives the benefit of expeditious enrollment. Welfare and Institutions (W&I) Code section 14043.26(d), mandates the statutory timeframe for enrollment as a preferred provider to be sixty (60) days. The Contractor shall process provider enrollment applications under the preferred provisional provider status as follows:

- a. Provider submits all of the necessary documentation to invoke this expedited process;
- b. Providers, who fail to submit the required documentation or are determined to be ineligible based on the information the provider submits, shall be credentialed according to the standard process;
- c. Providers choosing to invoke the Preferred Provisional Provider Status shall provide a signed cover letter in the application package certifying their eligibility with all four criteria as follows:
 - 1) The prospective provider shall hold a current license as a dentist issued by the DBC, which has not been revoked, whether stayed or not, suspended, placed on probation, or subjected to other limitation. If an applicant fails to include a copy of his/her dental license, the Contractor is instructed to search for the applicant's dental license information on the DBC website. If the Contractor finds a match to the prospective provider's name and their respective dental license information, the Contractor shall consider this criteria sufficiently fulfilled;
 - 2) Submit documentation showing the dental provider is credentialed by a health care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975. Documentation may come in various forms including, but not limited to, a letter by the Knox-Keene licensed plan notifying the provider successfully enrolled in the Knox-Keene licensed plan or proof of payment to the provider by a Knox-Keene licensed plan;
 - 3) The prospective provider must never have had revoked and/or suspended privileges from the Medi-Cal program. This includes verification the provider

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is not placed on the Medi-Cal Suspended and Ineligible List and verification the provider has never been suspended through the California Dental – Medicaid Management Information System (CD-MMIS); and

- 4) Have no adverse entries in the Healthcare Integrity and Protection Data Bank/National Practitioner Data Bank (HIPDB/NPDB). To meet this criterion, the prospective provider must submit documentation from HIPDB/NPDB verifying that the database has no adverse entries regarding this applicant.
- d. Providers who have successfully demonstrated meeting the criteria delineated above shall be considered within sixty (60) days for enrollment in the Medi-Cal Dental Program as preferred provisional providers;
 - e. Providers attempting to invoke this process but deemed unqualified for the Preferred Provisional Provider Enrollment process shall be notified within sixty (60) days of the determination of ineligibility and shall be credentialed according to the standard credentialing process described above;
 - f. All applicants are required to correctly populate the fields where the following information is solicited in the Medi-Cal Provider Application, Provider Group Application, Disclosure Statement, and Provider Agreement:
 - 1) NPI;
 - 2) Type of entity;
 - 3) Legal name of the provider;
 - 4) Business name, if different;
 - 5) Office telephone number;
 - 6) Business address;
 - 7) Taxpayer Identification Number (TIN) or Social Security Number (SSN);
 - 8) Dental license number; and
 - 9) Provider signature.
 - g. Once the fields above are complete and appropriately submitted, the Contractor shall enter these provisional providers into the PMF and provide an effective date according to the date the application was received by the Contractor. The Contractor shall verify all other standard provider enrollment credentialing requirements are met once the provider is successfully issued a billing number in the PMF;
 - h. Ensure providers successfully enrolled as preferred provisional providers have an eighteen (18) month provisional provider status applied to them;

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- i. After six months of provisional provider status, an integrity review profile shall be created, and if the profile reflects questionable actions then the Contractor shall notify the Department within ten (10) calendar days;
- j. Send written notification to the provider confirming the provider's enrollment effective date within seven business days. Payment for services shall not be made until the provider is actively enrolled in the Medi-Cal Dental Program; and
- k. Store hard copies of the application package and all provider correspondence regarding the enrollment of providers for the term of the Contract.

8. Billing Intermediaries

The Contractor shall:

- a. Ensure compliance with the most current federal and State laws, regulations, policies and procedures related to billing intermediaries concerning enrollment, submittal of claims, and other topics pertaining to billing intermediaries;
- b. Ensure that all billing intermediaries are registered with the Contractor and that the registration number is in the remarks section of all claims submitted for payment;
- c. Ensure a billing intermediary's registration form contains:
 - 1) A current billing service name and address;
 - 2) Telephone number;
 - 3) A previous Contractor-assigned registration number, if applicable;
 - 4) List of Medi-Cal dental providers who contract with the billing service, which shall include each provider's name, provider number, dental license number, and the effective date of the contract;
 - 5) Return address for submission of the registration form; and
 - 6) Any entity including a partnership, corporation, sole proprietorship, or person that will bill Medi-Cal Dental on behalf of a provider pursuant to a contractual relationship with the provider.
- d. Ensure providers who use billing intermediaries submit a form to the Contractor which includes the following information:
 - 1) Provider name, provider number, dental license number, address, service office;
 - 2) A DBA name, along with supporting documentation such as local business license, and a copy of valid legible fictitious name permit;
 - 3) A previously assigned registration number (when applicable);

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- 4) Billing intermediaries/service address(s);
 - 5) Contract start date;
 - 6) Contract end date;
 - 7) New contract or contract renewal;
 - 8) Provider's original signature and date; and
 - 9) A return address for submission of notification.
- e. Approve and process registration forms;
 - f. Develop and maintain an online tracking system of the registration forms from billing intermediaries;
 - g. Certify and respond to the provider and/or billing intermediary submissions within ten (10) business days of receipt of registration application. The Contractor acknowledgment and response shall include a Contractor-assigned registration number that will enable the billing intermediary to prepare and submit claims with a billing service registration number; and
 - h. Complete all required weekly and monthly reports to track the registration and activity of billing intermediaries with the billing intermediary registration number.

9. Electronic Data Interchange (EDI)

The Contractor shall:

- a. Ensure compliance with the most current EDI standards, as determined under provisions of the Health Information Portability and Accountability Act (HIPAA) and as outlined in Exhibit A, Attachment II, Claims Processing Subsystem section of this Contract;
- b. Accept, acknowledge, evaluate, and respond to applications from providers and/or billing agents who wish to enroll in the electronic billing systems within ten (10) business days of receipt of application forms. The acknowledgement shall include a registration number which shall enable the applicant to prepare and submit necessary test claims on the requested media type;
- c. Ensure providers and their duly authorized agents follow all required approval procedures and meet the most current federal and State regulations and Departmental policy standards for electronic billing. No other billing arrangement where the Contractor receives claims from providers on an electronic basis is allowed;
- d. Ensure providers and their authorized agents are identified and approved by the Contractor prior to electronic media billing. The approval process shall meet the most current federal and State regulation standards;

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- e. Ensure each provider and their duly authorized agent, completes a Department approved EDI enrollment form before testing begins. The form must contain provider statements of certification and understanding that satisfy the most current federal and State requirements;
- f. Work with the FI Contractor to develop and document procedures required to verify the provider's technical ability to comply with the EDI requirements;
- g. Notify the FI Contractor of all approved EDI applications to initiate and facilitate the testing prior to the submission of any claims;
- h. Work collaboratively with FI Contractor to test, certify, and process submitted test documentation from providers, which measures the applicant's technical ability to submit necessary test claim data, before allowing providers to submit claims electronically;
- i. Work with the FI Contractor to respond to the billing agent/intermediary within ten (10) business days of receipt of the test documents;
- j. Notify the Department of providers who are certified to begin submitting EDI transaction in production within five business days after approval of test documentation;
- k. Submit to the Department for review and approval a strategic plan to increase EDI participation and submission of digitized attachments at the end of every calendar year. The strategic plan must include the current baseline and the approach to meeting stated goals;
- l. Collaborate with the Department to develop reporting of the historical and current EDI submission volumes including submission of digitized attachments and the progress toward reaching annual goals;
- m. Provide identification labels and specially marked envelopes to providers for mailing additional information (e.g., radiographs or other documentation) in support of EDI documents;
- n. Request formal approval for publications related to EDI from the Contracting Officer;
- o. Provide assistance to EDI providers and billing agents in the submission of all electronic media claims in accordance with Contract requirements;
- p. Process provider requests to discontinue or modify existing EDI/billing agent's arrangements within five business days. Notify providers within five business days once the modifications of existing EDI/billing agent's arrangements have been processed within; and
- q. Establish and maintain staffing with the following responsibilities:
 - 1) Pre-enrollment Assistance;
 - 2) Technical Support;

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- 3) EDI Testing Certification;
- 4) EDI Information Maintenance; and
- 5) Production EDI Help Desk Support.

10. Provider Training

The Contractor shall provide a robust provider training program in accordance with the requirements delineated below. The Contractor shall provide all staff and equipment necessary to meet the requirements of this function.

The Contractor shall:

- a. By December 31st of every calendar year, provide a training plan for the upcoming calendar year for the Department's review and approval. At a minimum, the plan shall:
 - 1) Include a training methodology with training goals and objectives, curricula overview, and lesson plan outlines. The training methodology shall include:
 - a) The use of provider feedback from previous provider training seminars to identify course content;
 - b) Utilization of adult learning theories and practices, industry standard training strategies, and technologies (e.g., teleconferencing, online, interactive training on the internet, webinars), as authorized by the Department; and
 - c) The use of any other data, reports, and assessments to inform the provider training approach and strategy, consistent with provider retention objectives.
 - 2) Identify critical subject areas where providers have the most questions or find most problematic about the program. Critical subject areas may include, but not be limited to, questions and concerns related to: Medi-Cal Dental policies and procedures; billing in accordance with the Manual of Criteria (MOC); requirements of EDI submission; and questions related to Share-Of-Cost;
 - 3) Identify proposed dates, cities, and locations for each training based on the methodology used in the provider training plan;
 - 4) Utilization of claims data to identify geographic locations where the highest volume of denied claims exists;
 - 5) Identify proposed topics to cover for each date and location;
 - 6) Provide a description of the proposed training seminar leaders' professional background, skills, knowledge of subject matter, training experience, and qualifications;

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- 7) Include a comprehensive training assessment including, but not limited to, feedback from every provider training event from attendees and evaluation forms; and
 - 8) Report the previous year's attendees performance improvement (e.g., decrease in the denial rate) in the program to the Department at the end of the calendar year to determine the effectiveness of the training program.
- b. Ensure the provider training program meets the following requirements:
- 1) Develop and continually update the Training Manual;
 - 2) Ensure a minimum of four different types of training seminars available include: basic, advanced, workshop, and orthodontia seminars;
 - 3) Changes to course materials shall be submitted to the Department for approval a minimum of thirty (30) business days prior to each scheduled seminar;
 - 4) Training materials shall be posted to the Denti-Cal website within five business days of Department approval for new or revised training material;
 - 5) Schedule provider training seminars at a minimum of three months in advance of the training date(s) in accordance with the annual provider training plan approved by the Department. Submit the schedule to the Department for approval each quarter;
 - 6) Upon Department approval of the provider training schedule, the Contractor shall include the training schedule in the next bulletin cycle and post the approved schedule on the Denti-Cal website within five business days. Ensure the registration form, and instructions for completing the form, are simple and readily available on the Denti-Cal website;
 - 7) Directly contact providers practicing in surrounding areas, a minimum of thirty (30) days in advance of the training event, as defined by a fifty (50) mile radius from the location of the provider seminar training. Providers with high denial rates in claims submissions in the surrounding area shall be especially targeted to inform providers of the opportunity to learn ways to successfully bill the Medi-Cal Dental program;
 - 8) Consider more populated areas with a high volume of Medi-Cal dentists to ensure a larger number of attendees when developing the annual provider training plan and when scheduling provider seminars throughout the State. Training sites shall be alternated in the larger cities to provide greater access for attendance;
 - 9) Schedule seminars to allow as much time as necessary to cover subject matter and allow for a question and answer period; however, no seminar shall be less than four hours in length;
 - 10) Notify training participants to download seminar presentation materials prior to arrival at seminars;

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- 11) Include a minimum of two webinars per quarter; and
 - 12) Record and post one of each kind of training on the website for dental provider and office staff reference.
- c. Ensure the following provider seminars, at a minimum, are offered and available to dental providers:
- 1) **Basic Seminar** – The Contractor shall provide appropriate information that will assist providers to understand program policies and regulations governing the Medi-Cal Dental criteria, changes in Medi-Cal beneficiary identification, and eligibility verification. The seminar shall also provide information on how to complete and interpret all documentation required to obtain prior authorization and/or payment.

These seminars shall be general in nature and shall be designed to ensure providers, and office staff, have all the tools at their disposal and assistance they need in successful for successful billing in the Medi-Cal Dental Program. A total of thirty-six (36) basic seminars shall be provided each calendar year. The basic provider seminar shall, at a minimum, include:

- a) Information on the processing of claim forms, TARs, and CIFs;
 - b) Information on the review and receipt of Notices of Authorizations (NOAs);
 - c) The provider appeals process;
 - d) Information for the Interactive Voice Response (IVR) System; and
 - e) EDI procedures.
- 2) **Advanced Seminar** – The advanced seminar shall be conducted by a licensed dentist from the Contractor's staff, and shall address technical and clinical components of the Medi-Cal Dental Program. A total of twenty-four (24) advanced seminars shall be provided each calendar year. Major areas to be discussed include, but are not limited to:
 - a) Topics concerning Medi-Cal Dental criteria;
 - b) Radiograph requirements;
 - c) Documentation requirements;
 - d) Claims processing codes; and
 - e) Common billing errors.
 - 3) **Workshop Seminar** – Provide a minimum of one workshop seminar per contract year which shall consist of a combination of two hours of basic seminar curriculum and four hours of advanced seminar curriculum for a total of no less than six hours in length. The advanced seminar portion of the

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- Workshop shall be conducted by a licensed dentist from the Contractor's staff;
- 4) Orthodontic Seminar – Provide a minimum of one orthodontic seminar which shall be a minimum of four hours in length. The orthodontic seminar shall be conducted by a licensed dentist from the Contractor's staff;
 - 5) Make evaluation forms available at each session to enable participants to evaluate the training courses;
 - 6) Ensure that providers who attend the advanced seminars are eligible for four units of continuing education (CE) credit. Ensure that those providers who attend orthodontic seminars are eligible for three units of CE credit. Dental providers attending the basic seminars are eligible for three units of CE credits and dental providers who attend the Workshop are eligible for six units. The Contractor shall establish and maintain relationships with the DBC for the continuance of this benefit; and
 - 7) Ensure that no CE credit shall be disbursed for reviewing training material online. Providers shall receive CE credits only after participating in a live provider seminar or a webinar provider seminar.
- d. Conduct special provider training sessions necessitated by major program changes (e.g., changes in scope of benefits, billing procedures, or other major policy or procedure change) that exceed those of the otherwise mandated training requirements. The training shall be conducted by existing Contractor staff and shall be provided at the request of the Contracting Officer. This training shall be part of the Contractor's fixed price bid, except that the cost for rental charges incurred for the provision of adequate meeting space shall be paid by the Department on a Cost Reimbursement basis if these costs are incurred by the Contractor, pursuant to Exhibit B, Attachment I, Special Payment Provisions;
 - e. Make appropriate changes to the provider training plan as deemed necessary by the Contracting Officer (e.g., staff trainers, training courses, course content, method of presentation, training plans, training manuals, training site, updates, and status reports). Any changes, including those to the training schedule, seminar agenda, or training course contents, must be approved by the Department prior to the change(s) being implemented;
 - f. Provide a summary of all participant evaluation comments to the Department within five business days after each month. The summary shall include an analysis, statistics of number of participants, how many different provider seminar types were held throughout the month and in which locations and recommendations for improving future seminars and determine if changes to the training plan are needed. The Contractor shall maintain copies of these forms for the term of the Contract. Upon request by the Department, the Contractor shall provide the Department copies of the completed evaluation forms within five business days. Any modifications to the training evaluation forms must be approved by the Department prior to the change(s) being implemented;
 - g. Ensure all training seminars are open to federal and State government personnel; and

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- h. Represent the Department at approved forums upon request.

11. On-Site Provider Visits

On-site provider office visits shall be conducted at the discretion of the Department.

- a. On-site provider office visits shall be provided under the following circumstances:

- 1) For any enrolled provider, their office staff, and/or billing intermediary upon request;
- 2) Upon Department request to resolve an identified issue with the provider, their office staff, and/or their billing intermediary;
- 3) As a recommended solution by Provider Services staff to resolve an outstanding request for assistance; or
- 4) As a result of profiled providers with high claim/TAR submission error rates.

- b. The Contractor shall:

- 1) Provide on-site assistance at the provider's place of business to address questions or concerns regarding statutes, regulations, policies, and procedures related to the program when the issue cannot be resolved by other means;
- 2) Ensure Provider Services staff utilize applicable online files, screens, records, and paper documentation to research provider concerns and propose a resolution to the issue prior to scheduling an on-site provider visit;
- 3) Ensure attempts to troubleshoot issues experienced by providers and office staff have been made and all other remote options for assisting the provider have been exhausted;
- 4) On a quarterly basis, profile provider claims data to assess high denial rate volumes and make contact with provider or provider's office staff to provide technical assistance. After providing remote technical assistance, the Contractor shall offer an on-site visit to resolve the identified challenges;
- 5) Submit to the Department requests for on-site visits which shall be reimbursed through the Cost Reimbursement provisions of Exhibit B, Attachment I, Special Payment Provisions;
- 6) Ensure Provider Services staff completes the requested on-site provider office visit within twenty (20) business days after initial request by the provider/billing intermediary. The Contractor shall document in writing the visit within ten (10) business days after the visit, which will be made available to the Department upon request;
- 7) Ensure Provider Services' representatives document on-site visits by completing a Contractor-designed, and written Department-approved standard form. Both the provider and the Provider Services representative

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shall sign the form with each party retaining a copy. The Contractor shall provide the Department documentation of on-site visits within ten (10) business days after the on-site visit. Copies of this documentation shall be maintained by the Contractor for the term of the Contract;

- 8) For all Department requested on-site visits, the Contractor shall conduct the on-site provider office visit with the concurrence of the provider within ten (10) business days of the request. The Contractor shall document in writing the visit within ten (10) business days after the visit. Documentation shall, at minimum, include a copy of the aforementioned provider on-site visit standard form, the date the request was made, the date of the on-site provider office visit, the nature of the issue, and the manner in which it was resolved. Such documentation shall be made available to the Department upon request;
- 9) Provide to the Department upon request all follow-up documentation regarding open and resolved issues within two business days of the request;
- 10) Provide final resolution of any unresolved issues in writing to the Department within twenty-one (21) business days after the on-site visit and document the reasons for which the issue remained unresolved; and
- 11) Notify the Department immediately if the Contractor is unable to reach the provider or schedule an on-site provider office visit within the timeframes specified in this Contract and request to extend the timeframe for which the Contractor must complete and resolve the request for on-site visit.

12. Material Management and Print Distribution

The Contractor shall:

- a. In collaboration with the FI Contractor, ensure that the database(s) or files of mailing addresses used for providers, and other subscribers, is accurate and current. The Contractor shall also in collaboration with the FI Contractor ensure the database(s) or files of mailing addresses can be reported on by program types, specialty codes, provider county, and category of service;
- b. Provide claim forms and procedural information to billing providers. The Contractor shall also provide the Department with forms needed for system and acceptance testing;
- c. Ensure proprietary claim forms are available after the transition to the ADA claim form until Department approval. Ensure providers have access to print copies of the ADA claim form from the Denti-Cal website;
- d. Within ten (10) business days after the Contractor places a newly enrolled provider on active status on the PMF, at a minimum, mail to the provider the following:
 - 1) A welcome letter which includes their Medi-Cal dental provider unique provider number and information on how to access the Provider Handbook and all Medi-Cal Dental provider bulletins online;

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- 2) An EDI enrollment application;
 - 3) Digitized x-ray submission information;
 - 4) A direct deposit form;
 - 5) A referral form;
 - 6) Pamphlet with Medi-Cal Dental abbreviations;
 - 7) An initial stock of proprietary claim forms, pre-imprinted with the provider's identifying data; and
 - 8) An initial stock of envelopes (two sizes) for radiographs. The Contractor shall continue to provide envelopes for radiographs beyond the transition to the ADA claim forms.
- e. The Contractor shall mail forms and envelopes to providers within ten (10) business days of receipt of the provider's reorder request;
 - f. Maintain form inventories and records to substantiate the Contractor's response to provider requests for forms. The Contractor shall provide to the Department access to these records. The records shall be kept by receipt date of the provider's request and by date the requested forms were mailed to the provider(s). The Contractor shall bring unusual form order requests (i.e. large amounts or frequency of request) to the attention of the Contracting Officer prior to filling the request;
 - g. Make available to providers two sizes of envelopes: i.e., one that will accommodate full-mouth radiographs and a smaller size envelope to accommodate single tooth radiographs;
 - h. Utilize the nine digit Zip Codes (Zip + 4) to presort outgoing mail;
 - i. Comply with the United States Postal Service (USPS) regulations for all outgoing mail; and
 - j. Post any forms to the website within five business days of Department's request and/or approval.

13. Publications

The publications component of the Provider Services section serves as an essential part of providing the public with current information, policies and procedures related to the Medi-Cal Dental program.

The Contractor shall:

- a. Develop, draft, and post publications for providers, billing agents/intermediaries, government, constituent, and private entities using requirements established by the Department in this Contract;

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- b. Maintain all publications, including but not limited to, the provider bulletin publication and Medi-Cal Dental Provider Handbook in electronic media and posted to the Denti-Cal website;
- c. Develop and draft provider publications as directed by the Contracting Officer, including those resulting from Dental Operating Instruction Letters (DOILs), System Development Notices (SDNs), Problem Statements (PSs), Miscellaneous Change Documents (MCDs), or Contract correspondence as directed by the Contracting Officer;
- d. Ensure the Contractor and Contracting Officer work collaboratively on the topics of provider publications. All provider publications shall be submitted to the Department for final approval prior to publication and/or distribution;
- e. The following timeframes shall be met in relation to the publications function of this section:
 - 1) Priority bulletins shall be posted to the Denti-Cal website as directed by the Department no later than twenty-four (24) hours from the date of the Department's request and approval;
 - 2) Routine monthly provider bulletin publications shall be posted to the Denti-Cal website no later than the thirtieth (30th) calendar day of each month with the approval of the Department;
 - 3) Updates to the Provider Handbook shall be posted to the Denti-Cal website no later than the fifth calendar day of the month the changes are effective with Department approval unless otherwise directed by the Department;
 - 4) Other publications shall be posted to the Denti-Cal website as instructed by the Department through a web change request form;
- f. Revise and resubmit any Department approved change to the Contracting Officer's designee within two business days of receipt;
- g. Develop an archive (by subject matter, article, and bulletin) of all published bulletins. The archive shall be updated monthly or more frequently as necessary. The archive shall be maintained in chronological order and shall be easily accessible on the Denti-Cal website, as approved by the Department;
- h. Provide a monthly report, no later than the fifth calendar day of the month, that provides the following information related to the publications posted in the previous reporting month:
 - 1) Bulletins, Volume, and Number;
 - 2) Date bulletin article submitted by Contractor to the Department for review;
 - 3) Projected release date;
 - 4) Department approval date;

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- 5) Date published/posted; and
- 6) Explanation(s) if the deadline was not met that month.

14. Mass Email Communication Service

The Contractor shall:

- a. Collect email addresses from providers upon enrollment, revalidation, attendance at provider trainings, and through TSC agents for providers and other interested parties;
- b. Maintain an email address list for all interested providers and stakeholders to receive mass email communications;
- c. Ensure stakeholders and the dental professional community have easy access to subscribe and unsubscribe to the mass email service;
- d. Host an outgoing-only email address and send mass communications regularly on the status of program activities at a frequency that meets the needs of the Department;
- e. Report to the Department on a monthly basis the analytics related to mass email communications;
- f. Ensure all information distributed through this method of communication be reviewed and approved by the Contracting Officer prior to its distribution; and
- g. Assess, on an annual basis, by calendar year, the effectiveness of this method of communication and propose recommendations accordingly.

15. Provider Support Service

The Contractor shall provide accurate and timely responses to provider inquiries and issues as this directly affects their willingness to participate and deliver medically necessary dental care services to beneficiaries of the Medi-Cal program. The Contractor shall establish an organizational structure that is highly responsive to provider needs and employs industry standards and technologies in its delivery approach.

Provider Support Services staff shall only perform provider-related activities as specified in this section, and/or as authorized by the Contracting Officer. The Provider Support Services staff shall not be involved in the processing of claims/CIFs/TARs and other specialized documents. Additionally, staff shall only be involved in provider-related activities involving providers associated with the Medi-Cal Dental Program, Child Health and Disability Prevention Program (CHDP) Gateway, and California Children's Services (CCS)/ Genetically Handicapped Persons Program (GHPP) activities. If the need arises, staff shall be directed to identify and resolve problems that providers have with billing or for special projects as defined by the Department. Also, reference the Organization and Staffing subsection for additional information related to staffing requirements.

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The Contractor shall:

- a. Act as the liaison between dental providers and the Department;
- b. Answer all correspondence and appeals regarding statutes, regulations, policies, and procedures related to the Medi-Cal program;
- c. Process priority mail; track misdirected mail, requests for interim payments, miscellaneous correspondence, and mutilated claims;
- d. Receive and respond to provider inquiries via telephone, mail, email, and/or on-site visits;
- e. In conjunction with the FI Contractor, the Contractor shall propose modifications to the Provider and Beneficiary Correspondence Tracking System to allow the identification of email correspondence;
- f. Research issues unresolved by the Provider TSC and contact the provider(s) with a response. Notify the Department within twenty-four (24) hours of all unresolved or outstanding issues that could not be resolved;
- g. Compile separate daily logs and files of all correspondence inquiries and provider appeals. Upon request, provide to the Department access to daily logs and files. The daily log shall include, at a minimum, the number of appeals or inquiries received, listed by provider specialty, category of questions asked by providers, and actions taken. Daily logs and files shall be maintained for the term of the Contract;
- h. Actively review reports of provider billing errors and coordinate activities with provider and other Contractor staff to make contact with and provide the necessary information to identified providers and/or provider office staff for successful billing. The Contractor shall additionally revise, as necessary and/or by Department request, the list of top ten (10) identified errors in billing and subsequently issue a revised provider bulletin on the topic. If identified issues cannot be resolved for the identified providers and/or provider office staff via remote assistance, an on-site provider office visit shall be offered to the provider and/or provider office staff;
- i. When system-related problems are identified, Provider Services staff shall initiate the activities necessary to identify and contact the individual providers affected by the system and work with other Contractor staff to reach a resolution. The Contractor shall also research and respond to provider inquiries referred by the Department. All activities and results are to be thoroughly documented. The Contractor shall develop the documentation method, which shall be approved by the Department;
- j. Develop and maintain a report of newly enrolled providers (i.e., providers who have not been previously enrolled with the program). Based on this report, the Contractor shall:
 - 1) Make contact via phone call with all newly enrolled billing providers within the first ninety (90) calendar days of enrollment to request feedback about the

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program, inform providers of all the services and resources available to providers and/or office staff, and, if necessary, offer on-site visits for hands-on technical assistance;

- 2) If no contact was made in the first ninety (90) calendar days of enrollment, the Contractor shall attempt to make contact up to three more times within the first one hundred eighty (180) calendar days after the date of enrollment; and
 - 3) Keep a log and submit monthly reports to the Department on the progress for contact with newly enrolled providers. The report shall indicate the nature of the technical assistance provided and the feedback given to the Contractor by newly enrolled offices and/or office staff.
- k. Perform monthly database checks of all billing providers, rendering providers, and persons with any ownership interest or managing control in compliance with the most current federal and State law. The Contractor shall provide reports with the number of matches to exclusions and actions taken as a result on a monthly basis;
 - l. Develop and submit for departmental review and approval a process or solution by which Denti-Cal providers can report beneficiary no shows to scheduled appointments. The Contractor shall identify and reduce the number of missed appointments through direct communication with the beneficiary. A missed appointment is defined as an appointment scheduled through the Contractor that does not result in claims activity or a provider notifying the Contractor of an appointment the beneficiary did not attend. The Contractor must contact beneficiaries who missed scheduled appointments by utilizing Customer Relations Management (CRM) information captured at the time of referral. All efforts shall be consistent with the most current applicable federal and State Medi-Cal laws;
 - m. Assess the needs of the provider community regarding their awareness of HIPAA as it relates to the submission of Medi-Cal claims. Issue provider bulletins, letters, and web-based notification material as required to inform the provider community;
 - n. Perform operational tasks affected by the implementation of all HIPAA Final Rules, including HIPAA Transaction and Code Set Final Rule; and
 - o. Unless otherwise stipulated, all Provider Services activities shall be available Monday through Friday, 8:00 AM – 5:00 PM Pacific Time (PT).

16. Denti-Cal Provider Participation for Beneficiary Access

The Contractor shall be responsible for ensuring the public has access to current information pertinent to providing beneficiaries with referrals to providers to address their oral health needs.

The Contractor shall:

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- a. Conduct an annual referral list campaign to solicit the participation of all enrolled providers for the Denti-Cal Provider Referral List. Providers shall be required to return a completed referral form on an annual basis in order to continue participation on the Denti-Cal Provider Referral List.

The Denti-Cal Provider Referral List shall be used to provide referrals to beneficiaries seeking dental care and to update the PMF accordingly;

- b. Remove non-responsive providers from the Denti-Cal Provider Referral List at the end of the annual campaign;
- c. Submit to the Department for review and approval a work plan in December of each calendar year to describe how the Contractor plans to effectively increase the number of participating providers on the referral list as a result of this campaign;
- d. Operate an electronic referral system that will provide beneficiaries with a minimum of three provider names, addresses, phone numbers, and specialties of dental providers within their geographic location as defined by no more than twenty-five (25) miles driving distance from the beneficiary's address, or no more than thirty (30) minutes in urban areas and no more than ninety (90) minutes in rural areas. Referrals shall be provided in a manner that shall ensure that neither the Contractor nor the Department is perceived as recommending a particular provider or assuming responsibility for the quality of care rendered by any provider;
- e. Assist eligible beneficiaries with access to dental professionals enrolled in the Medi-Cal Dental Program should the TSC require assistance in resolving complex referrals. Detailed information regarding the beneficiary referral process can be found in Exhibit A, Attachment II, Telephone Service Center;
- f. Respond to beneficiary or Department inquiries on the same day the inquiry is received, to the extent possible. If a "same day" response is not possible, the response to an inquiry (i.e., the referral) shall be made within three business days from receipt of the request;
- g. Confirm all referrals in writing to the beneficiary. Confirmation letters shall be generated and mailed the next business day following the inquiry; and
- h. Document the activities related to individual access questions. The following documentation shall be made accessible to both Department and approved Contractor staff via an online database:
 - 1) Number of requests;
 - 2) Name of the beneficiary and their Medi-Cal identification number;
 - 3) Referring agency or name of the beneficiary's authorized representative, if applicable;
 - 4) Address, including Zip Code, and phone number;

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- 5) Date inquiry received;
- 6) Type of service sought (i.e., general dentistry, orthodontics, other specialty);
- 7) Type of appointment sought (i.e., emergency, non-urgent, preventive);
- 8) To whom referred by provider name, provider number, address of service location, including Zip Code, and phone number (multiple entries shall be made if appropriate);
- 9) Date referral was made;
- 10) Date of scheduled appointment, if applicable;
- 11) Distance traveled from beneficiary residence to provider office location;
- 12) Whether the referral was made by phone, written correspondence, or other source;
- 13) Any feedback from beneficiary or referring agency; and
- 14) Complaints received, date received, and date referred to the Contractor's complaints/grievances operation. Referral to the complaints/grievances operation shall occur no later than the next business day following receipt of the complaint.

The Contractor shall monitor statewide access to dental care, identify barriers, and provide solutions. This information shall be processed daily and updated to a database. This information, including raw data and working papers, shall be kept for the term of the Contract and shall be available to the Department upon request.

17. Provider Customer Service Survey

The Contractor shall assess, on an annual basis, its performance by collecting a statistically valid sample of the actively enrolled providers for the calendar year. Actively enrolled provider is defined for the purposes of this section as billing providers with active status in the PMF. Feedback provided from this survey shall assist Contractor staff to implement improvements to the program via internal process improvement or external recommendations to the Contracting Officer.

The Contractor shall:

- a. Conduct an annual provider satisfaction survey to assess the quality of service provided by the Medi-Cal Dental program;
- b. Ensure the survey follows scientific criteria related to survey development and collection as described in the Contractor's Proposal to the RFP;
- c. Ensure the survey collects a statistically valid sample of the targeted population;
- d. Ensure surveyed topics include, but are not limited to, provider satisfaction in the following areas:

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- 1) Claims adjudication;
 - 2) Timeliness of payment;
 - 3) Provider enrollment process;
 - 4) Customer service metrics; and
 - 5) Other policies and procedures related to the program.
- e. Submit provider survey results, the assessment and the Contractor's recommended solutions to issues identified to the to the Department within forty-five (45) business days after the completion of the survey.

The Department shall review and approve, on an annual basis, the methodology for the provider customer service satisfaction survey which shall include an implementation plan, work plan, and complete list of survey questions. The Department shall exercise their right to make modifications to the survey questions, survey topics, and implementation and work plans as necessary contingent on Departmental objectives and priorities.

18. Provider Services Reports

Provider Services reports produced manually or by CD-MMIS must meet requirements described in the Exhibit A, Attachment II, General Reporting Requirements section, unless otherwise specified.

The Contractor shall collaborate with the FI Contractor to determine if the reports shall be generated by the system. The Department will not be financially responsible to duplicate reporting. The Contractor shall submit to the Department the following information:

- a. Provider Network Reports
 - 1) Produce monthly reports with the following criteria to be delivered to the Department no later than the fifth calendar day of each month:
 - a) Number of all active billing providers, include by county;
 - b) Number of actively participating billing providers and their service office locations who submitted at least one claim in the last twelve (12) months, include by county;
 - c) Number of enrolled billing providers who have submitted claims for twenty-five (25) or more unduplicated beneficiaries in the last twelve (12) months, include by county;
 - d) Number of all enrolled rendering providers, include by county;
 - e) Number of enrolled rendering providers who have provided services to twenty-five (25) or more unduplicated beneficiaries in the last twelve (12) months, include by county;

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- f) Number of enrolled rendering providers showing up on at least one claim in the last twelve (12) months, include by county;
 - g) Utilizing the FAM110 report provided by the Department, provide by-county and state-wide provider-to-beneficiary ratios;
 - h) A by-county report on provider participation on the Denti-Cal provider referral list; and
 - i) A by-county report on specialist provider participation on the Denti-Cal provider referral list based on claim activity to service office locations.
- b. Provider Services
- 1) Monthly reports shall be made available to the Department no later than the fifth calendar day of each month, to include but not be limited to:
 - a) Provider related problems and/or concerns summarized by category and source, i.e. inquiries. These include concerns related to referrals provided by the Department, newly enrolled providers, provider appeals, suspected fraud or abuse, problems with hardware and/or software, and HIPAA violations;
 - b) Actions taken by the Contractor to resolve problems or to allow providers to correct the problems;
 - c) A narrative description of the actions the Contractor plans to take to resolve problems and a time schedule for each action/activity the Contractor proposes to take;
 - d) A listing of the providers contacted/visited during the report month, summarized by provider specialty, provider representative, nature of the problem, and the training and/or assistance provided; and
 - e) Proposed changes, if any, in the required Provider Services.
 - 2) Report on the progress of conducting monthly database checks. This report shall include, but not be limited to, reporting the number of matches to exclusion databases, the number of requests for directives sent to the Department, and a description of action taken against the provider;
 - 3) A list of provider on-site visit cases and resolutions for each case; and
 - 4) Work with the Department to develop a report and follow-up process for providers whose claim was denied for lack of provider enrollment information in the PMF. The Contractor shall identify providers submitting claims without being enrolled in the program and shall make contact, offer the appropriate provider enrollment information, and provide assistance as necessary in order to enroll interested providers.

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c. Provider Enrollment

- 1) Design, develop, and produce a monthly Enrollment Cycle Time report based on calendar days to be submitted to the Department no later than the tenth (10th) calendar day of the month to include, but not limited to the following:
 - a) Date application was received;
 - b) Number of days since application was received;
 - c) Number of days to process application to date;
 - d) If application was incomplete, date returned to provider;
 - e) Date information requested was received;
 - f) Date application was completed;
 - g) Disposition of each application;
 - h) Specialty of provider;
 - i) County of provider;
 - j) Date placed on and removed from provisional status;
 - k) Date letter confirming enrollment was mailed;
 - l) Average time to process completed enrollment applications within the reporting month;
 - m) Shortest processing time for a completed enrollment application within the reporting month; and
 - n) Longest processing time for a completed enrollment application within the reporting month.
- 2) Produce monthly revalidation reports including but not limited to:
 - a) Date seventy (70)-day notification was mailed;
 - b) Date twenty (20)-day notification was mailed;
 - c) Date revalidation package was received;
 - d) Actions taken on revalidation package;
 - e) Number of revalidation packages received;
 - f) Number of revalidation packages returned to providers;

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- g) Average length of time for a complete provider revalidation in calendar days; and
 - h) Minimum and maximum lengths of time for a completed provider revalidation completion in calendar days.
- 3) Produce monthly reports on provider attendance at enrollment outreach events and the success of said events calculated by the number of applications submitted as a result of the event. Reports should include, but not be limited to, monthly provider enrollment workshops and weekly provider enrollment assistance line (phone bank) events;
 - 4) Produce a monthly report that includes the volume of outgoing mail associated with provider services functions costs for each week and a monthly summary;
 - 5) Produce a monthly report due no later than the tenth (10th) calendar day of each month that measures the number of pieces of provider enrollment mail returned as undeliverable and action(s) taken to correct any deficiencies; and
 - 6) Produce a monthly report due no later than the tenth (10th) calendar day with provider city and county information and the number of applications received for the below categories:
 - a) New enrollment applications;
 - b) Re-enrollment applications;
 - c) Revalidation applications;
 - d) Supplemental applications; and
 - e) Denied applications.
- d. Billing Intermediaries
- Produce monthly reports no later than the tenth (10th) calendar day of each month for the registration and/or notification of billing intermediaries. Reports should list each new, current, and discontinued billing intermediary/provider and include:
- 1) Name of each provider the intermediary has contacted. Include the DBA name;
 - 2) Provider Number;
 - 3) Dental License Number;
 - 4) Business Address;
 - 5) Service Office;

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- 6) Service Office County Name;
 - 7) Contract Effective Date;
 - 8) Contract End Date; and
 - 9) Last Date of Update.
- e. EDI

Produce monthly documentation due no later than the thirtieth (30th) calendar day of each month, to include, but not limited to:

- 1) Verify new provider's technical ability to comply with EDI requirements;
- 2) Ensure compliance with EDI standards as determined under HIPAA; and
- 3) Statistics related to EDI enrollment and other reports as developed by the Contractor in the RFP Proposal.

19. Organization and Staffing

The Contractor shall provide an organizational structure and staffing to ensure sufficiently qualified staff is employed to meet all Provider Services duties/responsibilities identified within this section. Selected functions within Provider Services have specific staffing requirements and/or limitations on work activities. All vacancies shall be filled within thirty (30) calendar days unless specifically exempted by the Contracting Officer, or the Department shall be reimbursed for any vacant positions. (Refer to Exhibit E, Additional Provisions, Contractor Resource Levels.) Ensure sufficient management staff is available to participate in management control of activities, attend planning/problem resolution meetings, etc., as well as provide sufficient clerical and administrative support staff necessary to meet all Contract requirements. Provide staff with necessary workspace and all necessary computer resources, equipment, and materials, i.e. online systems access, telephones, publications, reports, manuals, etc., which are necessary in the performance of their assigned Provider Services activities. Access to dental professional staff shall be made available 8:00 AM - 5:00 PM PT, Monday through Friday, unless stated otherwise in this section, to address/resolve provider-related clinical issues.

20. Equipment

The Contractor shall furnish the necessary equipment to ensure effective Operations necessary to meet or exceed all of the Contract requirements.

The Contractor shall:

- a. Ensure that all staff has the same level of functionality and can effectively communicate amongst themselves, with other Contractor staff, and/or the Department as necessary;

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- b. Provide all computer software (including connectivity for facilitating access to information and communications) necessary to meet all contractual requirements;
- c. Provide telephones and, where appropriate, cell phones, faxes, and copiers;
- d. Oversee all telecommunication hardware and software for proper working conditions for the ongoing Operations of the Provider Services activities; and
- e. Ensure all computer systems and technologies employed by the Contractor to support the Provider Services Operations have the capability to be expanded and/or upgraded in anticipation of new programs or program expansions that are likely to occur over the term of this Contract. The systems/technologies must be compatible with the Contractor's and the Department's standards for hardware and software configurations.

21. Department Responsibilities

The Department shall:

- a. Develop and provide guidance on Medi-Cal Dental policy related to Provider Services and its functions;
- b. Review and approve all applications/agreements/forms and the provider enrollment package materials that shall be sent to prospective Medi-Cal dental providers prior to the distribution of such documents;
- c. Review, modify as necessary, and approve the Contractor's procedures for certifying that a provider is eligible to enroll in the Medi-Cal Dental program;
- d. Review and approve the Contractor's requests to take action against a provider. Following approval, the Department will instruct the Contractor to indicate on the PMF the action to be taken. The Department also retains the authority to initiate action against a provider independent of the Contractor's request;
- e. Identify providers to be inactivated from the Medi-Cal Dental Program and instruct the Contractor to initiate action resulting in inactivation;
- f. Continue to define those areas in states adjacent to California that qualify as border communities and allow providers there to enroll as in-state providers;
- g. Review and approve the Contractor's schedule of provider training seminars, including, but not limited to: proposed agendas, description of training content, training locations, handouts for each seminar, and any changes thereof;
- h. Review and approve the evaluation forms used by providers to evaluate training sessions, and any changes thereof;
- i. Review and approve the Handbook updates or amendments and provider bulletins prior to release;

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- j. Review and approve updates to the Denti-Cal website and prepare web change requests;
- k. Review and approve documentation relating to providers who are subject to special prepayment review, including prior authorization and special claims review status;
- l. Review and approve the Contractor's procedures for telephone responses, correspondence responses, provider services activities, and any changes thereof;
- m. Review and approve all forms utilized by providers to interact with the Medi-Cal Dental Program, prior to distribution to the providers;
- n. Monitor provider training, provider publications, and provider services to maintain integrity and consistency;
- o. Review and approve modifications that provide for the registering of billing intermediaries. In cases where the Department disapproves of any aspect of the modifications, the Contractor shall be directed to make the updates as deemed necessary by the Department;
- p. Monitor the PMF and subsequent CD-MMIS reports of billing intermediary services;
- q. Prior to distribution, review and approve all EDI materials prepared by the Contractor, including the annual increased EDI participation strategic plan;
- r. Determine all policy related to the registration, modification, and/or withdrawal of billing intermediaries;
- s. Review and approve all material distributed to providers;
- t. Review and approve all travel requests which are reimbursed by the Department prior to reservations being made;
- u. Ensure all Contractor's travel reimbursement complies with State travel requirements;
- v. Participate in consultations with providers and provider associations; and
- w. Review and approve any modifications to the provider suspense notification of TAR explanation codes created for TARs "In Process."

C. BENEFICIARY OUTREACH**1. Overview**

The Beneficiary Outreach component of the Contractor's organization is responsible for increasing access to and utilization of dental care for California's Medicaid population. The Contractor shall be primarily responsible for increasing beneficiary awareness of the importance of oral health, improving beneficiary knowledge of how

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to acquire services within the Medi-Cal Dental Program, and encouraging beneficiaries to find and continue receiving dental care services, especially preventive care. The Contractor shall work to increase access to care in all areas of the State and border communities, with an emphasis on areas and subpopulations with low utilization.

The Contractor shall propose a comprehensive implementation plan to advance the Triple Aim initiative, which includes improving the healthcare experience for the beneficiary, improving the health of a defined population, while lowering health care costs. Achieving the objectives of the Triple Aim can be facilitated in part through increased utilization of preventive services. Activities directed towards attaining objectives of the Triple Aim initiative shall become established methods and/or procedures of the Beneficiary Outreach Plan.

2. Objectives

The Contractor shall:

- a. Increase the utilization rates for Annual Dental Visits, Use of Preventive Dental Services, and Use of Dental Sealants;
- b. Identify, monitor, address, and resolve barriers to utilization of and timely access to dental care statewide, in border communities, and in those areas and subpopulations that are below targeted utilization levels as identified by the Department. The Contractor shall, at a minimum, work cooperatively with State, county, and city agencies, schools, nursing facilities, community organizations, beneficiary stakeholders, and the Provider Outreach unit to accurately identify barriers to care and develop plans to mitigate these barriers; and
- c. Maximize beneficiary awareness of the Medi-Cal Dental Program, information about the covered benefits available to them, and the tools at their disposal to schedule appointments and/or receive other assistance.

3. Assumptions and Constraints

- a. The Contractor shall:
 - 1) Collaborate with the California Dental Medicaid Management Information System (CD-MMIS) Fiscal Intermediary (FI) Contractor to obtain data, develop reports, and meet the requirements as defined throughout this section of the Contract;
 - 2) Attend Operations training hosted internally and by the CD-MMIS FI Contractor to develop staff knowledge of all aspects of the CD-MMIS;
 - 3) Obtain and use data that resides on CD-MMIS, California Medicaid Management Information System (CA-MMIS), and/or other data resources available to the Department to advance the objectives of Beneficiary Outreach;

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- 4) Include dental services performed at Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Indian Health Service (IHS) clinics in the calculation used to determine applicable performance measures;
 - 5) FQHC, RHC, and IHS clinic claims are adjudicated and paid by CA-MMIS. These data are obtained from the medical FI contractor; and
 - 6) Work with the Department to ensure compliance with security and privacy requirements.
- b. The following additional assumptions and constraints apply to the Beneficiary Outreach function of the Contract:
- 1) The Department will establish baseline target rates for precedent to payment items;
 - 2) The Provider Outreach unit shall focus on increasing and strengthening the provider network; and
 - 3) Significant overlap exists between Beneficiary Outreach and Provider Outreach.

4. General Responsibilities

The Contractor shall:

- a. Submit and implement an approved Beneficiary Outreach Plan, with updates to be reviewed and approved by the Department every November;
- b. Work with the Department to develop a means of communicating with Medi-Cal managed care health plan households to emphasize the importance of regular dental care and to provide the Contractor's toll-free number;
- c. Coordinate efforts with community organizations that interact with the Medicaid population, including, but not limited to, State and local Head Start agencies, State and local Women, Infant and Children's (WIC) programs, Area Agencies on Aging, State and local First 5 commissions, school-based dental programs, and other entities designated by the Department;
- d. Propose innovative solutions to address low beneficiary program utilization;
- e. Determine and develop performance measure reports required to monitor and meet the objectives of Beneficiary Outreach;
- f. Review on an annual basis the effectiveness of the beneficiary referral process and propose solutions to all identified barriers to providing beneficiaries with accurate referrals within an adequate timeframe and distance from their residence, or requested location; and
- g. Participate in all dental stakeholder meetings convened by the Department.

Exhibit A, Attachment II
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The Contractor shall provide a summary of identified issues, explain the methodology for targeting specific groups, and provide a justification for the effectiveness of the approach in addressing each of the following categories:

a. Utilization

- 1) Increase the Annual Dental Visit for California's Medicaid population enrolled in Medicaid for at least ninety (90) continuous days by ten (10) percentage points over three years. The Contractor shall increase the measure in the State by three point three (3.3) percentage points in the first Contract year and by three point three (3.3) percentage points in each of the first two Contract extension years;
- 2) Increase preventive dental services for children ages one through twenty (20) enrolled in Medicaid for at least ninety (90) continuous days by ten (10) percentage points over three years. The Contractor shall increase the measure by three point three (3.3) percentage points in the first Contract year and by three point three (3.3) percentage points in each of the first two Contract extension years;
- 3) Increase sealants on permanent molars for children ages six through nine enrolled in Medicaid for at least ninety (90) continuous days by ten (10) percentage points over three years. The Contractor shall increase the measure by three point three (3.3) percentage points in the first Contract year and by three point three (3.3) percentage points in each of the first two Contract extension years;
- 4) Annual increases to precedent to payment items are calculated against the baselines. Example of a ten (10) percentage point increase over three years:
 - a) Contract year one must increase at a minimum of three point three (3.3) percentage points over baseline.
 - b) Contract extension year two must increase at a minimum of six point six (6.6) percentage points over baseline.
 - c) Contract extension year three must increase at a minimum of ten (10) percentage points over baseline.
 - d) Subsequent Contract years must remain at or above ten (10) percentage points over baseline.

In the event the Contractor does not achieve required increases, the Department will apply precedent to payment requirements as described in Exhibit B, Attachment I, Special Payment Provisions.

- 5) All areas within the State shall be targeted for outreach activities, with priority given to areas and sub-populations where the utilization of Medicaid dental services is below targeted utilization levels as prescribed by the Department.

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b. Education

- 1) Include a comprehensive health promotion and prevention education and community engagement strategy utilizing beneficiary demographic information, scientific methodologies, justifications for adhering to the planned approach, and evidence of its effectiveness as an outreach strategy for the targeted population that shall encompass the following elements:
 - a) Utilize and promote the use of evidence-based and age-appropriate preventive procedures, including fluoride varnish and dental sealants. The Contractor shall stay current with the scientific literature on oral disease prevention and propose for the Department's consideration such modifications in preventive procedures as it views appropriate given the state of the science;
 - b) Address education and outreach requirements outlined in the Welfare & Institutions Code Section 14132.91;
 - c) Help families understand the importance of dental benefits and how to access dental services. Provide a description of how, and through what communication channels, this information will be disseminated to the beneficiaries, and if appropriate the beneficiary's parents/guardians;
 - d) Contact beneficiaries with information stressing the importance of early and periodic dental care, including instructions to reach the Contractor and schedule a dental appointment;
 - e) Identify and contact families of children who have not had a dental visit or received recommended diagnostic and preventive services within the timeframes recommended in the Department's dental periodicity schedule, including children who are patients of Medi-Cal managed care health plan pediatric providers. Develop an outreach package containing oral health education materials, referral tools, and participating pediatric providers;
 - f) In collaboration with the Department, develop guidelines for primary care-based prevention and treatment of oral health conditions, including indications and procedures for referral to a specialist, and describe how it will coordinate with the Department to make these guidelines available to their contracted health plans and their network Primary Care Providers involved in the care or coordination of medical services to Medicaid beneficiaries;
 - g) Assist beneficiaries with selection of a dentist within thirty (30) calendar days notification by the Department of a beneficiary's enrollment. Validate and report on the effectiveness of these procedures. The Contractor will not be responsible for assigning a beneficiary to a dentist;
 - h) Contact and provide training to primary care medical providers, including but not limited to pediatricians, family physicians, and obstetricians/gynecologists on the importance of oral health;

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- i) Provide training to State and local agencies and community organizations that serve low-income pregnant women on the importance of oral health;
- j) Development of American Dental Association (ADA) compliant education for parents on the need to bring children in for their first dental visit by age one;
- k) Development and provision of training, posters, referral pads, and other educational materials aimed at informing beneficiaries of their dental benefits and encouraging them to obtain regular dental care;
- l) Development and distribution of tools to dental and medical providers to advise patients of oral healthcare; provide oral health toolkits for their patients, to include a toothbrush, toothpaste, floss, and instructions on how to brush and floss; and 'prescription pads' from which medical providers can tear off a referral sheet to the beneficiary receiving the advice;
- m) Develop all beneficiary materials in both English and all threshold languages and assure that all written materials are at no higher than a sixth grade reading level;
- n) Development and distribution of informational posters and tear off pads with the Contractor's telephone number and information;
- o) Development of material to inform parents/guardians, medical providers, other governmental and non-governmental organizations, and community advocates on key information to promote oral health and the utilization of dental services under the Medi-Cal Dental Program;
- p) Encourage agencies and organizations to inform their clients about the importance of oral health and how to access dental services;
- q) Ensure physicians and beneficiaries are informed of all methods by which the Contractor receives communication;
- r) The use of brochures, flyers, and other print material used to inform beneficiaries of the available covered dental benefits with the Contractor toll-free number clearly noted;
- s) The use of the Denti-Cal website as a tool to inform the beneficiary population of covered benefits in the Medi-Cal Dental Program and how to access timely dental services;
- t) Ensure beneficiaries receive information about how to avoid inappropriate care or fraudulent providers; and
- u) Provide a description of how, and through what communication channels, educational information will be disseminated to beneficiaries, and if appropriate the beneficiary's parents/guardians.

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c. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services

EPSDT services are federally required, and includes dental services in the current Denti-Cal Program's scope of benefits for beneficiaries under the age of twenty-one (21). Federal law addresses EPSDT as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89). In addition, section 1905(4)(5) of the Social Security Act requires a medically necessary health care service listed in Section 1905(a) be provided to an EPSDT beneficiary even if the service is not under the state's Medicaid plan.

- 1) Identify and contact families of children who are due for an annual EPSDT dental screening, overdue for dental screening, initial and periodic dental examination, and prevention visits, and those who have missed such visits, and assist them in scheduling any necessary appointments, including, but not limited to, assistance with following up on missed appointments, scheduling transportation, and arranging interpreter services for beneficiaries with limited English proficiency and beneficiaries who are hearing or visually impaired;
- 2) Facilitate beneficiary access to and receipt of medically necessary dental care, diagnostic services, oral health services recommended pursuant to an EPSDT health assessment, and treatment for beneficiaries under twenty-one (21) years of age covered under the federal Medicaid program and described in Section 1905(a) of the Social Security Act regardless of whether the dental care, diagnostic services, and treatment are specified in the list of covered services and regardless of any limitations on the amount, duration, or scope of the services that would otherwise be applied. (See Denti-Cal Provider Handbook, Early and Periodic Screening, Diagnosis and Treatment Supplemental Services (EPSDT-SS) on the California Denti-Cal website, Provider Handbook, section 9 and Title 22 of the California Code of Regulations (CCR), Sections 51184, 51242, 51304, 51340, 51340.1 and 51532.);
- 3) Implement a prevention and intervention strategy to prevent oral disease, including dental decay and periodontal disease. The prevention and intervention strategy shall include both written and oral informing of EPSDT services to families of EPSDT eligible children;
- 4) Utilize monitoring, prevention, and intervention protocols, including a description of educational materials approved by the Department; and
- 5) Provide outreach to EPSDT eligible beneficiaries to meet the requirements of the EPSDT program as set forth in Sections 1902(a)(43) and 1905(r) of the Social Security Act.

6. Special Studies

a. Care Coordination and Case Management

Young children with early childhood caries or other acute or chronic health conditions that meet criteria established by the Contractor and the Department may benefit from care coordination and case management services. These services may include, but are not limited to, education, counseling, and

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specialized oral health care and intervention strategies with children and their parents or legal guardians to provide immediate treatment of current decay or other acute or chronic health conditions and to decrease the likelihood of their occurrence in the future.

For the purposes of this Contract, "care coordination" means services delivered to an identified beneficiary by a non-dental professional in order to provide assistance to the beneficiary to gain access to oral health care services. The referral for this service may be made by community non-dental providers, dental providers or the beneficiary and/or his/her representative or identified through analysis of claims data.

1) The requirements for care coordination include:

- a) Beneficiary is unable to navigate the health care system independently (e.g., developmentally delayed or mental health issues);
- b) Beneficiary has extensive dental needs secondary to neglect or non-compliance;
- c) Beneficiary has an issue which prevents him or her from obtaining dental care (e.g., homeless, mental health issues); or
- d) Beneficiary is identified as having inconsistent care and requires education.

For the purposes of this Contract, "case management" means the processes for identifying beneficiaries who have special health care needs, and developing a specific strategy to address these needs with the goal of attaining realistic, optimal oral health in an efficient manner between multiple medical and dental providers.

For the purposes of this Contract, special health care needs include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, health care intervention, and/or use of specialized services or programs. The condition may be developmental or acquired and may cause limitations in performing daily self-maintenance activities or substantial limitations in a major life activity. Health care for individuals with special needs is beyond that considered routine and requires specialized knowledge, increased awareness and attention, adaptation, and accommodative measures beyond what are considered routine.

2) The requirements for case management include:

- a) Beneficiary must have a significant medical diagnosis or diagnoses;
- b) Beneficiary must have special health care needs or extensive dental needs (i.e., it is not enough to just need preventive services); and
- c) Coordination of dental/medical treatment is needed between multiple practitioners.

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- 3) The goals of both care coordination and case management include:
- a) Keep the beneficiary as healthy as possible;
 - b) Improve the beneficiary's overall health;
 - c) Identify or treat an illness or condition; and
 - d) Help transition the beneficiary to be self-reliant in the future.

Typically, the beneficiary's dentist will coordinate dental and medical (as necessary) care for his/her patients who meet the criteria for care coordination and case management. The dentist will develop a written care plan to submit for review and approval by the Contractor.

- 4) The Contractor shall:
- a) Propose a process for reimbursing dental providers involved in the case management of a beneficiary with special health care needs;
 - b) Describe the process and protocols to be used for providing care coordination and case management services and the criteria for reviewing and approving case management requests from providers;
 - c) Describe the process to be used to assist beneficiaries who meet the approved criteria for receiving care coordination services and are not receiving case management services from their dentist, including:
 - i. Coordination with the beneficiaries' primary medical care providers;
 - ii. Consult with the beneficiaries' dentist and other providers to address barriers to care experienced by the beneficiaries;
 - iii. Referring, and if necessary, assisting beneficiaries to appropriate services; and
 - iv. Monitor the progress of the beneficiaries' care and treatment and adjusting and updating the care plans accordingly.
- 5) Report to the Department in a form, format and frequency as required by the Department, on the progress toward meeting the goals of the plan of care for those individuals who receive intensive care coordination.
- 6) Report to the Department in a form, format, and frequency as required by the Department, on the following care coordination and case management performance issues:
- a) Access difficulties for specific levels of care (dentist or dental home, referral to specialist, ability to receive care in the operating room, etc.);
 - b) Availability of services that are culturally sensitive;

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- c) Gaps in services in local areas (may include ancillary services such as transportation, etc.);
- d) Successful and creative treatments and/or interventions;
- e) Need for specialized treatments and/or interventions;
- f) Innovative and/or specialized programs that promote improved clinical outcomes; and
- g) Recommendations to resolve issues.

7. Reports

The Contractor shall:

- a. Collaborate with the CD-MMIS FI Contractor to produce Beneficiary Outreach reports through CD-MMIS;
- b. Provide the Department-requested ad-hoc reports using available systems and tools, including available databases, data warehouses, and decision support systems;
- c. Submit to the Department monthly, quarterly, and annual reports to include program utilization by the established FFS performance measures, as set by the department, by county and age group, including separate data from federally funded clinics. The Contractor shall include a summary of all counties and baseline numbers in effect at beginning of the Contract; and
- d. Ensure all reports meet requirements described in the Exhibit A, General Reporting Requirements section in this Contract, unless otherwise specified.

8. Staffing

The Contractor shall:

- a. Provide an organizational structure and staffing to ensure sufficiently qualified staff is employed to meet all Beneficiary Outreach duties and responsibilities identified within this section;
- b. Ensure sufficient management staff is available to participate in management control of activities, attend planning and problem resolution meetings, as well as provide sufficient clerical and administrative support staff necessary to meet all Contract requirements;
- c. Provide, at a minimum, one dedicated dental consultant (California licensed dentist) for both Beneficiary and Provider Outreach units to coordinate, oversee, and travel statewide to recruit and retain providers; educate health professionals, educators and beneficiaries; and create awareness of the Medicaid Dental Program, (Refer to Exhibit A, Attachment II, Provider Outreach);

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- d. Ensure one staff has media and marketing expertise to assist in the development of provider and beneficiary marketing and educational materials;
- e. Provide staff with necessary workspace and all necessary computer resources, equipment, and materials, such as online systems access, telephones, publications, reports, and manuals, which are necessary in the performance of their assigned activities;
- f. Access to dental professional staff shall be made available 8:00 AM - 5:00 PM Pacific Time (PT), Monday through Friday, excluding State holidays, unless stated otherwise in this section, to address and resolve beneficiary-related issues; and
- g. Reimburse the Department for any vacancies not filled after thirty (30) calendar days, unless specifically exempted by the Contracting Officer or the Department. For more information, refer to Exhibit E, Additional Provisions, Contractor Resource Levels, of this Contract.

9. Department Responsibilities

The Department shall:

- a. Review, modify, and approve the Beneficiary Outreach Plan on an annual basis;
- b. Review and approve precedent to payment conditions under this section in accordance with Exhibit B, Attachment I, Special Payment Provisions, of this Contract;
- c. Review and approve all per diem travel related to the Beneficiary Outreach unit in compliance with the annual Beneficiary Outreach Plan and State travel requirements;
- d. Review, modify, and approve all material before distribution to beneficiaries including, but not limited to, information published on the Denti-Cal website, mailed to heads of household, or otherwise distributed to beneficiaries;
- e. Review, modify, and approve the business requirements of all reports including, but not limited to, content, format, and other specifications;
- f. Collaborate with the medical managed care component of the Department with respect to primary dental care education and initiatives to improve ease of referral from and coordination between enrolled dentists and medical providers;
- g. Describe the criteria to be used to identify high risk children, adolescents, and adults who may be candidates for the care coordination and/or case management services.

Exhibit A, Attachment II
Scope of Work - Operations**D. PROVIDER OUTREACH****1. Overview**

The Provider Outreach component of the Contractor's organization serves as an essential element of the Medi-Cal Dental Program's overall strategy and objectives in its ability to provide adequate, timely, and quality services to the Medi-Cal beneficiary population. This component of the Contractor's organization shall focus primarily on maintaining and expanding the Medi-Cal dental provider network throughout the State, in border communities, in underserved or underperforming areas, and with underutilizing sub-populations.

The Contractor shall simultaneously advance the objectives of the Triple Aim initiative intended to improve the health care experience of beneficiaries, improve the health of the defined population, and lower healthcare costs. Achieving the objectives of the Triple Aim can be facilitated in part through increased utilization of preventive services. Activities directed towards attaining objectives of the Triple Aim initiative shall become established methods and/or procedures of the Provider Outreach Plan.

2. Objectives

The Contractor shall:

- a. Ensure that the beneficiary population has adequate and timely access to dental providers, including dental specialists;
- b. Ensure the number of participating dental providers can accommodate beneficiary demand for covered benefits of the Medi-Cal Dental Program;
- c. Increase the overall number of enrolled Medi-Cal rendering dental providers;
- d. Increase the number of participating Medi-Cal general and pediatric providers who have provided more than one service in a calendar year;
- e. Increase the number of service office locations accepting new Denti-Cal beneficiaries statewide; and
- f. Increase the number of providers accepting new Denti-Cal beneficiaries within rural counties and for underserved sub-populations.

3. Assumptions and Constraints

- a. The Contractor shall:
 1. Collaborate with the California Dental Medicaid Management Information System (CD-MMIS) Fiscal Intermediary (FI) Contractor to obtain data, develop reports, and meet the requirements as defined throughout this Contract;
 2. Attend Operations training to develop staff knowledge of all aspects of the CD-MMIS;

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3. Request and develop reports needed to meet the objectives of Provider Outreach; and
 4. Obtain and use data that resides in CD-MMIS, the California Medicaid Management Information System (CA-MMIS), and other data resources available to the Department necessary to fulfill the requirements set forth by this Contract.
- b. The following additional assumptions and constraints apply to the Provider Outreach function of the Contract:
1. The Department will establish baseline target rates for precedent to payment items; and
 2. Significant overlap exists between Beneficiary Outreach and Provider Outreach.

4. General Responsibilities

The Contractor shall:

- a. Submit and implement a Provider Outreach Plan, to be reviewed and approved by the Department every November;
- b. Develop innovative solutions to identified problems related to beneficiary access to care as it pertains to the adequacy and strength of the provider network;
- c. Coordinate with its Beneficiary Outreach unit, and other entities, to provide dental services in, and education to, dental organizations, federally funded clinics, school-based health centers, and dental professional schools, including: currently enrolled dental offices; community clinics; school-based health centers; Women, Infant, and Children (WIC); Head Start sites; and other sites through the use of mobile dental clinics and portable dental equipment;
- d. Contact newly licensed dentists, dental schools, and other organizations, including the California Dental Association (CDA) and local dental societies, specialty dental organizations, and ethnic dental associations to promote the Medi-Cal Dental Program and encourage participation;
- e. Expand the number of providers accepting new patients by directly engaging and recruiting currently enrolled Medi-Cal dental providers;
- f. Identify areas where the Medi-Cal Dental Program can be streamlined to reduce the administrative burden on providers without compromising program integrity;
- g. Work with staff dedicated to provider enrollment to monitor, track, and trend provider participation;
- h. Provide representation at all dental stakeholder meetings convened by the Department;

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- i. Ensure providers are aware of the information available on the Denti-Cal website;
- j. Research dental program outreach efforts of other state Medicaid programs; and
- k. Provide dental education and monitoring of beneficiary access to provider services statewide, in border communities, and in those areas among those sub-populations that exhibit or appear to be in danger of low or declining utilization.

5. Provider Outreach Plan

The Contractor shall:

- a. Increase the number of actively participating Medi-Cal dentists who have provided at least one service in the calendar year by ten (10) percentage points over four years. The Contractor must increase the measure by two point five (2.5) percentage points in the first Contract year and by two point five (2.5) percentage in each of the first three Contract extension years;
- b. Increase the number of service offices accepting new patients and referrals by ten (10) percentage points over four years. The Contractor must increase the measure by two point five (2.5) percentage points in the first Contract year and by two point five (2.5) percentage in each of the first three Contract extension years;
- c. Ensure annual increases to precedent to payment items described in (a) and (b) of this section are calculated against baselines. Example of a ten (10) percentage point increase over four years:
 - 1) Contract year one must increase at a minimum of two point five (2.5) percentage points over baseline.
 - 2) Contract extension year one must increase at a minimum of five percentage points over baseline.
 - 3) Contract extension year two must increase at a minimum of seven point five (7.5) percentage points over baseline.
 - 4) Contract extension year three must increase at a minimum of ten (10) percentage points over baseline.
 - 5) Subsequent Contract years must remain at or above ten (10) percentage points over baseline.

In the event the Contractor does not achieve required increases, the Department will apply precedent to payment requirements as described in Exhibit B, Attachment I, Special Payment Provisions.

- d. Implement proposed solutions to remedy identified dental access issues in underserved areas and underserved cohorts of Medi-Cal beneficiaries within California and the border communities due to the absence or low number of Medi-Cal providers in the area or serving underserved cohorts of Medi-Cal beneficiaries;

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- e. Target all areas within the State for outreach activities, with a focus on areas where the number of enrolled dental providers and/or facilities providing dental services to Medi-Cal beneficiaries is low in relation to the Medi-Cal population or sub-population in the area;
- f. On a monthly basis, evaluate beneficiaries' access to Medi-Cal dental providers throughout the State. This evaluation must highlight:
 - 1) Medi-Cal billing and rendering dental providers by provider type (general dentist, dental specialist by specialty, Registered Dental Hygienist in Alternative Practice (RDHAP), Registered Dental Hygienist (RDH)) by geographic area, including city, county (both residence county of beneficiary and provider county), Medical Service Study Area (MSSA), Zip Code and such other geographic areas of the State as may be designated by the Department;
 - 2) Medi-Cal billing and rendering dental providers by provider type (general dentist, dental specialist by specialty, RDHAP, RDH) by beneficiary age group, sex, race/ethnicity or such other demographic characteristics of beneficiaries as may be designated by the Department;
 - 3) Medi-Cal service offices that are currently accepting new Medi-Cal beneficiaries, by beneficiary age group, race/ethnicity, residence county, city, Zip Code or such other geographic areas of the State as may be designated by the Department;
 - 4) Current addresses and telephone numbers of provider service office locations; and
 - 5) Ratio of billing and rendering providers to beneficiary population and sub-population (e.g., age group) in each county (by beneficiary and provider county), city, Zip Code, or such other geographic areas of the State as may be designated by the Department. The Contractor shall utilize GeoAccess or GeoAccess-type reports as needed to graphically depict data.
- g. Increase the effectiveness of the beneficiary referral process. The Contractor shall describe the processes it will use to review, at intervals determined by the Department, the referral list and ensure that it is current, accurate, and indicates which providers listed are accepting new Denti-Cal patients and any other limitations imposed by providers;
- h. Use and promote the use of evidence-based and age-appropriate preventive procedures, including fluoride varnish and dental sealants. The Contractor shall stay current with the scientific literature on oral disease prevention and propose for the Department's consideration such modifications in preventive procedures as it views appropriate given the state of the science; and
- i. Conduct extensive outreach for dental providers in underserved areas or in areas where sub-population utilization rates are below targeted levels to ensure awareness of the Medi-Cal Dental Program, effectively recruit non-enrolled providers, and increase the number of beneficiaries seen by existing providers.

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6. Special Studies

a. New Service Delivery Methods

The Contractor shall research, document, evaluate, and propose on an annual basis new service delivery methods to the Department, e.g., the Virtual Dental Home demonstration project administered by the University of the Pacific, Arthur A Dugoni School of Dentistry. Additionally, document and propose how these methods could be used in the Medi-Cal Dental Program.

b. Risk Based Caries Management

Early Childhood Caries (ECC) is a chronic, infectious dental disease. Yet ECC is almost completely preventable. Children with ECC may have pain, difficulty with eating, sleeping, and speech and it may affect learning in the classroom. If left untreated, ECC can impact the proper development of permanent teeth.

Many children with ECC require surgical treatment at hospital-based dental clinics or with sedation or general anesthesia in the operating room. However, despite receiving such costly surgical treatment, high rates of children develop new and recurrent decay. Evidence exists that a disease management and prevention model in oral health care improves patient care delivery and improves patient outcomes.

The Contractor shall describe how it proposes to incentivize use of a risk- and evidence-based caries management strategy by Medi-Cal dental providers to help reduce the prevalence of ECC.

c. Increasing Utilization by Selected Adults

Oral health is essential to general health and well-being at every stage of life. Oral conditions have an impact on overall health and disease. Bacteria from the mouth can cause infection in other parts of the body when the immune system has been compromised by disease or medical treatments. Systemic conditions and their treatment are also known to impact oral health. In particular, periodontal disease has been associated with a number of systemic conditions, including cardiovascular disease, diabetes, respiratory illnesses, stroke, dementia, and adverse pregnancy outcomes. In addition, several studies have found that providing dental care to people with diabetes can result in medical care cost savings as a result of fewer hospitalizations, fewer physician visits, and fewer emergency department visits. While cost savings research is not widespread in peer-reviewed literature, it is compelling enough that some insurance companies have developed expanded oral health benefits for people with diabetes and other chronic conditions that involve inflammation.

The Contractor shall describe how it proposes to incentivize use of a risk- and evidence-based strategy to increase utilization of appropriate dental services by adults for whom evidence suggests that dental treatment can mitigate the health impact and medical care costs associated with 1) delivery of preterm and low birth weight babies, and 2) treating chronic disease, including, at least, treatment of adults with diabetes and its complications.

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d. Access to Care Survey

The Contractor shall conduct an annual survey of a statistically valid and representative sample of all licensed dentists in clinical practice in California with oversampling of dental specialists, to assess perceived barriers to dentist participation in the Medi-Cal Dental Program. Survey results and recommendations shall be submitted to the Contracting Officer within forty-five (45) business days.

7. Reports

The Contractor shall:

- a. Collaborate with the CD-MMIS FI Contractor to produce Provider Outreach reports through CD-MMIS once Departmental approval for the content and format of the reports has been acquired;
- b. Provide Department requested ad-hoc reports using available systems and tools, including available databases, data warehouses and decision support systems;
- c. Ensure all reports meet requirements described in Exhibit A, Attachment II, General Reporting Requirements section, unless otherwise specified; and
- d. Produce monthly, quarterly, and Contract phase annual reports to include, but not limited to, the following:
 - 1) Number of billing and rendering general dentist and dental specialist providers actively enrolled in the Medi-Cal Dental Program Provider Master File (PMF). Include a breakdown by county and specialty and baseline numbers as of start of the Contract;
 - 2) Number of billing and rendering providers with at least one claim submitted in the previous 12 month period. Include a breakdown by county and specialty and baseline numbers as of start of the Contract;
 - 3) Number of potential providers (i.e., those in clinical practice but not currently Medi-Cal enrolled dental providers) contacted by geographical location, provider names, provider identification (ID) numbers, and type of practice (general dentistry and/or specific specialty);
 - 4) Whether dentist is or is not accepting new Medi-Cal beneficiaries by age groups accepted, and any limitations imposed, e.g., age, number, special health care needs;
 - 5) Contact and report on dental professional schools, universities, federally funded dental clinics, school-based health centers, dental professional organizations contacted, invited to be Medi-Cal Dental Program providers and their response;
 - 6) Providers contacted through outreach efforts and their response;
 - 7) Providers using mobile and/or portable dental equipment;

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- 8) New providers enrolled;
- 9) New providers enrolled through outreach efforts; and
- 10) Program utilization by county and age group, including data from federally funded clinics.

8. Staffing

The Contractor shall:

- a. Provide an organizational structure and staffing to ensure sufficiently qualified staff is employed to meet all Provider Outreach duties and responsibilities identified within this section;
- b. Ensure sufficient management staff is available to participate in management control of activities, attend planning and problem resolution meetings, as well as provide sufficient clerical and administrative support staff necessary to meet all Contract requirements;
- c. Provide, at a minimum, one dedicated dental consultant (California licensed dentist) for both the Provider and Beneficiary Outreach units to coordinate, oversee, and travel statewide to recruit and retain providers; educate health professionals, educators, and beneficiaries; and create awareness of the Medi-Cal Dental Program;
- d. Ensure one staff has media and marketing expertise to assist in the development of provider and beneficiary marketing and educational materials;
- e. Provide staff with necessary workspace and all necessary computer resources, equipment, and materials, i.e. online systems access, telephones, publications, reports, manuals, etc., which are necessary in the performance of their assigned activities;
- f. Access to dental professional staff shall be made available 8:00 AM – 5:00 PM Pacific Time (PT), Monday through Friday, excluding State holidays, unless stated otherwise in this section, to address and resolve provider-related clinical issues; and
- g. Reimburse the Department for any vacancies after thirty (30) calendar days unless specifically exempted in writing by the Contracting Officer or the Department. Refer to Exhibit E, Additional Provisions, Contractor Resource Levels.

9. Department Responsibilities

The Department shall:

- a. Review and approve the required Provider Outreach plan on an annual basis;
- b. Review and approve all reporting content and format;

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- c. Review and approve all educational material dedicated to provider best practices on behalf of the Department;
- d. Ensure all Contractor's travel reimbursements comply with State travel requirements; and
- e. Collaborate with Medi-Cal Managed Care Division (MMCD) with respect to primary dental care education and initiatives to improve ease of referral from and coordination between enrolled dentists and medical providers.

E. BENEFICIARY SERVICES

1. Overview

The Beneficiary Services component of the Contract is responsible for providing courteous, reliable, and expedient services to the Medi-Cal beneficiary population for covered benefits of the Medi-Cal Dental Program.

The Beneficiary Services unit shall be responsible for resolving complex referrals, ensuring beneficiaries schedule appointments with providers accepting referrals, and resolving any barriers to care the beneficiary may encounter. The Beneficiary Services unit shall address both verbal and written correspondence related to complaints, grievances, and general inquires in a timely manner and within the requirements of this Contract.

The Contractor shall work collaboratively with the Fiscal Intermediary (FI) Contractor to ensure the quality and integrity of the California Dental Medicaid Management Information System (CD-MMIS) meets or exceeds the standards delineated in the sections below.

2. Objectives

The Contractor shall:

- a. Ensure that all beneficiary services are provided in full compliance with the most current federal and State laws, regulations, policies, and procedures related to dental services under the California Medicaid program;
- b. Provide high quality, reliable, and expedient customer service to the Medi-Cal beneficiary population and the general public;
- c. Actively inform beneficiaries via direct and indirect contact, and make readily available key information regarding the Medi-Cal Dental Program, including but not limited to, information regarding:
 - 1) Scope of coverage;
 - 2) Access to services;
 - 3) Beneficiary appeal rights and procedures;
 - 4) Beneficiary complaint and grievance processes;

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- 5) Share-Of-Cost, if applicable;
 - 6) The dental periodicity schedule; and
 - 7) Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services.
- d. Ensure beneficiary complaints, grievances, claims, and requests for clarification of denied or modified services are thoroughly researched, analyzed, and responded to in compliance with the requirements specified in this Contract;
 - e. Ensure State Hearing position statements and proposed withdrawal letters are developed in accordance with the dental State Hearing requirements specified in this Contract;
 - f. Ensure beneficiary reimbursement claims are processed in accordance with any court orders issued in the litigation of *Conlan v. Bonta* and *Conlan v. Shewry*;
 - g. Maintain regular communication with the beneficiary population through educational and informative publications;
 - h. Ensure access to CD-MMIS; language translation services; access to all other online, real-time interactive systems containing active Medi-Cal dental provider information; beneficiary dental history; and hard copy references; and
 - i. Develop proposals and recommendations to improve the customer service provided by the Medi-Cal Dental Program including, but not limited to, making policy recommendations, revising internal processes, and proposing improvements to the Denti-Cal website.

3. Assumptions and Constraints

The Beneficiary Services component of this Contract is subject to the following assumptions and constraints. The Contractor shall:

- a. Confirm the information collected and placed into the system of record is accurate, complete, and compiled to be consistent with the requirements as described in Exhibit A, Attachment II, Quality Management;
- b. Ensure all interactions with the public, including the resolution of each call, shall comply with the contractual requirements stipulated throughout this Contract and shall also be thoroughly documented in the system of record through CD-MMIS. All correspondence shall be easily retrieved as necessary and as requested by the Department;
- c. Work with the FI Contractor to resolve identified system issues related to the provision of beneficiary services within the Medi-Cal Dental Program;
- d. Work closely with the Telephone Service Center (TSC) in resolving referrals;
- e. Submit for Department's review and approval all State Hearing position statements and/or proposed letters of conditional withdrawal to the beneficiary, or their authorized representative, prior to distribution;

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- f. Ensure all beneficiary reimbursement invoices shall be approved by the Department prior to distributing written or verbal notification to a beneficiary regarding a valid reimbursement claim;
- g. Ensure that all written beneficiary information is provided to beneficiaries at a sixth grade reading level and within the standards expressed in the Linguistic Access portion of this Contract;
- h. Maintain the staffing levels necessary to perform the functions delineated in this section within the time frames required by this Contract;
- i. Confirm beneficiary notifications are generated and mailed at the start of Treatment Authorization Request (TAR) processing and maintained thereafter;
- j. Ensure beneficiary complaint, grievance, reimbursement, and State Hearing processes are operational at the start of TAR processing and maintained thereafter; and
- k. Provide sufficient computer resources and equipment to fully support beneficiary services activities and associated administrative support functions.

4. General Responsibilities

The Contractor shall:

- a. Submit and implement an approved Beneficiary Services Plan, with updates to be reviewed and approved by the Department annually. The Beneficiary Services Plan shall include all of the following:
 - 1) A proposed organizational chart with staffing identified;
 - 2) Sufficient professional, administrative, and clerical staff to meet or exceed performance and operational requirements;
 - 3) Sufficient management personnel to supervise Beneficiary Services operations and perform direct liaison activities with Department personnel;
 - 4) Contingency tasks and procedures to be followed should staffing prove inadequate for the Contractor to meet all of its contractual requirements;
 - 5) A description of how the Contractor shall:
 - a) Provide beneficiaries information about their dental benefits, how to access services, and how to find a provider on the Denti-Cal referral list;
 - b) Receive telephone calls, answer questions, and assist beneficiaries with finding providers in the geographic location of their choice;
 - c) Schedule appointments and assist beneficiaries in acquiring transportation, if necessary;

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- d) Follow up with beneficiary grievance cases until appropriately resolved and track the outcomes of all grievance cases; and
 - e) Comply with requirements of the State Hearing process and beneficiary reimbursement claim process as specified in this section of the Contract.
- b. Submit all notices, newsletters, and informing and educational material for the Department's review and approval prior to distribution of any communication developed for beneficiaries;
- c. Ensure the Contractor has a training program to ensure Beneficiary Services staff is knowledgeable in the practice of dentistry within California and have a familiarity of how claims and TARs are processed within the Medi-Cal Dental Program. Scope of knowledge and skill are defined to include, but not be limited to:
- 1) Knowledge of statutes, regulations, policies, and procedures related to the Medi-Cal Dental Program;
 - 2) Knowledge of beneficiary complaint and grievance processes;
 - 3) Thorough understanding of how to utilize the tools, resources, and technology available to the Beneficiary Services staff in resolving beneficiary inquiries;
 - 4) Ability to understand when a difficult inquiry or referral should be referred to supervisors; and
 - 5) Customer service experience through written or telephone contact.

The knowledge and skill requirement may be met through applicable work experience, being a licensed dental para-professional, or by attending Medi-Cal Dental Program training courses administered by the Contractor.

- d. Ensure beneficiaries are provided with assistance in locating a Medi-Cal dental provider within the geographic location of their choice. In the event a beneficiary is having trouble obtaining services through the Medi-Cal Dental program, staff shall, on the beneficiary's behalf, contact a provider to confirm the provider is accepting patients and set up a three-way call with the provider office while the beneficiary is on the line to schedule an appointment, as defined in Exhibit A, Attachment II, Telephone Service Center;
- e. Provide assistance and American Sign Language (ASL) interpretation services to hearing-impaired beneficiaries, Limited English Proficient (LEP) beneficiaries, and offer translation services for languages if more than five percent of the beneficiaries in any county within the State of California speak the alternative language;
- f. Respond to all inquiries related to beneficiary services from beneficiaries, the general public, FI Contractor staff, other Contractor staff, and the Contracting Officer;

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- g. Assist beneficiaries with scheduling appointments and providing access to Medi-Cal dental providers for covered benefits of the Medi-Cal Dental Program;
- h. Ensure staff have access to information regarding open and closed beneficiary complaints/grievances, scheduling information for clinical screenings, dental provider referral files, and information regarding the notification to beneficiaries whenever services that require prior authorization are denied or modified; and
- i. Ensure any individual representing themselves as an “authorized representative” of a Medi-Cal beneficiary is in compliance with the most current federal Health Insurance Portability and Accountability Act (HIPAA) requirements prior to disclosing Protected Health Information (PHI), as defined in Exhibit H, HIPAA Business Associate Addendum (BAA).

5. Beneficiary Access to Care

The Contractor shall:

- a. Monitor each beneficiary’s use of dental care services and assist beneficiaries in seeking dental care services; and
- b. Provide beneficiaries with scheduling assistance for a preventive care visit when a beneficiary’s last preventive care visit was not within the Medi-Cal dental program’s periodicity schedule guidelines for his or her age or if the beneficiary has not received any primary dental care.

6. Linguistic Access

The Contractor shall:

- a. Ensure adequate access to services by beneficiaries with limited English proficiency. These responsibilities shall include, but not be limited to:
 - 1) Promulgation and implementation of linguistic accessibility policies with application for Contractor staff and subcontractors;
 - 2) Identification of a single Contractor representative for ensuring compliance with linguistic accessibility policies;
 - 3) Provision of both oral interpretation and written translation services;
 - 4) Provision of notices of action and grievance/administrative hearing information in the threshold languages established by the Department; and
 - 5) Notification to its beneficiaries that oral interpretation is available for several languages.
- b. Describe beneficiary educational material to be used in alternative languages (with the exception of English and Spanish) for any county within the State of California if more than five percent of the beneficiaries speak the alternative language. However, this requirement shall not apply if the alternative language has no written form. Additionally, the materials shall take into consideration the

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special needs of those who, for example, have limited reading proficiency. The Contractor may rely upon initial enrollment and monthly enrollment data from the Department to determine the percentage of beneficiaries who speak alternative languages. In all materials and correspondence, the Contractor shall inform beneficiaries written materials are available in these alternative languages.

7. Treatment Authorization Request (TAR) Notification

The Contractor shall:

- a. Work with the FI Contractor to ensure that beneficiaries are notified of denied or modified TARs according to cycle time requirements;
- b. Ensure TAR notifications include clear information on the beneficiary's right to file for a State Hearing and how to request a State Hearing for their denied or modified TAR;
- c. Ensure adequate staffing levels to respond to beneficiary, or authorized representative, inquiries regarding TAR notifications;
- d. Work with the FI Contractor to ensure written notifications are generated when one or more of the service lines on a TAR or a Notice of Authorization (NOA) required prior authorization as a condition to payment and such service line(s) were denied or modified. The use of the replace and substitute procedures are considered modification of a TAR;
- e. Ensure written notifications include reason for action codes specific to beneficiaries, as directed by the Department; and
- f. Provide clarification to beneficiary inquiries regarding notification of a denial or modification of a requested service requiring prior authorization which shall include an explanation of the applicable program criteria.

8. Beneficiary Correspondence

The Contractor shall:

- a. Ensure beneficiaries, and/or their authorized representatives, have the ability to file a complaint or grievance via the toll-free TSC telephone number or by written communication. Complaints received by the Department may be referred to the Contractor for research and resolution. All complaints shall be subject to the same timeliness requirements delineated below;
- b. Ensure all complaints and grievances, regardless of whether the complaint/grievance was received in writing or over the telephone, are acted upon as follows:
 - 1) Provide a written acknowledgement within three business days of receipt. The acknowledgement shall advise the beneficiary the grievance and/or complaint has been received, the date of receipt, and provide the name, telephone number, and address of the representative who may be contacted about the grievance;

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- 2) Ensure the resolution containing a written response to the grievance shall be sent to the beneficiary within thirty (30) calendar days of receipt. The written response shall contain a clear and concise explanation of the resolution; and
 - 3) Grievances received over the telephone that are not coverage disputes or disputed health care services involving medical necessity or experimental or investigational treatment, and are resolved by the close of the next business day, are exempt from the requirement to send a written acknowledgment and response. The Contractor shall maintain a log of all such grievances containing the date of the call; complaint type; the name of the complainant; beneficiary identification (ID) number; detailed list of beneficiary demographics; nature of the grievance; nature of the resolution; and the representative's name that took the call and resolved the grievance. The Department reserves the right to request a copy of the log at any time.
- c. Ensure an electronic record of all complaint/grievances includes the following:
- 1) Date complaint or grievance was received and whether received in writing or through the TSC;
 - 2) Beneficiary's name, address, phone number, Medi-Cal ID number, and name, address, and telephone number of authorized representative, if applicable;
 - 3) Log number of the complaint;
 - 4) Name, address, and National Provider Identification (NPI) number of involved provider if complaint involved quality of care issues by a particular provider;
 - 5) Related complaints and their log numbers (related by the fact that the same beneficiary has another complaint(s), the complaint is about the same provider, etc.);
 - 6) Nature of the complaint;
 - 7) Actions taken to research, resolve, and respond to the complaint with such information listed by date of action;
 - 8) Name of provider referral(s) given and date referral(s) were made, if applicable;
 - 9) Resolution and the date resolution was achieved; and
 - 10) Date(s) acknowledgment/resolution notice(s) sent to the beneficiary.
- d. At a minimum, the Contractor shall provide reports to indicate the total number of grievances received, pending, and resolved in favor of the beneficiary at all levels of grievance review and to describe the issue or issues raised in grievances as 1) coverage disputes, 2) disputes involving medical necessity, 3) complaints about the quality of care, 4) complaints about access to care (including complaints about the waiting time for appointments), 5) complaints about the quality of service, and 6) other issues;

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- e. Ensure all involved parties are contacted to ascertain relevant facts. If the complaint involves quality of care concerns, the Contractor may refer the beneficiary for a second opinion clinical screening to determine if the complaint has merit. If the quality of care complaint is determined to have merit, a referral of the provider's name, provider ID number, the nature of the complaint, and the results of the complaint investigation shall be referred to the Surveillance and Utilization Review Subsection operation staff and the Department within five business days;
- f. Conduct its own investigation and complaint resolution and shall notify the Department as stipulated under the S/URS and Quality Management (QM) requirements when a complaint, whether provider or beneficiary, involves a referral that is within the Contractor's scope of responsibility;
- g. Redirect beneficiary inquires unrelated to the Medi-Cal Dental Program to other resources (e.g., other county, State or federal agencies, Dental Board of California, Department of Health Care Services (DHCS)) within one business day;
- h. Contractor shall maintain a record of all redirected inquiries, to include the beneficiary name, address, phone number, Medi-Cal identification number, nature of inquiry and the agency the beneficiary was redirected;
- i. Inform the beneficiary of their right to a State Hearing. If the Contractor is unable to resolve a complaint/grievance and the beneficiary's issue involves a denial or modification of service authorization resulting from a submitted TAR, the beneficiary shall be informed of how to file for a State Hearing on such a request in accordance with Title 22, California Code of Regulations (CCR), Section 50951(a);
- j. Ensure that anonymity of the complaint is offered and, if requested by the beneficiary or their representative, such anonymity is protected. The beneficiary or their representative shall be informed that such anonymity cannot be guaranteed in the case of the Department, or other duly authorized federal/State representatives, who may access the records of the Contractor;
- k. Ensure the resulting complaint/grievance records are retained for the term of the Contract and all records made available to the Department or duly authorized federal/State representatives, upon request;
- l. Maintain the ability and the capability to accept, resolve, and respond to beneficiary requests for assistance within the time frames allowed by this Contract;
- m. Provide clarification to general inquiries related to Share-of-Cost (SOC) requirements applicable to Medi-Cal eligibility for dental services; and
- n. Provide clarification, or refer to appropriate staff, on those inquiries related to dental State Hearing issues or beneficiary reimbursement issues.

Exhibit A, Attachment II
Scope of Work - Operations**9. Dental State Hearings**

The Contractor shall ensure beneficiaries are informed of their right to a State Hearing. If the Contractor is unable to resolve a complaint/grievance involving a denial or modification of a service authorization resulting from a submitted TAR, the beneficiary shall be informed of where to file such a request in accordance with Title 22, California Code of Regulations, Section 50951. The Contractor is responsible for upholding this right and providing a position statement on behalf of the Medi-Cal Dental Program to the California Department of Social Services (DSS). DSS is responsible for administering the State Hearing and providing a decision on the State Hearing case.

a. Incoming mail for State Hearings

The Contractor shall, on a daily basis, perform the following tasks associated with incoming State Hearing mail:

- 1) Open envelopes, date stamp contents, scan, and store all incoming documents related to State Hearing cases in the State Hearing Database (SHDB) as described in Exhibit A, Attachment II, State Hearing Administration;
- 2) Assign a case number and create online case files for new cases, if appropriate, and verify that all data is entered correctly;
- 3) When applicable, prepare and mail letters requesting information for EPSDT program evaluation to the treating dentist on all orthodontic related cases;
- 4) Maintain hardcopy case files, in addition to electronic case files, on all new orthodontia cases; and
- 5) Ensure all incoming diagnostic information associated with a case is noted, scanned, and delivered immediately to appropriate Department staff.

b. State Hearing position statements and conditional withdrawals

Position statements are used to provide the presiding Administrative Law Judge (ALJ) hearing the case with the recommendation, or position, of the Department using retrieved evidence. The position statements shall be written to clearly articulate the reasons in favor of or against the adjudication decision in question. Each position statement shall cite the appropriate regulatory requirement(s) that relates specifically to the treatment or reimbursement request.

A copy of the Department-approved position statement is provided to the beneficiary, the provider, if appropriate, and the ALJ prior to the scheduled State Hearing date. The position statement replaces the need for Department staff to attend each State Hearing. However, Department staff is required to be available via telephone and testify at hearings if requested by either the beneficiary or ALJ. Special circumstances may require the Contractor to provide subject matter experts (SMEs), as determined by the Department, to testify on behalf of the Department.

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State Hearings are to be processed, with a completed position statement, within thirty (30) calendar days from date of receipt of a State Hearing request, unless the State Hearing is scheduled within thirty (30) calendar days or unless otherwise directed by the Department. Should a State Hearing be scheduled under thirty (30) calendar days, the Contractor shall provide a position statement fifteen (15) calendar days before the scheduled State Hearing date unless otherwise directed by the Department.

The Contractor shall, upon receipt of a new dental State Hearing request, complete the following tasks within thirty (30) calendar days of the receipt of such request:

- 1) State Hearing position statements shall include:
 - a) Declaration of the Department's position and the regulatory basis for supporting the approved position;
 - b) A summary of the facts and issues involved in the case;
 - c) Disposition of the case and explanation of the disposition;
 - d) The findings for each State Hearing case;
 - e) The date the TAR or claim in question was received;
 - f) A description of the treatment or reimbursement requested;
 - g) Applicable facts of the case including, but not limited to, telephone conversations, correspondence, radiographs received, clinical screening examinations, and any other relevant information pertaining to the State Hearing case;
 - h) If applicable, a statement regarding the provider's responsibility in regard to the reason the service(s) or reimbursement(s) was denied;
 - i) If applicable, a re-evaluation of the request, including the name and title of the dental consultant who re-evaluated the request;
 - j) Copies of documentary evidence and attach all evidence as the exhibits to the State Hearing case;
 - k) Verify subsequent TAR/Claim/NOAs or any incoming documents that may be pertinent to the State Hearing case;
 - l) Provide copies of all documents to the Department relevant to the service(s) at issue for each State Hearing case, including but not limited to:
 - i. TARs;
 - ii. Claims for payment;

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- iii. MMIS screen prints;
 - iv. Applicable grievance and/or complaint records and relevant provider appeal documentation;
 - v. Pertinent correspondence that may be retained in the provider's file maintained by the Contractor;
 - vi. Correspondence Reference Number (CRN) screen prints regarding pertinent beneficiary services call information; and
 - vii. Proof of date denial notice sent.
- 2) Prepare a written analysis of the dental service(s) at issue in each State Hearing case, which shall include a portion of the State Hearing position statement entitled "Finding(s)." In the analysis, specific reference must be made to the Document Control Number (DCN) that substantiates the adjudication and reason(s) for denial or modification and or the reason(s) why provider payment was not issued, if applicable. There shall be a chronological listing of events to include, but not be limited to:
- a) Date provider requested service(s);
 - b) Date TAR and/or claim received;
 - c) Date TAR and/or claim adjudicated; and
 - d) Date denial notice sent.
- 3) Include in the "Finding(s)" portion of the State Hearing position statement an analysis of the adjudication decision in question. Following are tasks that must be performed to develop the analysis:
- a) For all cases involving denial of dentures (full or partial), relines, treatment plans for five or more crowns, or when the denial reason was based on an incomplete treatment plan being submitted by the provider, the Contractor shall schedule the beneficiary for a second opinion clinical screening, unless a screening has been conducted within the past four months. The screening dentist shall not be the last screener of record to examine the patient. When screenings are required to substantiate the Contractor's position on the service(s) at issue, screening appointments shall occur within eleven (11) calendar days from date of receipt of the State Hearing request;
 - b) If the beneficiary fails to attend the first screening, the Contractor shall contact the beneficiary through telephone communication or mail, if necessary, to determine why they failed to appear. The Contractor shall automatically schedule a second screening within two weeks of the missed first screening and notify the beneficiary accordingly. Failure to appear for the first screening appointment and any reschedule information shall be documented by the Contractor staff in the SHDB "comments" section. This information shall also be documented in the

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position statement analysis to uphold the original modification or denial of dental services;

- c) For State Hearing cases where the services at issue were denied based on radiographs that accompanied the initial TAR, the Contractor shall prepare a written request to the provider using State letterhead requesting resubmission of diagnostic radiographs within five calendar days from receipt of the Department's letter unless otherwise directed by the Department. This written request to the provider shall be completed within ten (10) calendar days of receipt of the State Hearing request unless otherwise directed by the Department. If the provider's response or radiographs are not received within ten (10) calendar days of the Department's request, the Contractor shall, on the eleventh (11th) calendar day make one follow-up call to the treating provider's office to speak with an individual to determine the status of the request. Leaving a voice mail message is not acceptable; and
- d) Upon receipt, or absence, of the requested radiographs, or the screening dentist's report, the Contractor shall determine which of the following substantiated actions to take:

- i. Grant dental services at issue:

The Contractor shall contact the beneficiary or their authorized representative, inform them of the proposed decision related to their State Hearing case, and attempt to secure concurrence from the claimant to withdraw the request rather than continue with the State Hearing process, hereafter referred to as a "conditional withdrawal".

- A. Claimant agrees to withdraw their hearing request:

The Contractor provides the claimant with the DSS toll free telephone number to cancel the hearing request. The Contractor shall prepare authorization letters for the beneficiary, on State letterhead, using pink, white, and green paper. Forward the letters for signature to the Contracting Officer or designee for review and approval, and at the same time process all pended claim or TARs for the claimant.

- B. Claimant does not agree to withdraw their hearing request:

If the Contractor is unable to contact the claimant by phone, or if the claimant does not agree to withdraw the case, the Contractor shall annotate the telephone conversation, or lack thereof, in the SHDB, and prepare and forward a position statement to the Department for review and approval.

- ii. Grant a modification of dental services at issue:

The Contractor's dental consultant shall contact the treating dentist and discuss the proposed change. If the treating dentist concurs, the consultant annotates this information in the SHDB and then the

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Contractor must contact the claimant to discuss the change in treatment.

A. Claimant is in agreement:

Contractor prepares/routes a conditional withdrawal letter as described above.

B. Claimant disagrees:

This information is entered in the "comments" section of the Department's SHDB. A State Hearing position statement is prepared by the Contractor, and then forwarded to the Department for review and approval. All radiographs, screening reports, and/or other documentation used by the Contractor in concluding an alternate treatment plan, shall accompany the position statement when transmitted to the Department.

iii. Uphold the original denial:

The Contractor shall prepare and submit to the Department a position statement explaining the basis for such determination/conclusion. All applicable radiographs, screening reports, and/or other documentation used to substantiate this conclusion must accompany the position statement when submitted to the Department for review and approval.

- e) Distribute Department approved position statements or conditional withdrawals seven calendar days prior to the scheduled State Hearing to the beneficiary, and/or authorized representative, including county of involvement, unless otherwise directed by the Department.

c. Reimbursement State Hearings and position statements

When a beneficiary appeals the denial of a requested reimbursement, a dental reimbursement State Hearing position statement shall be prepared for the Department's approval. There are two claims adjudication outcomes of a reimbursement claim that will lead to a new reimbursement State Hearing procedure opportunity. This procedure extends the State Hearing to both the beneficiary and the Medi-Cal dental provider. The denial of a beneficiary's reimbursement claim based on adjudication criteria will result in the right to a State Hearing for the beneficiary. The tentative reimbursement approval requiring recoupment of the Medi-Cal dental provider's funds will result in the right to a State Hearing for the Medi-Cal dental provider. The Contractor shall, upon receipt of a new reimbursement State Hearing request, complete the following within thirty (30) calendar days of the receipt of such request:

- 1) Verify subsequent dental treatment received, approved, and/or denied;
- 2) Verify any other documents that may be pertinent to the State Hearing case;

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- 3) Provide copies of all documents to the Department relevant to the reimbursement at issue for each State Hearing case, including, but not limited to, the claim packet, CD-MMIS screen prints (i.e., beneficiary treatment or call and correspondence history), beneficiary Medi-Cal eligibility records, provider enrollment history, correspondence, and information submitted by the beneficiary and provider;
- 4) Prepare a written analysis of the reimbursement at issue in each State Hearing case, which shall be included in the portion of the State Hearing position statement entitled "Finding(s)." In the analysis, specific reference shall be made to the dates of service, treatment rendered, amount of reimbursement the beneficiary is requesting, provider who rendered the services, beneficiary's Medi-Cal eligibility records, and provider enrollment history and status. As applicable, the "Finding(s)" shall also include, but not be limited to:
 - a) A chart illustrating dates of service; treatment provided; amount billed; adjudication and payment by the beneficiary; and Scheduled Maximum Allowance and SOC; etc.;
 - b) Evaluation of diagnostic information by a dental consultant;
 - c) Timeline of correspondence to the beneficiary and provider; and
 - d) Additional information submitted by the provider.
- 5) Upon completion of the analysis, the Contractor shall determine if the claim was correctly adjudicated. If the original adjudication was correct, the Contractor shall prepare a position statement as outlined above. If the original adjudication was incorrect, the Contractor shall prepare a letter authorizing full or partial reimbursement. The letter authorizing reimbursement shall be approved by the Department prior to contacting the beneficiary, and included in the position statement. For provider State Hearing, the Contractor shall contact the provider to explain the reimbursement process and review additional information submitted by the provider, as applicable;
- 6) The Contractor shall distribute Department approved position statements to the beneficiary, and/or the provider, and DDS two weeks prior to the hearing; and
- 7) Upon receipt of the granted or partially granted beneficiary State Hearing decision, the Contractor shall submit a beneficiary reimbursement invoice to the Department, within thirty (30) calendar days from the receipt of the decision. For denied State Hearing, the Contractor shall contact the provider to ensure they comply with the decision. If the provider does not comply with the decision within sixty (60) calendar days from the date of decision, the Contractor shall submit a beneficiary reimbursement invoice to the Department for approval.

Exhibit A, Attachment II
Scope of Work - Operations**10. Beneficiary Reimbursement Claims**

Court orders issued in *Conlan v. Bonta* and *Conlan v. Shewry*, require the Department to reimburse eligible beneficiaries for covered out-of-pocket medical and dental expenses. The Department must provide a means to reimburse the beneficiary either directly or compel providers to directly reimburse the beneficiary in accordance with the aforementioned lawsuits.

Beneficiary reimbursement claims shall be processed within sixty (60) calendar days of receipt of a complete claim.

a. Assumptions:

- 1) All requests from beneficiaries for reimbursement of dental services, provider claims, and State Hearing requests will be sent to the Contractor for processing at a P.O. Box dedicated for reimbursement claims.
- 2) If the Contractor determines that a claim belongs to another entity, the claim will be forwarded to the appropriate entity. Other entities include Senior Care Action Network (SCAN), Dental Managed Care (DMC), and other entities within the Medi-Cal program.
- 3) The Contractor shall be responsible for tracking, processing, reporting on, and adjudicating these claims within timeframes in accordance with the requirements specified by this Contract.
- 4) Calls from beneficiaries will be received through a dedicated toll free line. The toll free line will be maintained by the DHCS' Medical FI for the Medi-Cal Program California Medicaid Management Information System (CA-MMIS). Calls regarding dental claims will be routed from this line to the Contractor's Interactive Voice Response (IVR) system. These minutes will be included in the monthly TSC billing report and shall be tracked separately as outlined in Exhibit B, Attachment I, Special Payment Provisions.

b. General Requirements

The requirements and timeframes to process beneficiary reimbursement claims are as follows. The Contractor shall:

- 1) Send an acknowledgement to the beneficiary within fifteen (15) calendar days of receipt of a claim unless the beneficiary reimbursement claims need to be redirected;
- 2) Redirect claims for other departments or programs (i.e., SCAN, DMC, or Medi-Cal) within seven calendar days of receipt of a claim;
- 3) By calendar day fifteen (15) of receipt of a claim, notify the provider in writing requesting reimbursement to the beneficiary;
- 4) By calendar day sixty (60) of receipt of a claim, notify the beneficiary that additional information is required to adjudicate the claim, if applicable;

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- 5) Process complete and valid claims within sixty (60) calendar days of receipt. This will ensure sufficient time (including the remaining sixty (60) days) for the Department to complete the direct payment process;
 - 6) Electronically track all claims, their status, the resolution, and all associated documentation and provide the Department access to assist in monitoring Contract compliance;
 - 7) Respond, in writing, to the beneficiary with either a closure letter that the claim has been paid by the provider, a denial, or a request for additional information [up to three times]. If information is not provided on the third attempt, issue a denial letter along with a notification of their State Hearing rights;
 - 8) Work directly with provider(s) to assist the beneficiary in obtaining the necessary documentation required to adjudicate the claim;
 - 9) Prepare valid claims where either the provider did not comply or is not a Medi-Cal dental provider for direct payment to the beneficiary to be reviewed and approved by the Department;
 - 10) Recoup money from enrolled providers, as directed by the Department and in California Welfare & Institutions (W&I) Code Section 14019.3;
 - 11) Process provider submission of claims for services reimbursed to the beneficiary by the provider; and
 - 12) Notify the beneficiary in writing, including a State Hearing NOA, when there is a change in the claim status.
- c. Department direct payments to beneficiaries

For valid claims, where either the provider did not comply or is not a Denti-Cal provider, the Department must directly reimburse that beneficiary. The Contractor shall:

- 1) Prepare a beneficiary reimbursement invoice to be used to complete the direct payment process. Submit for review and approval by the Department, within sixty (60) calendar days from the date of receipt of complete claim. The Contractor shall submit with the invoice the following:
 - a) Reimbursement invoice form;
 - b) Summary sheet of services being approved and/or denied for reimbursement;
 - c) The Department letter to the beneficiary;
 - d) Completed STD 204 form; and
 - e) All associated claim documents (i.e., claim packet, account ledgers, proof of payment, eligibility information, provider information, etc.).

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- 2) Place an accounts receivable (AR) on enrolled Denti-Cal providers as directed by the Department;
 - 3) On a quarterly basis, issue a check to the Department for recoupment amounts from providers; and
 - 4) Electronically track all invoices, accounts receivable, status, and all associated documentation, and provide the Department access.
- d. Reporting Requirements

The Contractor shall provide the following statistics on a monthly basis:

- 1) Reimbursement calls routed to the TSC;
- 2) Number of claim packets mailed to beneficiaries;
- 3) Complete and incomplete claims received;
- 4) Claims in hold status by category (e.g. incomplete letter sent, letter sent to provider, and DHCS direct payment process);
- 5) Claims paid through the Department direct payment process;
- 6) Claims where the provider directly reimbursed the beneficiary. Include the amount that the provider paid to the beneficiary for each claim, indicate who filed the claim for payment, and the amount paid on that claim;
- 7) Claims referred to outside parties;
- 8) Beneficiary State Hearings, cases heard, cases pending scheduling, cases withdrawn, cases granted and denied, etc.; and
- 9) Number of days of processed claim(s) requested by the Department.

11. Beneficiary Clinical Screening Provisions

The Contractor shall:

- a. Conduct screenings at a reasonable time and in a place that is reasonably accessible to beneficiaries. "Reasonably accessible" shall be defined herein as follows:
 - 1) Beneficiaries shall not be required to wait more than one hour beyond the scheduled time of their screening appointment;
 - 2) Screening appointments shall be scheduled during the normal working hours of the clinical screening dentist. However, special scheduling accommodations shall be made available to beneficiaries based on needs stemming from, but not limited to, disability, required travel time to the screening site, transportation, employment hours, or child care needs;

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- 3) No beneficiary shall be required to travel more than:
 - a) Thirty (30) minutes to the screening site in urban/suburban areas; and
 - b) Ninety (90) minutes to the screening site in rural areas;
 - 4) No clinical screenings shall be allowed to occur in any private residence.
- b. Provide on-site screening visits to institutionalized beneficiaries (e.g., those in nursing homes, convalescent homes, or any State licensed facility). The clinical screening dentist arranges these types of screenings. It is the screener's responsibility to contact the facility and schedule a time to conduct the examination;
 - c. Ensure a letter is sent to the facility notifying them that the patient will have a screening examination performed. Also, the Contractor shall send a screening informational packet to the clinical screening dentist the same day the letter is sent to the facility. Upon completion of the screening, the clinical screening dentist shall return all packets to the Contractor within forty-eight (48) hours of the examination;
 - d. Appointments for clinical screenings are scheduled and beneficiaries are notified of appointments within eleven (11) calendar days of the determination that a clinical screening is needed;
 - e. A clinical screening appointment is scheduled within three weeks of the request and the beneficiary is notified of the appointment;
 - f. Provide beneficiaries or their authorized representative with assistance in rescheduling and/or canceling clinical screenings and respond to questions/concerns regarding the screening process;
 - g. Reschedule the clinical screening if the beneficiary notifies the Contractor that he/she is unable to attend the scheduled appointment. The screening shall be rescheduled at a time and place that is mutually acceptable to the beneficiary and the clinical screening dentist;
 - h. Schedule one further clinical screening appointment if the beneficiary fails to keep the scheduled appointment, or if the beneficiary notifies the Contractor of a scheduling difficulty. The clinical screening dentist shall return all packets to the Contractor within forty-eight (48) hours of the missed appointment. The Contractor shall keep a log and all correspondence of notification from the screening consultant and make the information available to the Department within two business days of the Department request;
 - i. Ensure the clinical screening dentist examines the beneficiary and renders his/her findings in a written report of the clinical examination based on professionally recognized standards of care; and
 - j. Ensure whenever the clinical screening dentist cancels the screening appointment, and if the Contractor is unable to notify the beneficiary prior to the beneficiary appearing for the appointment, the beneficiary shall not be required to

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wait for a reschedule nor shall the services be denied, modified, or delayed based upon the failure to have a screening. However, if the Contractor is able to reach the beneficiary in advance of the scheduled appointment, the appointment shall be rescheduled at the beneficiary's convenience.

12. Second Opinions, Specialist Referrals, and the Referral Process

The Contractor shall:

- a. Maintain a roster of screening dentists to perform second opinion clinical screenings requested for dental treatment plans or for State Hearing related cases;
- b. Inform beneficiaries of their option, and assist beneficiaries in obtaining a second opinion from a qualified health care professional within the Medi-Cal Dental provider network prior to their dental provider's submitting a TAR;
- c. Ensure specialist referrals are available to beneficiaries when medically necessary and medically appropriate;
- d. Respond to all provider referral requests the same day or no more than five business days from initial request. A minimum of three referrals will be provided to the beneficiary unless otherwise requested by the beneficiary.
- e. Ensure all referrals shall be confirmed in writing and mailed by the FI Contractor to the beneficiary within five business days from the initial request. If limited provider access is identified, this information shall be forwarded to the Provider Outreach unit within five business days of receiving the challenging referral; and
- f. Implement and maintain policies and procedures for the arrangement and documentation of all referrals to specialty providers.

13. Beneficiary No Show Process

The Contractor shall develop and submit for departmental review and approval a process or solution by which Denti-Cal providers can report beneficiary no shows to scheduled appointments made by the Contractor.

The process shall enable the Contractor to identify and monitor beneficiary attendance to scheduled appointments. The Contractor shall be responsible to reduce the number of missed appointments through direct communication with the beneficiary. A missed appointment is defined as an appointment scheduled through the Contractor that does not result in claims activity or a provider notifying the Contractor of an appointment the beneficiary did not attend.

The Contractor shall contact beneficiaries who missed scheduled appointments by utilizing Customer Relationship Management System (CRMS) information captured at the time of referral. All efforts shall be consistent with the most current applicable federal and State Medicaid laws.

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The Contractor shall be responsible to provide the public with accurate information regarding current policies and procedures related to the Medi-Cal Dental program. The Contractor shall:

- 1) Develop, draft, and post publications for Medi-Cal beneficiaries, government, constituent, and private entities in accordance with requirements established by the Department in this Contract;
- 2) Ensure all publications will be maintained in electronic media and posted to the Denti-Cal website;
- 3) Develop and draft beneficiary publications, general releases, and/or newsletters as directed by the Contracting Officer, including those resulting from Dental Operating Instruction Letters (DOILs), System Development Notices (SDNs), Problem Statements (PSs), Miscellaneous Change Documents (MCDs), or Contract correspondence, within eight business days of a Department request, unless otherwise directed by the Contracting Officer. Additional beneficiary publications may be developed at the discretion of the Contractor;
- 4) Request formal approval for all publications and documents prior to release. The Contractor shall ensure the Contracting Officer's approval has been secured prior to the release of any publication and/or document;
- 5) The following time frames shall be met in relation to the publications function of this section:
 - a) Priority newsletters shall be posted to the Denti-Cal website as directed by the Department but no longer than four business days from the date of the Department's approval;
 - b) Routine monthly beneficiary newsletters shall be posted to the Denti-Cal website no later than the thirtieth (30th) of each month with the approval of the Department; and
 - c) Other publications shall be posted to the Denti-Cal website as instructed by the Department through a web change request form.
- 6) Revise and resubmit any Department approved change to the Contracting Officer's designee within two business days of receipt;
- 7) Develop an archive by subject matter, article, and date published of all newsletters. The archive shall be updated at least monthly. The archive shall be maintained in chronological order and shall be easily accessible on the Denti-Cal web site, as approved by the Department; and
- 8) Provide a monthly report that provides the following information related to the publications posted in the reporting month:
 - a) Bulletins, volume, and number;

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- b) Date bulletin article submitted by Contractor to Department for review;
- c) Department approval date;
- d) Date published/posted; and
- e) Any explanation if the deadline was not met that month.

15. Beneficiary Customer Service Satisfaction Survey

The Contractor shall assess, on an annual basis, its performance by collecting a statistically valid sample of eligible beneficiaries for the calendar year. Feedback provided from this survey shall assist Contractor staff in developing recommendations to improve the program through internal process improvement or external recommendations to the Contracting Officer.

The Contractor shall:

- a. Conduct an annual beneficiary satisfaction survey to assess the quality of service provided by the Medi-Cal Dental program;
- b. The survey shall follow scientific criteria related to survey development and collection as described in the Contractor's Proposal for the Request for Proposal (RFP);
- c. The survey shall collect a statistically valid sample of the targeted population;
- d. Surveyed topics shall include, but are not limited to, beneficiary customer satisfaction in the following areas:
 - 1) Interaction with the TSC;
 - 2) Accessibility of dental services;
 - 3) Accuracy of referral information provided;
 - 4) Customer service metrics; and
 - 5) Other policies and procedures related to the program.
- e. Submit provider survey results and the assessment to the Department within forty-five (45) business days after the completion of the survey.

The Department shall review and approve, on an annual basis at the beginning of the year, the methodology for the beneficiary customer service satisfaction survey which shall include an implementation plan, work plan, and complete list of survey questions. The Department shall exercise its right to make modifications to the survey questions, survey topics, implementation, and work plans, as necessary pursuant to departmental objectives and priorities.

Exhibit A, Attachment II
Scope of Work - Operations**16. Reporting Requirements**

The Contractor shall:

On a monthly basis submit reports to the Department on the following beneficiary services activities. These reports shall provide the following:

- a. Type of contact (toll-free telephone or written communication);
- b. Number of contacts received by category;
- c. The information sought or the complaints received by summary categories that have been prior approved by the Department;
- d. Action taken by the Contractor and/or resolution;
- e. The mode, mean, and median span of time (in calendar days) from the initial contact with the beneficiary or their authorized representative until resolution of the situation has occurred;
- f. Categorization by the following four major subjects listed below and with the resulting report being on-line accessible to Department staff as well as the Contractor's Beneficiary Services staff:
 - 1) Beneficiary inquiries for dental provider referral;
 - 2) Beneficiary complaints, grievances, and State Hearings;
 - 3) Beneficiary denial and/or modification of dental service notifications;
 - 4) Beneficiary inquiries on second opinion clinical screenings; and
- g. Establish and maintain daily logs and specific documentation to gather the source data for this summary report. All such logs and supporting documentation shall be made available to the Department upon request.

17. Organization and Staffing General Responsibilities

The Contractor shall:

- a. Provide an organizational structure and staffing to ensure qualified staff is employed to perform beneficiary services duties/responsibilities identified in this Contract;
- b. Ensure sufficient management/supervisory personnel and administrative/clerical support staff is utilized to control work activities, assign priorities, attend planning/problem resolution meetings, and monitor daily operations to ensure contractual compliance;
- c. Ensure selected functions have specific requirements, limitations on work activities/locations, and/or time requirements for filling vacant positions;

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- d. Ensure all Beneficiary Services staff shall be provided with computer resources, equipment, and materials that are necessary in the performance of their assigned activities; and
- e. Ensure a dental consultant is available Monday through Friday 8:00 AM to 5:00 PM Pacific Time (PT), as necessary, to address/resolve clinical related issues/complaints, reimbursements, State Hearings, patient screenings, etc.

18. Equipment

The Contractor shall furnish the necessary equipment to ensure effective Operations necessary to meet or exceed all of the Contract requirements.

The Contractor shall:

- a. Ensure that all staff has the same level of functionality and can effectively communicate amongst themselves, with other Contractor staff, and/or the Department as necessary;
- b. Provide all computer software (including connectivity for facilitating access to information and communications) necessary to meet all contractual requirements;
- c. Provide telephones and, where appropriate, cell phones, faxes, and copiers;
- d. Oversee all telecommunication hardware and software for proper working condition for the ongoing operations of the beneficiary services activities; and
- e. Ensure any computer systems or technologies employed by the Contractor to support the Beneficiary Services Operations have the capability to be expanded and/or upgraded in anticipation of new programs or program expansions that are likely to occur over the term of this Contract. The systems/technologies must be compatible with the Contractor's and the Department's standards for hardware and software configurations.

19. Department Responsibilities

The Department shall:

- a. Review and approve the Beneficiary Services Manual and updates prepared by the Contractor prior to release;
- b. Review and approve all State Hearing documents and invoices for direct beneficiary reimbursement;
- c. Develop, clarify, and provide guidance and direction on policies and procedures;
- d. Review and approve all materials sent to beneficiaries, including beneficiary newsletters, and beneficiary educational and informing material developed by the Contractor's Beneficiary Outreach unit;
- e. Approve forms utilized by the Contractor prior to distribution;

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- f. Review and approve of the proposed beneficiary no-show process intended to identify barriers for access to care and assisting beneficiaries in attending scheduled appointments;
- g. Review and approve Contractor procedures for correspondence responses and any changes thereof; and
- h. Provide policy guidance on reimbursement and State Hearing operations.

F. TELEPHONE SERVICE CENTER (TSC)**1. Overview**

The Telephone Service Center (TSC) serves as the primary source for Contractor interaction with the provider community and beneficiaries and/or authorized representatives. The Contractor's telecommunication system is the infrastructure used to provide information to support the access, delivery and payment of Medicaid services.

The TSC helps ensure the Medicaid population can obtain timely access to needed Medicaid services, and that the provider has the information needed to deliver those services.

During the course of this Contract, call volumes will fluctuate, and scaling the operation is a key component in providing effective and efficient customer service. Performance standards are used to ensure the Contractor complies with service level agreements as defined in this Contract.

It is important the Contractor structures the TSC to be agile and flexible to quickly address change. The reimbursement methodology allows the Contractor to be compensated for required staffing changes, but the Contractor shall be responsible to implement changes timely to ensure performance measures are continuously met.

2. Objectives

The Contractor shall create an efficient TSC operation to meet all of the requirements of this Contract and produce consistency in terms of customer service across all TSC functions. The Contractor shall:

- a. Ensure that all TSC interactions and the services provided to the public are delivered in a manner that complies with the most current federal and State Medicaid laws;
- b. Provide highly responsive and high quality customer service to the Medicaid beneficiary population, providers, and the general public;
- c. Enable beneficiaries and providers to easily and efficiently access information and services through the TSC;
- d. Establish a highly responsive TSC operation with a robust complaint management process;

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- e. Ensure staff are qualified, trained, and fully equipped to address the beneficiary population, the provider community, the stakeholder community, and the general public;
- f. Ensure performance standards are continuously met regardless of call volume; and
- g. Maintain and operate a telephone call system that is adequately staffed at all times.

3. Assumptions and Constraints

The TSC is subject to the following assumptions and constraints:

- a. The Contractor may propose a new hardware/software solution or use the existing tools utilized in the prior Contract. Additional information on existing tool solutions and capabilities can be found in the data library;
- b. The Contractor must provide, own, maintain, and support the hardware and software licenses required to operate the system;
- c. Assistance to Limited English Proficient (LEP) callers shall be provided as needed by beneficiaries and providers;
- d. Ensure TSC staff has access to California Dental Medicaid Management Information System (CD-MMIS) as well as all other online systems with current and accurate information of active Medi-Cal dental providers, providers accepting referrals for Denti-Cal beneficiaries, beneficiary dental history, and/or hard copy references to fully support TSC functions;
- e. Ensure TSC staff has access to all CD-MMIS files and all necessary reference materials required to fulfill the Contractor's responsibilities at the start of Treatment Authorization Request (TAR) processing and maintained thereafter, including digital stored/imaged claim copies, images of all attachments and supporting documentation to claims with the exception of non-digitalized radiographs;
- f. Provide sufficient computer resources to fully support TSC activities and associated administrative support activities;
- g. Maintain a sufficient level of TSC staff for the toll-free lines; however, the Contractor may adjust the staffing levels of the beneficiary toll-free telephone lines and the provider toll-free telephone lines to better meet the needs and demands of beneficiaries and providers;
- h. Provide and maintain sufficient toll-free lines in order to meet all TSC requirements; and
- i. Maintain and operate an integrated TSC that will incorporate the call center activities listed in this Contract.

Exhibit A, Attachment II
Scope of Work - Operations**4. General Responsibilities**

The Contractor shall:

- a. Provide assistance to hearing-impaired callers through text-telephone device (TTD) or an equivalent system to communicate by telephone;
- b. Provide assistance to Limited English Proficient (LEP) callers;
- c. Ensure TSC staff provide services in all threshold languages, including, but not limited to, written translations as directed by the Department;
- d. Provide a TSC that is user friendly for the callers by:
 - 1) Routing the caller to an operator or Interactive Voice Response (IVR) system within four telephone vectoring prompts; and
 - 2) Easily allowing the caller to navigate through the IVR.
- e. Ensure providers and beneficiaries are aware of the toll-free telephone number(s) and the hours of operation. All provider and beneficiary incoming lines must use an Automatic Call Distributor (ACD) to allow calls to be handled on a "first in, first answered" basis when all operators are busy;
- f. Ensure that if calls are not answered in fifteen (15) seconds, the TSC shall initiate a recorded message encouraging the caller to remain on the line and assuring the caller that a qualified staff person will answer the call momentarily;
- g. Provide proposed call vectoring scheme for the entire TSC;
- h. Provide a Customer Relationship Management (CRM) system consisting of CRM database software, call activity recording software, online claims viewing and connection features, onsite referral and scheduling system and other Contractor-proposed applications to support the CRM concept. The system allows the Contractor management staff and Department staff the ability to monitor telephone conversations on a real-time basis for quality purposes. Additional information on the existing tool solution is available in the data library;
- i. Ensure the TSC component of the Contract has a robust training program to train staff on the California Medicaid dental program and customer service skills;
- j. Include as part of the TSC Plan contingency tasks and procedures to be followed should TSC staffing prove inadequate for the Contractor to meet all of its contractual requirements. This includes a plan for handling the increase of calls during any transitional period;
- k. Ensure Quality Control over TSC staff and their responses by periodically monitoring live calls and recorded calls as directed by the Department; and
- l. Ensure that staff can adequately address call volumes separately by provider and beneficiary in order to meet performance requirements.

Exhibit A, Attachment II
Scope of Work - Operations**5. TSC Performance Standards**

The Contractor shall ensure the TSC meets or exceeds the following performance standards:

- a. The monthly average number of incoming calls for beneficiary and provider that are blocked (calls receiving a busy signal) shall be no more than five percent, i.e. the "P" factor; and shall be reported separately;
- b. The monthly average abandon rate for provider and beneficiary calls shall be no more than five percent and shall be reported separately. A call will be considered abandoned when a caller chooses to disconnect after reaching the ACD;
- c. The monthly average wait or hold time shall not exceed sixty (60) seconds (see glossary for definition) for both provider and beneficiary calls and shall be reported separately;
- d. All calls must be answered within three rings (a call pick-up system that places the call in queue may be used);
- e. Execute all Department requests for temporary phone messages within twenty-four (24) hours of the request; and
- f. All voicemail calls shall be returned within one business day.

The Contractor may only invoice for hold times up to one minute. If the Contractor exceeds the one minute hold time limit, the Department will require the Contractor to invoice according to the requirements described in Exhibit B, Attachment I, Special Payment Provisions.

- 1) The Contractor shall additionally:
 - a) Monitor the Contractor's compliance with the timely access standards delineated below and provide feedback and education to staff to ensure compliance with the following scheduling standards accordingly:
 - b) Emergency cases shall be seen immediately or referred to an emergency facility;
 - c) Urgent cases shall be seen within forty-eight (48) hours; and
 - d) Preventive and non-urgent or emergent care visits shall be scheduled within eight weeks.
- 2) Operate and maintain an electronic referral system that will provide beneficiaries with a minimum of three provider names, addresses, phone numbers, and specialties of dental providers within their geographic location as defined by no more than twenty-five (25) miles driving distance from the beneficiary's address or no more than thirty (30) minutes in urban areas and no more than ninety (90) minutes in rural areas. Referrals shall be provided in a manner that will ensure that neither the Contractor nor the Department is

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perceived as recommending a particular provider or assuming responsibility for the quality of care rendered by any provider.

6. Beneficiary Telephone Service Center Responsibilities

The Contractor shall:

- a. Utilize TSC staff to assist eligible beneficiaries with access to participating dental professionals actively accepting Medi-Cal Dental Program beneficiaries on the referral list. The Contractor shall provide the following referral service:
 - 1) Assist eligible beneficiaries with access to Medi-Cal Dental providers who are accepting new Denti-Cal patients and will provide them with medically necessary dental services;
 - 2) In the event a beneficiary is having trouble obtaining services through the Medi-Cal Dental program, TSC staff will, on the beneficiaries' behalf, contact a provider to confirm the provider is accepting patients and set up a three-way call with the provider office while the beneficiary is on the line to schedule an appointment. This process is known as a 'warm transfer';
 - 3) Respond to provider referral requests the same day, if possible, but not more than three business days from initial request;
 - 4) All appointments scheduled through the warm transfer process described above shall be collected and reported on a monthly basis in accordance with the Timely Access Standards. All appointments, including information for distances travelled from beneficiary residence to provider office, type of appointment (urgent, non-urgent, routine/preventive), and scheduling timeframe from the date of call to the date the appointment was scheduled, shall be reported to the Department no later than the third business day of the month following the reported month;
 - 5) Failure to schedule an appointment or receive the warm transfer service will require TSC agents to document the reasons why, including demographic information such as beneficiary county of residence and other beneficiary specifications;
 - 6) A minimum of three referrals must be provided. All referrals shall be confirmed in writing and mailed to the beneficiary within five business days from the initial request; and
 - 7) If limited provider access is identified, this information shall be forwarded to the Contractor's Provider Outreach unit within five business days.
- b. Upon receipt, resolve and respond to beneficiary and/or authorized representative complaints, grievances, and general inquiries related to the Medi-Cal Dental Program within the time frames previously stipulated;
- c. Redirect beneficiary non-jurisdictional inquires to other resources (i.e. federal, State, or county agencies, Health Care Options (HCO), contracted dental

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managed care plans, Dental Board of California, Department of Health Care Services (DHCS), etc.);

- d. Provide clarification to beneficiary inquiries regarding notification of a denial or modification of a requested service(s) requiring prior authorization which shall include an explanation of applicable program criteria;
- e. Provide clarification to general inquiries related to Share-of-Cost (SOC) and/or co-payment requirements applicable to Medi-Cal eligibility for dental services;
- f. Provide clarification and/or refer to appropriate staff those inquiries related to dental State Hearing issues and/or beneficiary reimbursement issues;
- g. Refer complex inquiries to correspondence and research staff or other appropriate staff for more complete and extensive research; and
- h. Ensure staff has access to information regarding open and closed beneficiary complaints/grievances; scheduling information on clinical screenings; dental provider referral file; and information regarding the notification to beneficiaries whenever services that require prior authorization are denied or modified.

7. Provider Telephone Service Center Responsibilities

The Contractor shall:

- a. Receive, investigate, and respond to inquiries from Medi-Cal Dental providers and office staff related to billing issues, billing procedures, claim status, prior authorization issues, and missing radiographs; clarify Explanation of Benefit (EOB) codes and Erroneous Payment Corrections (EPCs); answer questions related to dental program policies, procedures, processes, and regulations;
- b. Research provider telephone inquiries using CD-MMIS files and digitally stored/imaged claim copies, and other available systems provided by the Contractor;
- c. Provide accurate and comprehensive responses to the caller (e.g., questions are thoroughly answered and/or, in the case of a billing issue, assure the caller is able to accurately correct a claim issue and resubmit the claim for a successful adjudication). The exception should be if the issue is of a complex nature and requires detailed research; and
- d. Refer inquiries which cannot be answered immediately by the TSC to TSC supervisors, correspondence, and/or research staff or other appropriate staff for more complete and intensive research.

8. Organization and Staffing

The Contractor shall provide an organizational structure and staffing to ensure sufficiently qualified staff is employed to meet all TSC duties/responsibilities identified throughout this Contract.

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There shall be sufficient management personnel to supervise telephone operations; perform direct liaison activities with Department personnel; participate in management control of activities; attend planning/problem resolution meetings, etc.; and sufficient clerical and administrative staff to meet toll-free telephone operational needs.

Provide staff with necessary workspace and all necessary computer resources, equipment, and materials, i.e. online systems access, telephones, publications, reports, manuals, etc., which are necessary in the performance of their assigned activities.

The Contractor shall ensure TSC is operational and staffed to handle incoming and outbound call volumes between the hours of 8:00 AM and 5:00 PM Pacific Time (PT), Monday through Friday and shall have a dental consultant accessible for consultation and/or to assist the operators in speaking with the beneficiary and/or their dental provider. After regular business hours, provide an automated message system to collect caller information (i.e., voice mail).

Any vacancies shall be filled within thirty (30) calendar days unless specifically exempted by the Contracting Officer or the Department shall be reimbursed any vacant positions, per Exhibit E, Additional Provisions, Contractor Resource Levels.

The Contractor shall

- a. Ensure TSC staff is knowledgeable in the practice of dentistry within California and have a familiarity of how claims and TARs are processed within the Denti-Cal program. Scope of knowledge and skill are defined to include, but not limited to:
 - 1) Thorough understanding of the Medi-Cal Dental Program's regulations, policies, and procedures;
 - 2) Knowledge of beneficiary and provider complaint processes;
 - 3) Thorough understanding of how to utilize the tools, resources, and technology available to TSC staff in resolving beneficiary or provider inquiries;
 - 4) Ability to understand when a difficult inquiry or referral should be referred to supervisors; and
 - 5) Customer service experience, either direct or telephone contact.

The knowledge and skill requirement may be met through applicable work experience, being a licensed dental para-professional, or by attending Medi-Cal Dental Program training courses administered by the Contractor prior to being assigned to the TSC.

- b. Ensure TSC staff is trained to understand when a call is non-jurisdictional and refer the caller to the appropriate entities. The Contractor shall track and report on such calls on a daily, weekly, and monthly basis;

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- c. Ensure TSC staff applies critical thinking, and problem solving skills to resolve complex problems. TSC staff shall practice good judgment and understanding in escalating more complex inquiries and referrals;
- d. Respond to all telephone inquiries from providers, billing agents/intermediaries, beneficiaries, Department, and/or Contractor staff. Telephone assistance shall include:
 - 1) Answering incoming calls;
 - 2) Making outbound calls to return voice messages received after regular business hours within one business day of receipt;
 - 3) Making outbound calls to follow up on inquiries that could not be completed during the initial incoming telephone call;
 - 4) Escalating calls, where appropriate, to supervisors within Provider and Beneficiary Services Operations or to other areas of the Contractor's organization, as applicable;
 - 5) Forwarding requests for on-site provider visits to Provider Services staff; and
 - 6) Providing other pertinent telephone numbers or resources to the caller.

9. Reports

The Contractor shall produce and deliver to the Department daily, weekly, and monthly reports disclosing the following, separated by provider and beneficiary calls:

- a. Statistics of all completed calls: Number of attempts, completions, and retries; average hold time in minutes, maximum hold time in minutes, and minimum hold time in minutes; average length of calls, maximum length of call, and minimum length of call; maximum number of calls, minimum number of calls, average number of calls, and total number of calls, number of busy signals, number of abandoned calls, and voice mail return rate. Provide analysis of this data, sampled in two hour intervals, by day;
- b. Percentage of connected calls vs. non-connected calls and/or busy signals, (i.e., "P" grade of service), by week including lowest, highest, average, and median "P" factor percentage;
- c. The type of contact (toll-free telephone or written communication) and the information sought or the complaints received by summary categories that have prior approval by the Department;
- d. Daily, weekly, and monthly reports separated by call category for both beneficiary and provider customer service lines. All call categories shall be reported in all reports, regardless of whether there were any entries in that call category in the reporting period;

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- e. Reports for appointments scheduled against the Timely Access Standards and distances traveled in the beneficiary referral reports including the following information:
- 1) Number of referral requests;
 - 2) Name of the beneficiary and their Medi-Cal identification number;
 - 3) Referring agency or name of the beneficiary's authorized representative, if applicable;
 - 4) Address, including Zip Code, and phone number;
 - 5) Date inquiry received;
 - 6) Type of service sought (i.e., general dentistry, orthodontics, other specialty);
 - 7) Type of appointment sought (i.e., emergency, non-urgent, preventive);
 - 8) To whom referred by provider name, provider number, address of service location, including Zip Code, and phone number (multiple entries shall be made, if appropriate);
 - 9) Date referral was made;
 - 10) Date of scheduled appointment, if applicable;
 - 11) Distance traveled from beneficiary residence to provider office location;
 - 12) Whether the referral was made by phone, written correspondence, or other source;
 - 13) All feedback from beneficiary and/or referring agency; and
 - 14) Complaints received, date received, and date referred to the Contractor's complaints/grievances operation. Referral to the complaints/grievances operation shall occur no later than the next work day following receipt of the complaint.

10. Hardware and Software Responsibilities

- a. Provide computer telephony equipment for the provider and beneficiary toll-free telephone lines which includes the following technology:
- 1) A Private Branch Exchange (PBX) switch and all required hardware needed for Computer Telephony Integration (CTI). The switch must allow integration with other technologically advanced systems;
 - 2) Equipment required to achieve operational requirements;
 - 3) Management of call traffic through the use of computer-based systems;

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- 4) CTI equipment shall allow for future upgrades and additions of current computer telephony applications;
 - 5) Online, real-time interactive server capable of serving all toll-free telephone lines, staffing, and supervisors;
 - 6) Order, maintain, and support all components of the toll-free telephone lines and telecommunication lines necessary for the support of interconnectivity among the various call center activities under the provider and beneficiary telephone service center lines umbrella; and
 - 7) The number of toll free numbers to be utilized for access to the TSC
- b. Ensure the TSC system unscheduled downtime does not exceed one-half hour for any given month. In the event of system failure the Contractor shall:
- 1) Notify the Department of any incident of TSC downtime within one hour of the incident, or as soon as the Contractor is aware of the interruption. As soon as the cause and projected duration of the unplanned interruption is known, the Contractor shall provide that information immediately to the Department. Upon Department approval, providers and beneficiaries shall be updated via the Denti-Cal website;
 - 2) Within twenty-four (24) hours of the systems repair, notify the Department in writing of the actual cause, the areas impacted, the measures taken to correct the problem and what will be done to prevent the problem from reoccurring; and
 - 3) Provide an electronic notice to applicable Contractor staff and the Department of any planned system interruption, shutdown, or file non-access, at least three business days prior to the system interference.

11. Department Responsibilities

The Department shall:

- a. Review and approve all invoices related to precedent to payment conditions;
- b. Review and approve contingency plans; and
- c. Review and approve all desk-level documents used for communication purposes to convey and explain program policies, procedures, and regulations.

G. CLAIMS PROCESSING SUBSYSTEM

1. Overview

The Claims Processing Subsystem is an integrated manual and automated system to process Treatment Authorization Requests (TARs) and claims received from Medi-Cal dental providers as well as dental providers of the Child Health and Disability Prevention (CHDP) Gateway, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), Regional Center Consumers,

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

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

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

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

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

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

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

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

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2. Objectives

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

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

3. Assumptions and Constraints

- a. The Medi-Cal Dental Fee-For-Service program consists of two separate Contracts - one pertaining to the ASO Contractor and one pertaining to the FI Contractor. These two Contractors are expected to work in concert with each other to perform all activities associated with the requirements of claims processing during the term of the Contracts.
- b. Claims that successfully pass all edits and audits are forwarded to the payment module for final adjudication.
- c. Application of the whole document concept is applied in the processing and payment of claims/NOAs/TARs. Each document is processed as a whole; however, each service line is reviewed and adjudicated separately.
- d. Provider and recipient data in the Provider Master File (PMF), Fiscal Intermediary Access of Medi-Cal Eligibility file (FAME), and all supporting files accessed by the Claims Processing Subsystem will be utilized in an accurate and timely manner.
- e. Eligibility verification for claims processing shall reference against the Department's FAME file and information associated with the Eligibility Verification Confirmation (EVC) file.

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- f. In instances where the EVC record is in conflict with the Department's FAME file, the claim/NOA/Claim Inquiry Form (CIF) shall be adjudicated based on the record which is most favorable toward paying the document for the provider. In other words, if the FAME file indicates no eligibility but the EVC number provided on the claim/NOA/CIF indicates eligibility, the document will be adjudicated based on the EVC.
- g. The FI Contractor shall:
- 1) Execute the weekly check run cycle and submit payment files to the State Controller's Office (SCO) for the issuance of provider warrants;
 - 2) Print and mail the Explanation of Benefits (EOBs) to providers;
 - 3) Perform the functions associated with Document Management. Refer to the FI Contract, Exhibit A, Attachment II, Claims processing for additional information and FI Contract, Exhibit A, Attachment II, Document Management System;
 - 4) Maintain all electronic media documents and comply with the EDI standards adopted pursuant to HIPAA and in accordance with Department approved formats and specifications;
 - 5) Track, record, and report all activity for each claim/NOA/TAR from receipt through final adjudication to include the update to the adjudicated claim history files. This tracking shall include the identification of all appeals, CIFs, or any adjustments related to each claim/NOA/TAR. This shall include the documentation of each Data Control Center (DCC) location and date as the document moves through the system. This tracking system that shall be maintained by the FI Contractor will also provide a history of all edits and audits where the document has failed;
 - 6) Reflect all activities on appropriate CD-MMIS reports with each Document Control Number (DCN), Most Recent Document Control Number (MRDCN), Correspondence Reference Number (CRN) or other identifying number and each DCC location with date of DCC entry to ensure a complete audit trail and to meet all reporting requirements;
 - 7) Purge the approved and denied TARs from the database to an appropriate storage media to be retained for a period of no less than three years; and
 - 8) Generate all Claims Processing Subsystem reports produced by CD-MMIS. Refer to FI Contract, Exhibit A, Attachment II, Claims Processing and FI Contract, Exhibit A, Attachment II, General Reporting for additional information.

4. General Responsibilities

The ASO Contractor shall:

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

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- b. Ensure that appropriate Contractor staff with relevant knowledge, skills, and qualifications attend and actively participate in the Department's Dental Policy Advisory Group (DPAG) to resolve claim/TAR adjudication problems and to address changes in dental technologies within the Claims Processing Subsystem (administered by the FI Contractor). Problem resolution may occur through development of or revision to program policies, as well as proposing new and/or modified edits/audits, etc., that are necessary to adjudicate claims/TARs in an accurate and consistent manner. All decisions and/or directions will be communicated, in writing, to the FI and ASO Contractors by the Department (e.g., in the form of Dental Operating Instruction Letters (DOILs), Contractor Letters, System Development Notices (SDNs), Miscellaneous Change Documents (MCDs), Changes Orders, Problem Statements (PSs), etc.).
- c. Assist the Department in responding to dental State Hearings as described in ASO Contract, Exhibit A, Attachment II, Beneficiary Services section.

5. Electronic Data Interchange (EDI) Document Responsibilities

The Contractor shall:

- a. Accept for processing all EDI documents that pass the preliminary edits performed by the system;
- b. Ensure the DCN assigned to each claim/TAR submitted via EDI be the same DCN assigned to the corresponding attached documents. The DCNs/MRDCNs must be assigned by the system in accordance with date of EDI receipt. (EDI and paper claims/NOAs/TARs/RTDs are to be identified through embedded intelligence assignment of a special number in the DCN/MRDCN/CRN);
- c. Adjudicate EDI documents after entering the normal system workflow process after assignment of the DCN/MRDCN by the system;
- d. Ensure all attachments and/or radiographs are for the correct claim/TAR/NOA/RTD entered into the system via EDI (i.e., same beneficiary, provider and service office); and
- e. Ensure that upon adjudication the radiographs are returned to the provider within twelve (12) calendar days. Encourage the provider to submit duplicated or digitized radiographs to avoid return. The hard copy radiographs shall be recycled in the event the provider does not want the radiographs returned. The provider must request the return of radiographs at the time the radiographs are submitted.

6. Adjudication Responsibilities

The Contractor shall:

- a. Apply Department approved CD-MMIS prepayment/pre-authorization edits and audits to verify accuracy and validity of claim/TAR/CIF data for proper adjudication as necessary. The CD-MMIS edits/audits may be categorized as:
 - 1) Claim/TAR Data Entry Edits.

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- 2) Provider Edits.
 - 3) Recipient Edits.
 - 4) Procedure Edits.
 - 5) History Cross Check Audits.
 - 6) S/URS Edits.
- b. Modify processing procedures to adjudicate special claim categories as operational in CD-MMIS or as directed by the Contracting Officer;
 - c. Ensure claims that fail any edits and/or audits require suspense processing for resolution of those edits or audits which failed;
 - d. Ensure claims that require the manual review of radiographs and/or documentation are system edited first by CD-MMIS, for basic information and data validity, including, but not limited to, provider eligibility, beneficiary eligibility, procedure code validity, and the presence of required data. Following this initial editing completed by CD-MMIS, claims and attached radiographs/documentation will be subjected to the manual review process to be carried out by the Contractor;
 - e. Ensure during the manual review process, dental consultants and dental paraprofessionals review the diagnostic material presented and the procedures listed on the claim to determine that the services were medically necessary and in accordance with Medi-Cal dental policy and procedures or to ensure that claims resulting from a TAR are completed as approved. Paraprofessionals are allowed to approve services based on the documentation submitted. However, if the paraprofessional cannot determine that the service is a benefit of the program or cannot determine that the service is medically necessary, the document shall be reviewed by a dental consultant. Only a dental consultant can modify or deny a claim service line (CSL) on the basis of medical necessity;
 - f. Apply CD-MMIS requirements/procedures to claims/TARs/CIFs for out-of-state providers as mandated in Title 22, California Code of Regulations (CCR), Section 51006. Out-of-state provider groups are exempted from the requirement to submit a rendering provider number on their claims when the service is performed by other than the billing provider;
 - g. Ensure border providers are subject to all requirement/procedures applied to in-state providers;
 - h. Edit only new fields on a returned NOA. Returned NOAs with prior review as a TAR do not go through the full edit process. Most of these NOAs upon return can be auto-adjudicated with a minimum of manual intervention upon return. However, the Manual of Criteria for Medi-Cal Authorization (Dental Services) requires some NOAs to be subject to professional/paraprofessional review upon their return. In the event that a provider adds additional lines to the claim form, these additional lines must be received and adjudicated accordingly;

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- i. Control radiographs to ensure they are retained until all affected CSLs associated with a claim document have been adjudicated. The hard copy radiographs submitted by the provider shall not be returned pursuant to Department policy, and must be recycled by the Contractor. The Contractor shall encourage providers to submit duplicated or digitized radiographs to avoid potential loss of original radiographs;
- j. Review CD-MMIS edits/audits to determine any that are appropriate to modify in order to ease provider billing requirements. The Contractor shall conduct edit/audit surveys as specified by the Department;
- k. Override a specific edit or audit as directed in writing by the Department. The Contractor shall not override any edit or audit without specific prior written approval from the Department. Further, if the Department approved edit/audit criteria requires manual review prior to override, the Contractor shall not, without the approval of the Contracting Officer, use automated processing methods to perform the override; and
- l. Review reports reflecting override activity, as currently generated by CD-MMIS. Refer to Exhibit A, Attachment II, General Reporting Requirements.

7. Recipient Edits

- a. The Contractor shall verify that all beneficiaries for whom claims are submitted qualify to receive benefits that will be reimbursed through the CD-MMIS. This verification must substantiate that the beneficiary:
 - 1) Was eligible for the service on the day it was performed and has no eligibility limitations, (e.g., member of a prepaid health plan which covers dental services);
 - 2) Has no other insurance coverage;
 - 3) Has met the Share-of-Cost (SOC);
 - 4) Is not on restricted status for the services with no prior approval document, etc., which would preclude or affect payment.
- b. Eligibility verification during claim adjudication under the current CD-MMIS is accomplished by matching data on claims with data on the FAME file. If a valid match cannot verify eligibility, the Contractor shall review for the presence and validity of one of the following Department-sanctioned proofs of eligibility:
 - 1) Original or copy of Department-generated or county-generated non-restricted or restricted proof of eligibility;
 - 2) Automated Eligibility Verification System (AEVS) number (i.e. EVC number) listed in the remarks data field on the claim form that shall be verified through a match with the AEVS record; and
 - 3) Other forms of proof of eligibility as defined by the Department.

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- c. If eligibility cannot be verified by a valid match with the FAME file and one of the above proofs of eligibility is not present, the claim shall be held in suspense for five calendar days. At the end of that time, a second attempt shall be made to verify eligibility. If eligibility cannot be established via the FAME transaction and no EVC record is found, the claims shall be RTD'd. (Refer to the Suspense and Error/File Maintenance Processing Manual.);
- d. Medi-Cal eligibility, not month of eligibility, is verified for TARs as service(s) requested is/are in the future. If the TAR document indicates eligibility pending, then a beneficiary record is created using the Social Security Number (SSN) and/or Beneficiary Identification (ID) number on the TAR. However, if no beneficiary eligibility is found via FAME, or EVC number is not present, the TAR shall be RTD'd (Refer to the Suspense and Error/File Maintenance Processing Manual.); and
- e. The Contractor shall utilize recipient identification cross-reference data to maintain continuous beneficiary claims history, despite beneficiary ID number changes.

8. Provider Edits

- a. The Contractor shall determine the provider is eligible to perform the services requested and/or was eligible to receive reimbursement for the billed service on the date of service. Any individual provider-related restriction such as special claims review, payment withholds, including withholds for delinquent taxes, or other limitations must be applied as instructed by the Department.
- b. The Contractor must verify that the provider is certified to perform the specialty service.
- c. For in-state and border provider groups, in accordance with existing CD-MMIS design, if the billing provider did not perform all services billed, enrollment and eligibility of the rendering provider must meet the same requirements as those stated above.
- d. A claim shall not automatically be RTD'd or denied if the billing provider number is incorrect or missing. The Contractor shall research the provider number on file and correct if possible. If a match is not found, the Contractor shall deny the claim with a message that the provider number is incorrect or missing.
- e. Payment for services rendered by an ineligible dental provider shall be denied.

9. Procedure Edits / History Cross Check Audits

The Contractor shall:

- a. Adjudicate claims/TARs in accordance with all Medi-Cal Dental Program policy and procedures as reflected in the most current California statutes and regulations, the Manual of Criteria for Medi-Cal Authorization (Dental Services), Title 22, CCR, DOILs, policy related to CCS and/or GHPP; and Department approved manuals or directives. Prior to approval of payment for service(s) billed, the Contractor shall ensure procedures meet the following requirements:

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- 1) A covered Medi-Cal dental benefit;
 - 2) Authorized in advance, if required, and that all critical claim data agree with the critical TAR data as described in TAR processing;
 - 3) Authorized in advance if required for processing CCS claim data. This information is verified against the Service Authorization file;
 - 4) Performed in place of service is allowed for the procedure;
 - 5) Consistent with the diagnosis reported, the age and/or sex of the beneficiary, and is based on a medical necessity; and
 - 6) Not a duplicate of a service previously paid for the same date of service or within the specified frequency limitations as stated in the Manual of Criteria.
- b. Utilize the Current Dental Terminology (CDT) codes as the Department requires all dental providers who bill Denti-Cal (Medicaid) through the FI Contractor use the CDT codes to designate services provided;
 - c. Utilize the Replace and Substitute (R&S) method, allowing modification of a procedure code that is in conflict with the actual description of service and/or documentation submitted; and
 - d. Ensure approved service limits are not exceeded. Welfare and Institutions (W&I) Code, section 14115, and Title 22, CCR, sections 51008 and 51008.5, dictate that claims for service shall be received no later than the sixth month following the month of service for full payment, except for good cause, and that where a delay in the submission of the claim(s) was caused by circumstances beyond the control of the provider, the period for the submission of bills can be extended up to but cannot exceed one year after the month of rendered service.

10. Additional TAR Processing Requirements

The Contractor shall perform prior authorization for treatment in accordance with Medi-Cal dental policy and procedures as described in the Manual of Criteria for Medi-Cal Authorization (Dental Services).

- a. As part of the ongoing quality of care review and evaluation, selected providers may be required to obtain prior authorization for some or all services, except those exempted by Title 22, CCR, Section 51455.
- b. All out-of-state services require prior authorization except:
 - 1) Emergency services as defined in Title 22, CCR, Section 51056(a); and
 - 2) Services provided in border areas adjacent to California where it is customary practice for California residents to avail themselves of such services. Under these circumstances, Medi-Cal and CCS program controls and limitations are the same as for services from providers within the state. No services are covered outside the United States, except for emergency services requiring hospitalization in Canada or Mexico.

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- c. Necessary out-of-state dental care, within the limits of the program is covered only under the following conditions:
 - 1) When an emergency arises from an accident, injury, or illness;
 - 2) Where the health of the individual would be endangered if care and services are postponed until it is feasible that the individual return to California; or
 - 3) Where the health of the individual would be endangered if the individual undertook travel to return to California.
- d. TARs that fail basic system edits shall suspend for review, and, when applicable, requests for additional information from the providers are to be generated via RTD;
- e. Paraprofessionals and, if necessary, dental consultants shall review TARs. Dental paraprofessionals are allowed to authorize services based upon the documentation submitted. However, if the paraprofessional cannot determine that the service is a benefit of the program or is medically necessary, the TAR shall be forwarded to a dental consultant. Only a dental consultant can modify or deny TARs on the basis of medical necessity;
- f. Process all TAR reevaluations which include returned TARs requesting reconsideration of previously denied requested services in accordance with the processing time requirements stipulated in TAR Processing Cycle Time Requirements; and
- g. Letter of notification shall be sent to beneficiaries and/or their authorized representative(s) when services requiring prior authorization have been modified or denied. The Contractor shall, through the Beneficiary Services, provide assistance to inquiries resulting from such notification (see Exhibit A, Attachment II, Operations, Beneficiary Services).

11. Priority Processing

The Contractor shall use the priority processing select program to identify claims/TARs/CIFs for priority processing. The Contractor shall:

- a. Process specific claims (e.g., court ordered payments, special billing waivers, State Hearing decisions, etc.), as directed by the Department. This processing requirement applies to previously adjudicated claims. Processing instructions and requirements for payment will be provided by the Contracting Officer. These claims shall not be automatically denied due to changes in edits and/or audits implemented subsequent to the processing of the original document. These claims shall be processed within ten (10) business days or as directed by the Contracting Officer;
- b. Process specific claims/TARs/CIFs or claims/TARs/CIFs in specific DCCs already in the system or new documents, on a priority basis as defined by the Contracting Officer. Documents to be processed could be selected out of suspense. A group of documents, for a specific provider, which have not yet been entered into the system and must begin with front-end processing, can also

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

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

12. Exceptional Processing Instructions

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

13. Clinical Screening of TARs

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

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

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- 3) Quality of care reviews; and
 - 4) S/URS related reviews.
- c. Payment to the Contractor for the Clinical Screening process shall be part of the Contractor's fixed price for TARs.
- d. The Contractor shall:
- 1) Screen all TARs involving non-immediate removable prosthetics when the documentation or radiographs do not justify the need for the requested services;
 - 2) Screen all TARs for beneficiaries residing in a State-licensed facility except for cases involving less than four extractions or less than three restorations;
 - 3) Control radiographs to ensure they are retained until all affected requested service lines have been adjudicated; and
 - 4) Process TARs for orthodontic services as determined by the Medi-Cal Handicapping Labio-Lingual Deviation (HLD) Index. These services shall be available to individuals with a qualifying malocclusion up to the age of twenty-one (21) years. The Manual of Criteria for Medi-Cal Authorization (Dental Services) describes this program benefit and the HLD Index method.

14. Additional Contractor Responsibilities

The Contractor shall:

- a. Maintain sufficient California licensed dental consultants and dental paraprofessional staff to ensure accurate and timely resolution of suspended claims, TARs, and CIFs to meet cycle times and inventory aging requirements;
- b. Ensure that dental consultants and dental paraprofessionals review the diagnostic materials presented and the dental procedures requested or billed to determine if the services were covered benefits and medically necessary in accordance with Medi-Cal dental policy. Dental paraprofessionals are allowed to approve services based on documentation submitted. However, if paraprofessionals cannot determine the service is a benefit of the program or is medically necessary, the document shall be reviewed by a dental consultant. Only the dental consultant can modify or deny a CSL on the basis of medically necessity;
- c. Ensure a dental consultant shall manually price Medi-Cal dental covered services according to Medi-Cal dental policy, for which no price is available in the automated system or which are billed as a by-report procedure. All manual pricing procedures and methods shall be documented within the Professional/Paraprofessional Adjudication Manual (PPAM);
- d. Ensure Medi-Cal dental policy, as determined by the Department, is consistently applied to all claims/CIFs/TARs. Policy is interpreted through utilization of the Department-approved edits/audits. All Department approved processing

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requirements must be maintained in the Suspense and Error/File Maintenance Processing Manual and the PPAM and all other related manual(s) to assure consistent policy application;

- e. Ensure a close working relationship is maintained between the Contractor, the FI Contractor, and the Department to resolve processing problems and to provide input in developing edits and audits in accordance with dental program policy and procedural requirements. A formalized component of this relationship is the requirement that the Contractor provide representatives to attend and contribute to the Department Policy Advisory Group (DPAG) meeting;
- f. Refer to the Department and the Contractor's S/URS function within thirty (30) calendar days of detection. Notice or inquiry those providers who are identified by the Contractor as being potential abusers of the program. These providers may be identified through the review of claims suspended for manual review through referrals, complaints, or inquiries received by the Contractor. The Contractor shall begin S/URS reviews of these providers as described in Exhibit A, Attachment II, Surveillance and Utilization Review Subsystem;
- g. Ensure a required function of professional review is Special Claims Review (SCR). This is a separate review designed to conduct manual review of claims from providers placed in SCR status by the Department. These providers have been referred by the Contractor and determined by the Department to be potential misusers of the Medi-Cal dental program and identified on the PMF by the Contractor as being subjected to SCR. This manual review includes, but is not limited to, the determination of clinical quality and the medical necessity for the covered service prior to payment or authorization; and
- h. The dental consultant staff be available to respond to SCR provider inquiries to explain Contractor action on specific claims.

15. Third Party Liability Recoveries

The Contractor shall:

- a. Process and identify claims/NOAs for beneficiaries with potential third party dental coverage through application of specific Department approved edits and by accessing FAME for indicators of other insurance or other program coverage, or by using additional other coverage information provided to the Contractor by the Department. If it is confirmed that a beneficiary has third party dental coverage, the Contractor must utilize the CD-MMIS reference system capabilities to cost avoid future payments. In cases where the Contractor or its parent entity may be the liable third party, the Contractor shall not make payment under the Medi-Cal Dental Program until the third party liability has been fully utilized or it has been determined that the third party has no liability for the cost of services. In instances where the Contractor is the liable third party, and it was not known at the time the Medi-Cal payment was made, the Contractor shall reimburse the Medi-Cal program to the extent of the Contractor's liability within ten (10) business days of discovery by the Contractor;
- b. Make no claim for recovery of the value of covered services rendered to a beneficiary when such recovery would result from an action involving the tort

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liability of a third party, casualty liability insurance, including Workers' Compensation awards and uninsured motorist's coverage, or recovery from the estates of deceased beneficiaries. The Contractor shall not claim or be entitled to these third party liability recoveries. The Department shall make these recoveries;

- c. Identify and notify the Department within ten (10) business days of discovery of cases in which an action by a Medi-Cal beneficiary involving the tort or Workers' Compensation liability of a third party could result in recovery by the beneficiary of funds to which the Department has lien rights under W&I Code section 14124.70;
- d. Notify the Department in cases where the Medi-Cal beneficiary is age fifty-five (55) years or older, or deceased. The Department may file a claim, pursuant to W&I Code Section 14009.5. The Contractor shall refer such cases to the Department within ten (10) business days of discovery;
- e. Identify cases where payment was made for certain prescribed trauma service codes and send out monthly questionnaires to identified beneficiaries to determine if a third party is responsible for paying for dental treatment for the illness/injury. All completed questionnaires indicating that the beneficiary has filed or intends to file a claim or lawsuit and/or that insurance coverage is available to cover the recipient's dental expenses must be forwarded to the Department within ten (10) business days of discovery;
- f. Submit monthly reports to the Contracting Officer for the following:
 - 1) Claims with an indicator of employment-related illness/injury;
 - 2) Claims with an indicator of a tort-related illness/injury; and
 - 3) Claims with payment by a third-party or indication by a provider of other coverage although eligibility records indicate no third-party resources.
- g. Ensure each report contains the following data items:
 - 1) Beneficiary name;
 - 2) SSN;
 - 3) Date of birth;
 - 4) Contractor name;
 - 5) Provider name;
 - 6) National Provider Identification number (NPI);
 - 7) Indicator of employment or tort-related illness/injury;
 - 8) Date(s) of service;

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- 9) Procedure code and/or description of services rendered;
 - 10) Amount billed; and
 - 11) Amount paid.
- h. Identify to the Department the name, address, and telephone number of the person(s) responsible for receiving and complying with requests for service history information;
 - i. Direct any requests received from attorneys, insurers, or recipients for copies of claims and/or services data for a tort liability action, to the Contracting Officer or his/her designee;
 - j. Identify and report all claims/NOAs for which services are potentially covered by other insurance;
 - k. Under federal law, if the third party coverage is known at the time that the claim is processed, ensure that the third party benefits have been exhausted before Medi-Cal payment. The Contractor shall not pay claims for a beneficiary whose Medi-Cal eligibility record indicates third party dental coverage without proof that the provider has first exhausted all benefits of the other liable party(ies). Proof of denial for prepaid dental coverage because the provider does not participate in the beneficiary's dental plan is unacceptable. Proof of denial of coverage because the provider did not meet the insurer's billing requirements (such as prior authorization or timely filing) is also unacceptable. Proof of third party billing is not required for services provided to beneficiaries with Other Health Coverage (OHC) codes provided by the Department for payment of only the insurance co-payments;
 - l. Ensure application of Medi-Cal policy prior to payment is beyond that discussed above is not feasible, be responsible on a post payment basis (except for Medicare or Civilian Health and Medical Program of the Uniform Services Title 10, United States Code, section 1071 (4) (CHAMPUS)) or those beneficiaries identified as being in a dental health plan on the Department eligibility file for identifying those coverage (commercial) sources which have an obligation to pay all or a portion of the dental care costs incurred by recipients.

The Department uses the Medi-Cal Eligibility Data System (MEDS) to maintain information about the recipient's health or dental insurance and Medicare coverage. Health or dental coverage information is stored on the MEDS Health Insurance System (HIS) database. The HIS provides recipient specific OHC information, including policy effective dates, policyholder, and scopes or categories of coverage.

Insurance carrier/plan information is also maintained in the HIS. This information will be available to the Contractor. This information is also available to providers through the Department's AEVS; and

- m. If the Contractor identifies dental coverage unknown to the Department, the Contractor shall report this information to the Department within ten (10) calendar

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days of discovery; and when possible, encourage Medi-Cal recipients to retain any available private health or dental coverage.

16. Share-of-Cost (SOC)

SOC information is created by CD-MMIS from the AEVS transactions log file, which is transmitted to CD-MMIS from the Medi-Cal Eligibility Verification/Claims Management System (CA-EV/CMS) on Tuesday through Saturday each week. This log file is also referred to as the EVCOI (Eligibility Verification - Other Intermediary) file. CD-MMIS automatically assigns the SOC control number.

The Contractor shall:

- a. Process claims with a SOC obligation. The Contractor will access the SOC Control number through CD-MMIS. The SOC adjudicator retrieves the SOC information to adjudicate claims for beneficiaries identified by FAME as having potential SOC obligation; and
- b. Process each claim/NOA/CIF through the application of the edits and audits. Manually priced claims/NOAs shall be processed as directed by the Department and as specified in the CD-MMIS detail design, policy Statements, and Processing Team Manual.

17. Resubmission Turnaround Document (RTD) Processing

The Contractor shall:

- a. Correct the document using data on the claim/NOA/TAR or CD-MMIS reference files.
- b. In the event a RTD is returned from the provider and the information is insufficient to resolve the claim/NOA/TAR suspension:
 - 1) Deny the service(s) associated with the RTD and continue with the processing of the remaining services as appropriate;
 - 2) If the suspended CSL affects the entire claim/NOA, deny the entire claim/NOA and notify the provider of the reason(s) for complete denial via an EOB; and
 - 3) If the suspended CSL affects the entire TAR, deny the entire TAR and notify the provider of the reason(s) for complete denial via a NOA.
- c. Manually review and adjudicate all claims/NOAs/TARs suspended for potential denial; and
- d. Identify the reason(s) for the denial.

18. Claim Inquiry Form (CIF) Processing

The Contractor shall process and respond to all CIFs. All CIFs shall be acknowledged within seven calendar days of receipt. All CIFs shall be processed to

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meet CIF processing cycle time requirements are identified in Cycle Time Requirements within this section.

a. CIFs are categorized as follows:

- 1) Tracer - The provider is seeking the status of a certain claim/NOA/TAR;
- 2) Adjustment - The provider is seeking an adjustment to a previously paid claim/NOA; and
- 3) Reevaluation - The provider is seeking re-consideration of a previously denied claim.

b. CIF processing requirements

Suspend, manually review, and correct CIFs for the following conditions:

- 1) Key data entry errors;
 - 2) Pertinent information is provided on the CIF document but is incorrect or is found elsewhere in the submission as an attachment or in the remarks section, (e.g. clarification of previous claim error, correction of obvious errors such as beneficiary number or DCN). For example, if a claim was denied for failure to provide a correct beneficiary identification number and the provider submits the CIF with corrected information, the CIF shall be suspended to provide for correction and processing of the CIF;
 - 3) DCN information to access the related claim; and
 - 4) In cases where a provider desires to return a payment to the Department or the Department directs a specific adjustment, the Contractor shall also adjust the claims history database. All adjustments must update claims history so as to be reflected on Claim Detail Reports (CDRs).
- c. In cases of an overpayment where no history is found, adjustments shall be documented on a special report;
- d. Ensure that CIFs submitted by providers requesting an adjustment of a paid claim or reconsideration of a denial are submitted no later than six months following the date of payment or denial of the claim, as specified in Title 22, CCR, Section 51008(d). (Overpayments are an exception to the six month policy and are to be processed whenever they are received.) CIFs received after this time period shall be denied;
- e. Accept provider personal checks regardless of the date of Medi-Cal payment and adjust history. If the date of the Medi-Cal payment is older than thirty-six (36) months, accept the money and report the data on the quarterly report(s). Checks from providers shall be made payable to the Department of Health Care Services. Should a check be received from a provider that is not made payable to the Department of Health Care Services (DHCS), the Contractor is to return the check to the provider with instruction to reissue a check made payable to the DHCS; and

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

19. Provider Grievances Requirements

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

The Contractor shall:

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

20. Payment Responsibilities

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

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

- a. Checkwrite Process
 - 1) Ensure payment files are accurate prior to their release to the SCO.
 - 2) Review and approve the reports for payment process is accurate prior to submission to SCO issuing checks to providers.
 - 3) Notify the Department and the FI Contractor of any errors prior to the release of checks. For claims found to be in error, identify the error in a PS, work with the FI Contractor to reprocess the claims, and make adjustments as necessary.
 - 4) Resolve restrictions prior to payment, such as overpayments, improper payments, liens, and levies, and process all accounts receivable activity;

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- 5) Convert any negative balance(s) to an accounts receivable (A/R) prior to the next checkwrite. A negative balance occurs when a provider's obligation to the Department as a result of adjustments, overpayment collections, etc., exceeds the total payment due to the provider for a given checkwrite. Upon establishment of the A/R, the Contractor shall initiate a 100 percent (100%) withhold against payment for claims, or the percentage of the payment that will clear the A/R. The Department may, at its discretion, alter the percentage of withhold against the provider's claims payment; and
 - 6) Process retroactive rate changes in accordance with Department-approved policies and procedures and as directed in DOILs.
- b. Interim Payment Process
- 1) Process and maintain records for interim payments. Interim payments are normally those payments made to providers for unpaid claims that have been in the system for thirty (30) calendar days or more due to Contractor or Department errors, or for paid claims affected by retroactive changes.
 - 2) Providers may request interim payments in writing or by telephone subsequently followed up in writing. Upon receipt of the provider request, the Contractor shall log all requests by provider name, provider number, dollar amount of the request, and the date received (and the time if the request is by phone);
 - 3) If the Contractor determines a provider does qualify for an interim payment, the Contractor shall forward to the Department the findings that the interim payment requirements have been met. The Contractor shall deliver these findings to the Department within two business days of its determination. The Department will review the Contractor's findings and make the final decision to approve or deny the interim payment request;
 - 4) If the Contractor is unable to make a determination, the provider shall be notified by telephone within twenty-four (24) hours of this finding. If no additional information is obtained, a follow-up letter shall be mailed within two business days;
 - 5) If the Contractor determines that a provider does not qualify for an interim payment based on Department established criteria, the Contractor shall forward to the Department such requests within seven business days from the date the Contractor receives the provider's written request. The Department will review the Contractor's findings and make the final decision to approve or deny the interim payment request;
 - 6) When the Department approves an interim payment, the Department shall verbally notify the Contractor and confirm the notice in writing. The Contractor shall then verbally notify the provider within twenty-four (24) hours of the Department's verbal notification, follow-up with written notice, and issue the interim payment within two business days;
 - 7) When the Department denies an interim payment request, the Department shall verbally notify the Contractor and confirm this notice in writing. The

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Contractor shall verbally notify the provider within twenty-four (24) hours of the verbal notification by the Department and follow with written notice within two business days; and

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

c. Adjustment Process

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

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

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- 6) Research and process all other adjustments to adjudicated claims and provider payments as directed by the Department. Prior to initiating adjustment transactions, either on an individual claim basis or as part of a mass adjustment and/or recovery action, the Contractor shall first determine if the provider has already initiated the adjustment(s). If a provider has submitted a personal check to adjust an identified overpayment, the Contractor shall not initiate an adjustment, and/or recovery action for the same overpayment;
- 7) All adjustments, including record corrections, shall be completed within thirty (30) calendar days of the date of the Department notice. The thirty (30) calendar-day limit may be extended if the Contractor requests an extension in writing and is approved by the Department. Upon completion of the adjustment, the Contractor shall provide written notification, which includes dates of completion and rescheduled payments, to the Department; and
- 8) The requirement of prior authorization may be waived where medical conditions or a time factor relating to treatment makes it inappropriate. Approval for payment of services provided in such circumstances rests with the Department based on submitted documentation justifying failure to obtain prior authorization.

21. Cycle Time Requirements

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

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

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

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- 4) "Final adjudication" or "final adjudicate" is the date of the check write or EOB for claim/NOAs. "Adjudication" and "final adjudication" for TARs are defined as the date the NOA is processed; and
 - 5) All cycle times shall be computed on a monthly basis.
- b. Claims Processing Cycle Time Requirements

The Contractor shall:

- 1) Utilize the following calculation methodology when determining compliance. The time that claims/NOAs are in the following DCC locations is excluded from the claims processing cycle time calculations:
 - a) State review (DCC 3W, 4W, 5W, 6W, 7W);
 - b) FAME cycle wait (DCC 3E);
 - c) SOC cycle wait (DCC 3S);
 - d) RTD sent (DCC 6R);
 - e) Prior Authorization Special Claims Review (DCC 5S);
 - f) Clinical Screening (DCC 5G and 5P); and
 - g) Claims/NOAs affected by a processing problem/error as defined by the Department.
- 2) Ensure Claims/NOAs requiring Contractor professional review shall be included in the overall processing time requirements of Claims Processing Cycle Time Requirements;
- 3) For claims where an RTD has been generated, exclude the time from receipt of the original claim to the date of receipt of the corrected RTD. The MRDCN shall be used to calculate cycle time;
- 4) For NOAs where an RTD has been generated, exclude the time from receipt of the NOA to the date of receipt of the corrected RTD. The MRDCN associated with the RTD (not the MRDCN associated with the NOA) shall be used to calculate cycle time;
- 5) Process and final adjudicate all claims/NOAs, except those that are in Prior Authorization or Special Claims Review (PA/SCR), within an average of twenty (20) calendar days from receipt by the FI Contractor to check write/EOB date;
- 6) Process and final adjudicate ninety percent (90%) of all claims/NOAs within twenty-five (25) calendar days and ninety-nine percent (99%) within fifty-five (55) calendar days from receipt by the FI Contractor to check write/EOB date;

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

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

The Contractor shall:

- 1) Utilize the following calculation methodology for determining compliance of TARs and TAR reevaluations:
 - a) Exclude the following DCCs from the TAR processing cycle time calculations:
 - i. State review (DCC 3W, 4W, 5W, 6W, 7W);
 - ii. FAME cycle wait (DCC 3E);
 - iii. SOC cycle wait (DCC 3S);
 - iv. RTD sent (DCC 6R);
 - v. Clinical Screening (DCC 5G and 5P);
 - vi. TARs and TAR reevaluations affected by a processing problem/error as defined within this Contract; and
 - vii. PA/SCR (DCC 5S).
 - b) Include professional review of TARs and TAR reevaluations within the overall processing time requirements;
- 2) Process and final adjudicate all TARs and TAR reevaluations within an average of fifteen (15) calendar days of receipt in the system;

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- 3) Process and final adjudicate ninety percent (90%) of all TARs and TAR reevaluations within fifteen (15) calendar days and ninety-nine percent (99%) within thirty (30) calendar days;
 - 4) Ensure that the number of TARs and TAR reevaluations held for final adjudication over twenty (20) calendar days shall not exceed nine percent of total inventory. No TAR or TAR reevaluation shall be over sixty (60) calendar days old. Inventory is defined as non-adjudicated TARs in suspense and in "in process" DCCs, including daily receipts and daily cycle approved TARs. TARs are considered in the inventory until the NOA is processed; and
 - 5) Priority process TARs and TAR reevaluations, as described in this Contract, within seven calendar days of receipt of the Department's request.
- d. Clinical Screening Dentist Review Cycle Time Requirements

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

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

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

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- 1) Provider suspense notification:
 - a) All claims/NOAs suspended eighteen (18) calendar days or more; and
 - b) All TARs that have been suspended eighteen (18) calendar days or more.
- 2) Respond to CIF Tracer:
 - a) Claims/NOAs; and
 - b) TARs.
- 3) Respond to CIF (Adjustments and Resubmittals) Claims;
- 4) Acknowledgment of CIFs received;
- 5) Respond to phone calls;
- 6) Acknowledge and respond to provider appeals;
- 7) On the following check write, report on the EOB one hundred percent (100%) of each provider's claims, TARs, and TAR reevaluations that have been suspended eighteen (18) calendar days or more. These documents shall appear on each subsequent EOB as documents "in process" until adjudicated;
- 8) Respond to ninety-five percent (95%) of all CIF tracers within fifteen (15) calendar days and one hundred percent (100%) within thirty (30) calendar days;
- 9) Respond to, process, and final adjudicate ninety percent (90%) of CIF adjustments and resubmittals for claims within twenty-five (25) calendar days and ninety-nine percent (99%) within fifty-five (55) calendar days with a twenty (20) calendar-day average;
- 10) Acknowledge one hundred percent (100%) of CIFs received within seven calendar days;
- 11) Respond to one hundred percent (100%) of phone inquires within fourteen (14) calendar days;
- 12) Acknowledge one hundred percent (100%) of written grievances or complaints within twenty-one (21) calendar days;
- 13) Issue a written notice to providers of findings/conclusions for one hundred percent (100%) of all provider appeals which do not require professional review within thirty (30) calendar days of acknowledgment of receipt of provider appeals; and

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- 14) Process and issue a written notice of findings/conclusions for one hundred percent (100%) of all provider appeals requiring professional review, within sixty (60) calendar days of the issuance of the acknowledgment letter.

22. FI Contractor Processing Requirements

This section provides additional information regarding performance requirements administered on the FI Contractor. The FI Contractor shall:

- a. Scan the form documents, capture, and validate all documents to include claims, TARs, CIFs, returned RTDs, and NOAs to an electronic format within one business day of receipt by the FI Contractor.
- b. Assign a DCN, CRN, MRDCN, or other identifying number to each of the following documents whether received on hard copy or as electronic media documents; claim, TAR, NOA, RTD, CIF, appeal, and supporting attachments(s) indicating date of receipt within one business day of receipt by the FI Contractor;

23. Treatment Authorization Request (TAR) Purge Requirement

The Contractor shall:

- a. Purge TARs according to the guidelines in the CD-MMIS Processing Team Manual; and
- b. Negate and purge an existing unused TAR when a new TAR is received from a different provider accompanied by a letter from the beneficiary requesting to see the new provider. In addition, a telephone call to the provider of the unused TAR shall be made to ensure that no treatment has been rendered to the beneficiary.

24. Report Production

The Contractor shall work in conjunction with the FI Contractor to ensure the format and content of CD-MMIS reports meets all requirements as determined by the Contracting Officer.

25. Document Retrieval Responsibilities

Documents can be requested through the on-line Automated Document Retrieval (ADR) system, including claims, NOAs, TARs, EOBs, CIFs, and RTDs. Requests for other documents are currently submitted in written form. The Contractor shall follow the retrieval methods and procedures for all documents described in the Records Retention Procedures Manual. (See Exhibit A, Attachment II, Records Retention Requirements).

26. Department Responsibilities

The Department shall:

- a. Determine the scope of dental program benefits, benefit limitations, and provide overall policy direction to the Contractor;

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- b. Provide beneficiary eligibility and SOC certification information via FAME and AEVS;
- c. Develop and maintain all policies and procedures related to TARs and Medi-Cal dental services requiring prior authorization;
- d. Perform all tort liability, Worker's Compensation, probate or causality insurance recoveries and deposit into the Health Care Deposit Fund;
- e. Accumulate data and maintain file of beneficiaries with other health coverage;
- f. Determine EDI claims submission policy and approved formats and specifications;
- g. Review and approve Contractor-edited DCC changes;
- h. Review and approve all manuals;
- i. Attend and actively participate in DPAG meetings;
- j. Assist with dental State Hearings;
- k. Mandate, review and approve any and all dental edit and audit rules;
- l. Provide appropriate written directives;
- m. Provide instruction regarding priority processing whenever necessary; and
- n. Review and approve provider interim payment decisions.

H. SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM (S/URS)**1. Overview**

The Surveillance and Utilization Review Subsystem (S/URS) operated and maintained by the Contractor, is one part of the management information reporting capability of the California Dental Medicaid Management Information System (CD-MMIS). The S/URS is a post-payment system designed to provide a means to identify provider and beneficiary fraud and abuse and to identify services provided which are below the community standard of care.

S/URS was developed to meet specific monitoring and reporting requirements of the Department. The goal of S/URS is to provide a manageable approach to the process of aggregating and presenting data on program beneficiary and provider activities in order to satisfy two major concerns:

- a. Surveillance - The process of monitoring the delivery and utilization of covered services by Medi-Cal dental beneficiaries and providers. Surveillance includes use of itemized data for overall program management and use of statistics to establish norms and averages so that unusual practices and potential abuse can be detected; and

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- b. Utilization Review - The process of analyzing and evaluating delivery and utilization of services on a case-basis to guard against fraudulent or abusive use of services by either providers or beneficiaries of the Medi-Cal Dental Program and to identify those providers who provide services below the community standard of care.

2. Objectives

S/URS creates, over a period of time, statistical profiles detailing the services provided by providers, the utilization patterns of beneficiaries, and other related management information.

- a. The Contractor shall:
 - 1) Monitor the level of care being provided to beneficiaries;
 - 2) Monitor trends in dental services that could lead to changes in program policy;
 - 3) Document Medi-Cal dental annual income for the Internal Revenue Service (IRS) or various court proceedings; and
 - 4) Gather data reported in S/URS, taken from the Adjudicated Paid History Files in CD-MMIS.
- b. Utilization reviews may reveal potential fraudulent provider practices such as:
 - 1) A pattern of inappropriate billings;
 - 2) A pattern of inappropriate services;
 - 3) A degree of documented shortcomings; and
 - 4) Financial gain accrued by the provider as a result of such practices.
- c. The S/URS subsystem produces three major sets of reports that reflect increasingly greater degrees of detail.
 - 1) At the highest level are the Management Summary Reports which are the class group norms of care to which each beneficiary and provider is compared. The norms are developed by classifying each beneficiary and provider into the appropriate class group;
 - 2) The next level of reporting consists of Summary Profile Reports for each beneficiary and provider who has exceeded the norms (i.e., the exception limits) for that class group. These reports present an interrelated set of statistical indicators that have been selected to reveal areas of potential fraud and/or abuse; and
 - 3) The lowest level of reporting is the Claim Detail Report (CDR) produced for each beneficiary and provider, available upon request to the Department. These reports reflect detail from each adjudicated claim. For each

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beneficiary and provider, the claim details to be printed may be selected according to dates of service, procedure code, or various other criteria.

3. Assumptions and Constraints

- a. Audits of providers suspected of fraud and abuse activity will be conducted by Department Audits and Investigations (A&I) staff.
- b. All recovery activities will be performed by Department Third Party Liability (TPL) staff.
- c. S/URS reporting and exception profiling is augmented by reports and data extracted from the decision support system.
- d. S/URS provides the following capabilities:
 - 1) Availability of claims history data elements for computational and reporting purposes;
 - 2) Capability of establishing statistical indicators (measurement items) as well as the methods used for their computation;
 - 3) Ability to define class groups by specifying value limits for a desired set of available characteristics;
 - 4) Ability to define normal values for group profile items;
 - 5) Ability to control the comparison process by which individuals within a given class group are tested against that group's norms;
 - 6) Ability to define the content of various reports;
 - 7) Ability to assign priorities to discovered abnormalities; and
 - 8) Ability to examine participants ranked according to significant statistical indicator values.
- e. S/URS produces a series of statistical and detailed reports on Medi-Cal dental beneficiary and provider activities. S/URS obtains data on individual Medi-Cal dental beneficiaries and providers from the CD-MMIS subsystems. This data is used to divide the beneficiaries and providers into peer or class groups according to various demographics and other characteristics as defined by Department staff.
- f. S/URS develops a behavioral profile for each beneficiary and provider in a class group. The purpose of the behavioral profile information is to assist Department staff in identifying normal and abnormal activities for each class group; the abnormal activities are referred to as exception situations. Exception situations are identified by comparing individual activity to class group norms. Exceptions are then "weighted", as determined by users, in order to produce ranked exception reports. The Contractor shall note exceptions to peer group or class norms that may indicate possible beneficiary and/or provider abuse.

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- g. The beneficiary and provider identification (ID) numbers are unique and can be accurately cross-referenced.
- h. The large volume of claims data requires consistently efficient and reliable operations for the timely and accurate production of reports.
- i. S/URS Operations require a close working relationship with the Fiscal Intermediary (FI) Contractor and the Department.
- j. All S/URS reports shall meet the reporting requirements in the CD-MMIS Administrative Services Organization (ASO) Contract, Exhibit A, Attachment II, General Reporting Requirements.
- k. During Takeover, the Contractor shall work in conjunction with the FI Contractor to update the S/URS User manual and Fraud and Abuse/Quality of Care manual to reflect the transition of the Audit and Recovery functions to the State. The manuals shall be delivered to the Department for approval thirty (30) calendar days before claims processing is initiated (Refer to Exhibit A, Attachment II, Documentation and System Access).

4. General Responsibilities

The Contractor shall:

- a. Detect potential occurrences of fraud and abuse or quality of care issues associated with provider and beneficiary claim activity and correspondence;
- b. Ensure adequate staffing to perform all S/URS case detection and development activities. All actions recommended by the Contractor shall be presented to the Department for review and approval at Case Review Committee (CRC) meetings. Approval from the Department must be obtained prior to implementation of any action(s);
- c. Prior to the implementation of any change that affects or alters S/URS Operations, user interaction, reporting, data presentation, etc., the Contractor shall submit a written request to the FI Contractor's Enterprise Project Management Office (EPMO) and the Contracting Officer. This request shall include a description of the change and how it may affect existing procedures/Operations, and the projected implementation date. The request shall be submitted no less than thirty (30) calendar days prior to the projected implementation date, unless prior approval has been granted by the Contracting Officer;
- d. Ensure at least one S/URS staff is accessible to Department-designated personnel during the hours of 7:00 AM to 5:00 PM Pacific Time PT, Monday through Friday, excluding State and Contractor holidays to perform S/URS Liaison activities;
- e. Ensure any and all duties, requirements, policies and procedures as defined in this S/URS section are adhered to. Should the Contractor fail in this regard and this results in an award against the Department or results in the Department losing the ability to recover overpayments, then those amounts shall be paid by

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the Contractor according to the judgments directed by the Court or other administrative body;

- f. Upon Department request, provide expert witness services as defined in the California Dental ASO Contract, Exhibit A, Attachment II, Expert Witness, on contractual definitions or benefit coverage and necessity in fraud, abuse, civil, and administrative legal proceedings. Once approved by the Department, the Contractor shall retain a court-experienced expert witness to handle specialty cases, such as orthodontics, on an on-call basis. All S/URS staff shall be prepared to serve in the capacity of expert witness as required;
- g. Provide to the Department, within three State work days of any request, all reports, records, information and documentation to facilitate any audit or investigation of potential provider and/or beneficiary fraud and abuse;
- h. Make available to the S/URS Operation necessary legal counsel to support and advise S/URS staff in development and implementation of policy for Department consideration; and
- i. Work in conjunction with the FI Contractor to maintain and update the S/URS User Manual monthly throughout the term of the Contract to reflect Department approved changes. The manual shall clearly describe the Contractor's S/URS Operation, user intervention and procedures, system capabilities and limitations, description and use of CD-MMIS computer screens, building of parameters and their range uses. (Refer to CD-MMIS FI Contract, Exhibit A, Attachment II, Data Processing and Documentation);

5. Training

The Contractor shall:

- a. Work in partnership with the FI Contractor to provide S/URS and CDR training to Department-authorized users, within thirty (30) calendar days of receipt of the Department's written request. The Department's request will specify the number of Department staff or persons to be trained (e.g. Department of Justice (DOJ) staff). This training is also part of the training requirement described in Exhibit A, Attachment II, Staff Training Requirement and shall be included in the bid price for Operations;
- b. Ensure the training encompasses the following:
 - 1) S/URS Operations;
 - 2) A review of the S/URS user manual;
 - 3) Procedures for ordering CDRs (overview);
 - 4) Procedures for ordering Aged History Reports (AHR); and
 - 5) S/URS reports;

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- c. Acquaint attendees with S/URS Operations and system user interactions, to increase the level of competence of those who use the system in their work;
- d. Submit a written training plan to the Contracting Officer for review and approval no more than one month after the assumption of claims processing. If the Contracting Officer directs that specific changes/additions be made to the plan, the Contractor shall have thirty (30) calendar days from receipt of the Contracting Officer's directions to make the modifications; and
- e. Ensure the training plan shall also include the professional qualifications of each trainer (i.e., the trainer's current job classification and responsibilities, his/her knowledge and experience in the assigned subject(s), and his/her ability to impart that knowledge to others).

6. Report Production

The Contractor shall work in conjunction with the FI Contractor to maintain, update, and review all S/URS reports produced by the CD-MMIS including, but not limited to, those listed below. Reports shall meet the requirements described in this section and in Exhibit A, Attachment II, General Reporting Requirements. If inconsistencies are identified, the S/URS section shall take precedence.

- a. Claim Detail Reports
 - 1) Beneficiary and provider CDRs shall be produced upon the Department's request and approval. The Contractor shall deliver local CDRs in print, electronic media, or CD format within twenty-four (24) hours of request. "Local" deliveries shall be to any location within twenty-five (25) miles of the State Capitol Building. All other CDRs shall be delivered via secure, bonded courier as described in ASO Contract, Exhibit E, Additional Provisions;
 - 2) Create CDR distributions accordingly. CDR requests and Claims Detail Report Requestor Numbers (CDRRN) are input at the same time. CDRRN are assigned by the Department and identify the requestor and the respective report delivery address; and
 - 3) Ensure production of CDRs for payment data for the most recent seventy-two (72) months of dental service history and once-in-a-lifetime procedures.

- b. Statistical Sampling Module and Reports

The S/URS Statistical Sampling Module and Reports enables authorized S/URS users to produce reports based on random samples of paid claims drawn from the thirty-six (36) Month Provider Paid Claims History File.

- 1) Sampling reports shall be produced on a monthly basis. Input requests provided by the first business day of the month shall be delivered by the fifteenth (15th) business day of the same month. Input requests prior to the fifteenth (15th) business day of the month shall be delivered by the last business day of the same month.

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- 2) The number of samples requested by the Department through this module shall not exceed three hundred (300) during any Contract year.
- c. S/URS Activity Report
- 1) Ensure a monthly report due by the fifth business day of each month is produced and distributed to the Department. The report shall include:
 - a) A list of each provider currently on Prior Authorization (PA) and/or Special Claims Review (SCR), the timeframe and term for the PA and/or SCR, the date State approval was given for each action, and which State representative granted approval; and
 - b) All providers referred to the Department's A&I Division, DOJ, and/or Dental Board of California.
 - 2) Ensure a report is produced and distributed to the Department by the fifth business day of the beginning of each quarter to include the following:
 - a) A list of the providers and beneficiaries that were profiled during the most recent calendar quarter;
 - b) A list of the providers selected for comprehensive desk review as a result of the profiling;
 - c) A list of potential provider fraud cases forwarded to A&I; and
 - d) A list of potential beneficiary fraud cases forwarded to the Department.

7. Quality of Care

The Contractor shall:

- a. Submit a proposed quality of care review plan to the Department for approval two months prior to assumption of claims processing. The plan should include specific recommendations regarding proposed corrective actions that can be taken to improve the quality of care for Medi-Cal dental beneficiaries and possible methods to follow-up to ensure the corrective actions have been effective. The Contractor shall update the plan every twelve (12) months thereafter;
- b. Implement the plan following Department approval, in accordance with the Contracting Officer's directives;
- c. Develop an operational quality of care review system, employing the services of California licensed dentists and paraprofessionals to ensure quality dental care is provided to beneficiaries by continually assessing and addressing problems brought to its attention by various sources, (e.g., Contractor's dental professional/paraprofessional staff; clinical screening dentist staff; dental record/claim/Treatment Authorization Request (TAR) audits; beneficiary complaints; complaints or concerns resulting from a beneficiary referral or advocacy groups; statistical reports, etc.);

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- d. Ensure the quality of care review system shall be based upon the community standard of care in the dental profession;
- e. Identify less than satisfactory performance of care by considering information from all reasonably available sources, some of which are listed above;
- f. Establish valid and achievable dental standards for those identified elements of care that are amenable to standard setting and compliance measurement;
- g. Assure that the standards that are established will be related to conditions that can be affected by dental intervention that are within the scope of benefits in the program, that can apply to a significant number of beneficiaries and apply to all providers, not just one class of providers;
- h. Document staff meetings dealing with this requirement and any assistance sought from and given by sources outside Contractor's staff;
- i. Objectively measure the actual performance as reflected in data gathered from dental records, beneficiary complaints and other sources so as to include a representative sample of all such performance, to determine apparent noncompliance with standards;
- j. Analyze the validity of the objective measurement results by Contractor professional staff; and
- k. Work in conjunction with the FI Contractor to maintain and update the Fraud and Abuse/Quality of care manual maintained on a monthly basis. The manual shall be delivered to the Department for approval thirty (30) calendar days before claims processing is initiated; thereafter the manual shall be updated monthly. The manual shall describe all methods governing fraud and abuse and the quality of care system. Refer to the Exhibit A, Attachment II, Documentation and System Access Responsibilities.

8. Profiling and Utilization Review

a. Provider Profiling and Utilization

The Contractor shall:

- 1) Use the quarterly cycle of provider profiling and the decision support system to identify potential overutilization and abuse;
- 2) Set the parameters to identify exceptional providers and submit them to the Department for review and approval;
- 3) Apply the following guidelines for the identification of exceptional providers:
 - a) Each quarter review at least one percent of the total body of active billing dental providers.

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- b) From those providers reviewed in a) above, examine all, but select a minimum of fifty percent (50%) of those providers for a comprehensive desk review.
 - 4) Submit all reports related to the Provider Profiling Modules on paper, electronically, compact disc (CD), or other media as requested by the Contracting Officer;
 - 5) Review all provider utilization reports produced by the CD-MMIS. Ad hoc reports shall be generated and utilized as necessary in the process;
 - 6) Maintain documentation of the entire utilization review process to form an audit trail of utilization review activity. This documentation shall be made available to the Department within two State work days of a written request. The documentation shall include but not be limited to the following:
 - a) All copies of reports;
 - b) All written documentation of findings;
 - c) All documentation of findings from reviews;
 - d) All report pages appropriate to each utilization review process;
 - e) All notes (e.g. electronic mail) shall be maintained throughout this process;
 - f) Any other relevant information relating to the review process; and
 - g) Meet the federal MMIS requirements.
- b. Beneficiary Profiling and Utilization
- The Contractor shall:
- 1) Use the quarterly cycle of beneficiary profiling and the decision support system to identify potential overutilization and abuse;
 - 2) Set the parameters for identifying exceptional beneficiaries to detect billing conflicts of procedures on the same patients utilizing History Cross Check of TARS;
 - 3) Review all reports related to the Beneficiary Profiling Modules and submit on paper, electronically, CD, or other media as requested by the Contracting Officer;
 - 4) Maintain documentation of the entire utilization review process to form an audit trail of utilization review activity for each case. This documentation shall be made available to the Department within two State work days of a written request. The documentation shall include, but not be limited to, the following:
 - a) All copies of reports;

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- b) All written documentation of findings;
 - c) All documentation of findings from other sources;
 - d) All notes (e.g. electronic mail) shall be maintained throughout this process;
 - e) All report pages appropriate to each utilization review process; and
 - f) Any other relevant information relating to the review;
- 5) Apply the following guidelines for the identification of beneficiaries:
- a) Each quarter, review at least one one-hundredth (1/100th) of one percent of the total body of active beneficiaries;
 - b) Each quarter, submit for Department review and approval all documentation regarding each beneficiary review case with the Contractor's recommended action to be taken (e.g. restriction);
 - c) Impose all restrictions approved by the Department; and
 - d) Edit claims for beneficiaries that have been placed on restriction.
- 6) Provide assistance to the Department when it conducts State Hearings for beneficiaries that protest the imposition of a restriction for dental services. The Contractor shall provide all documentation related to beneficiaries' cases within three State work days of the request, prepare a written Position Statement of reason(s) for restriction in accordance with ASO Contract, Exhibit A, Attachment II, Beneficiary Services, Dental State Hearing section of the Contract and ensure S/URS staff are available to represent the Department in the State Hearing, if requested by the Department;
- 7) Forward cases of potential beneficiary fraud and abuse activity in excess of four hundred dollars (\$400) to the Department following completion of beneficiary utilization reviews (see Fraud and Abuse/Quality of Care Manual);
- 8) Review all beneficiary utilization reports produced by the CD-MMIS. Ad hoc reports shall be generated and utilized as necessary in the process. The reports shall meet the requirements described in Exhibit A, Attachment II, General Reporting Requirements and Quality Management sections of the Contract; and
- 9) Provide for S/URS post-treatment screening services pursuant to the Fraud and Abuse/Quality of Care Manual and S/URS User Manual.
- c. Comprehensive Desk Review

A comprehensive desk review is the internal review and analysis of documents readily available through various reports or documents. The primary purpose of the desk review is to develop cases for potential monitoring and review and/or referral to A&I. The Contractor shall determine which review cases will be selected for the following actions:

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1) Monitor and Review

A billing provider, rendering provider and service office may be placed on utilization controls to monitor and review a provider when they have demonstrated possible over-utilization, questionable billing activities and/or poor quality of care.

The Contractor shall:

- a) Identify the providers to be placed on utilization controls through various reports, documentation, medical necessity, and standard of care or other sources. A provider may be placed on one or both of the following utilization controls:
 - i. PA – One year term
 - ii. SCR – Nine month term
- b) Recommend the procedures to be placed on PA and/or SCR for each provider;
- c) Present recommendation to the Department at CRC for approval;
- d) Send notification to the provider once the Department has approved the Contractor's recommendation;
- e) Respond to providers' inquiries regarding PA/SCR utilization controls;
- f) Continue to monitor providers on PA and/or SCR to ensure the provider is meeting the PA and/or SCR requirements; and
- g) Recommend extended term or early removal for providers on PA and/or SCR.

2) A&I Division

The Department will forward to the Department's A&I Division billing provider, rendering provider and/or service offices that have demonstrated possible fraud, over-utilization, questionable billing activities or poor quality of care.

The Contractor shall:

- a) Identify the providers to be placed on utilization controls through various reports, documentation, medical necessity, and standard of care or other sources; and
- b) Refer providers to the Department when possible fraud, overutilization, questionable billing activities or poor quality of care has been identified.

d. S/URS CRC

The Contractor shall:

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- 1) Establish a CRC comprised of the Contractor S/URS and management staff and representatives of the Department, to be selected by the Contracting Officer, to review and evaluate findings from reviews and make recommendations to conduct audits and impose sanctions when appropriate;
- 2) Prepare agenda and record minutes of the CRC. The draft minutes shall be submitted to the Department within three business days for review and approval prior to the recording of the final version;
- 3) Include in the CRC, but not be limited to, the following Department staff:
 - a) Manager of the Surveillance Utilization and Review Subsystem Unit, Medi-Cal Dental Services Division;
 - b) Dental Consultant of the Medi-Cal Dental Services Division; and
 - c) Analyst of the Surveillance Utilization and Review Subsystem Unit, Medi-Cal Dental Services Division.
- e. Specialized Support

The Contractor shall provide specialized support and consultative services to Department of Health Care Services (DHCS) upon request. Staff utilized to fulfill specific DHCS approved service requests must contain the appropriate skill set to meet the needs of each specific request. Specialized support or consultative services may be needed on a temporary basis at remote locations to support either Department staff or staff designated by the Contracting Officer. DHCS will provide written notice for any requests under this provision.

9. Department Responsibilities

The Department shall:

- a. Review and approve/disapprove all S/URS manuals, report parameters, and proposed administrative actions against providers/beneficiaries;
- b. Approve/disapprove providers recommended for audit review;
- c. Approve/disapprove all data release requests from other agencies or entities;
- d. Serve on the CRC;
- e. Request S/URS and CDR training to be conducted by the Contractor; and
- f. Approve/disapprove referrals of suspected fraud and/or abuse by recipients and providers to the A&I Division and other agencies.

Exhibit A, Attachment II
Scope of Work - Operations**I. EXPERT WITNESS REQUIREMENTS****1. Overview**

This section describes the requirements governing the manner in which the Contractor shall provide expert witness services for the State and for agents of its political subdivisions. It also provides for the delivery of expert witness services in those instances in which the Department has no direct involvement or interests. This section further describes the Contractor's obligation to appear in court and at hearings to provide testimony, and respond to subpoenas and/or subpoenas duces tecum.

2. Objective

To provide expert witness services for the State and its political subdivisions when instructed by the Department. Services may be provided at hearings, proceedings, or other meetings or events. Expert witness services shall speak to all aspects of the Contractor's Operations under this Contract. On behalf of the State, the Contractor shall provide accurate responses to subpoenas and subpoenas duces tecum by the stipulated time requirement(s) in manners concerning requests for information regarding the administration of the Medi-Cal dental program.

3. Assumptions and Constraints

- a. The State and its political subdivisions will have a need to provide courts, administrative law judges, hearing officers, attorneys, or other authorized persons with accurate descriptions of the manner in which claims are processed and adjudicated.
- b. The Department and its political subdivisions will make approximately fifty (50) requests annually for expert witness services in the various kinds of actions, including actions in small claims court and responses to subpoenas and/or subpoenas duces tecum.
- c. There may be demand for expert witness services in regard to actions by, or on behalf of, third parties, to which the Department is not a party (e.g., two providers engaged in a lawsuit against one another).

4. General Responsibilities

The Contractor shall:

- a. At the request of the Department provide expert witness services at locations within California for hearings, proceedings, or other meetings or events dealing with legal matters in the administration of the Contract. In Contractor-at-fault cases, the Contractor will be responsible for all costs related to the case, including filing fees;
- b. At the request of the Contracting Officer, provide expert witness services in matters dealing with certification of copies of information (e.g. Claim Detail Reports (CDRs), Provider Enrollment application information, etc.);

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- c. Provide written analysis, supporting documents, and expert witness services in hearings and in court, including small claims court, regarding the actions the Contractor has taken in exercising its responsibilities under this Contract;
- d. Ensure the qualifications of the individual(s) designated to provide expert witness service include possession of a bachelor's degree in business administration, or a bachelor's degree in a related field, or the equivalent in comparable experience; an additional three years' experience in professional/technical procedures for system operation; and excellent verbal and written communication skills. The designated expert witness staff shall be properly trained by the Contractor to perform this function and shall be thoroughly familiar with all aspects of Operations under this Contract;
- e. In addition to the designated expert witness in item d. above, provide a Dental Consultant (licensed by the Dental Board of California) for expert witness services in matters dealing with the delivery of dental care;
- f. During takeover, and annually thereafter, designate and identify staff persons available to perform the expert witness function so as to meet all requirements and time limitations under this section, including time limits set by any subpoena or subpoena duces tecum served on the Contractor or the Department. The Contractor shall determine if any subpoenas or subpoenas duces tecum served are appropriate to the administration of the Medi-Cal dental program. The Contractor shall respond to the subpoenas and subpoenas duces tecum with appropriate references to the Evidence Code and/or Code of Civil Procedure;
- g. Provide specific additional or substitute employees, other than the designated court-experienced expert witness staff, to provide testimony or information about the Contractor's Operations under this Contract at the option of the Department. This option shall be extended to political subdivisions of the Department only upon written permission from the Contracting Officer. The designated court-experienced expert witness shall be properly trained by the Contractor to perform this function and shall be thoroughly familiar with all aspects of Operations under this Contract;
- h. Make an expert witness available to provide testimony at hearings, proceedings, and other events in which the Department has no direct involvement or interest. The Contractor shall receive written approval from the Contracting Officer prior to the delivery of expert witness services as defined in this paragraph. The Department shall not provide any additional reimbursement to the Contractor for the provision of such services. The Contractor may receive payment for these services from the court or other parties requesting the appearance of an expert witness;
- i. Provide written notification to the Department prior to the delivery of all expert witness services, and/or response(s) to subpoenas or subpoenas duces tecum. The notice shall be no later than twenty-four (24) hours after the Contractor is aware of the request, notification, subpoena or subpoena duces tecum. The response to all subpoenas and/or subpoenas duces tecum shall clearly define the relationship between the Contractor and the Contracting Officer;

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- j. Notify the Department in writing of any third party action or other proceeding as described in paragraph h. above, in which it will provide expert witness services. The notice shall briefly summarize the nature of the case and the issues on which expert testimony will be given. The notice shall be given to the Contracting Officer within twenty-four (24) hours after the date on which the Contractor is notified that an expert witness will be required;
- k. Not release any Personal Health Information (PHI) or Personal Confidential Information (PCI) in response to a subpoena or subpoena duces tecum without prior written authorization from the Contracting Officer; and
- l. Within two business days after providing the Department expert witness services, provide the Department with a summary of the proceeding(s) and the name of the individual/entity that provided the expert witness service.

5. Court Obligations, Administrative Hearings and Conlan Hearings

When the Contractor is named as a party in any civil court case (e.g., small claims court case) related to claims payments, the Contractor shall:

- a. Appear in court to defend against actions related to payment of claims or non-payment of claims under this Contract. In cases that raise or include issues relating to the administration of Department policy, the Contractor shall promptly notify the Contracting Officer that such a case has been served. The notice shall be in writing to include a copy of the plaintiff's claim and submitted to the Contracting Officer within one business day that the case was served. If there is insufficient time prior to the hearing for representatives of the Department to prepare and appear, the Contractor shall appear and defend the case until such time as the defense of the case can be tendered to the Department;
- b. Not initiate legal actions related to payment of claims or any other legal activity under this Contract without prior written authorization from the Contracting Officer;
- c. Notify the Department prior to the Contractor's appearance in civil court cases, and prior to the Contractor's response(s) to any court subpoenas or subpoenas duces tecum. These notifications to the Department shall occur no later than (beginning with the receipt of notification) one business day after the Contractor has notice of the subpoena, subpoenas duces tecum, or otherwise receives a need to appear; and
- d. At the request of the Department, provide testimony at a dental administrative hearing, Conlan hearing or court proceeding, if deemed necessary by the Contracting Officer.

6. Cost Stipulations

- a. The cost of the expert witness service and/or the cost of initiating or defending court actions shall be in the Contractor's fixed price Operations bid.
- b. The Contractor is required to indemnify the Department for the cost of claims in which the Contractor does not choose to defend against an action, which results

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in an award by default being made against the Department. In that case, the amount of the award shall be paid by the Contractor according to the judgment directed by the Court.

7. Department Responsibilities

- a. The Contractor's designation of staff as expert witness is subject to prior written approval by the Department.
- b. The Department will notify the Contractor in a timely manner of the date, time, and location of proceedings, or other meetings or events at which specific expert witness services are to be provided.
- c. The Department will notify the Contractor in a timely manner of the nature of the subject matter to be covered and the type of testimony to be presented.
- d. The Department will approve all expert witness services provided.

J. QUALITY MANAGEMENT OPERATIONS

1. Overview

The Quality Management (QM) process shall provide continuous and routine measurement of Contractor work and oversight of subcontractor performance. The QM process shall determine the Contractor's compliance with all Contract requirements including the determination of accuracy and timeliness of the Contractor's performance in each area of responsibility.

The Contractor's internal performance standards shall also be monitored and the reviews must be completed and approved to determine whether the internal processes result in timely, accurate, effective, and efficient operational and administrative activities including processing of claims and all other documents, thereby achieving the Contractor's compliance with Contract requirements. The Contractor shall work with the Department to set these internal standards, which are in addition to those already contractually required. The review of the reporting results shall assist the Contractor and the Department in measuring the quality of the work being performed and facilitate recommendations for necessary operational changes.

The QM process shall consist of the following activities:

- a. QM
- b. Quality Assurance (QA)
- c. Utilization Management (UM)

2. Objectives

The Contractor shall include the following in the QM process, but is not limited to:

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- a. Develop and implement a QM Plan to address quality planning, quality control, quality assurance and quality improvement.
- b. Retrospective measurements and reporting of system and process performance.
- c. Prospective reviews and recommendations to the Department on program policies and/or procedures.
- d. Work in conjunction with the Fiscal Intermediary (FI) Contractor regarding the identification (ID) and tracking of the California Dental Medicaid Management Information System (CD-MMIS) Operations, and/or performance problems, and subsequent development and implementation of corrective actions necessary to remedy such problems.
- e. Identification and tracking of performance problems throughout all levels of the Administration Services Organization (ASO) Contractor Operations, including subsequent development and implementation of corrective actions necessary to remedy such problems.
- f. Communication and dissemination of QA and improvement information throughout all levels of Contractor Operations and concurrently to the Contracting Officer.
- g. Utilize independent staffing to conduct activities identified within the QM process. The Contractor staff performing the QM reviews shall be independent from staff performing any of the operational activities required of the Contractor in meeting the Contract requirements.

3. Assumptions and Constraints

The QM process is subject to the following assumptions and constraints:

- a. The Medi-Cal Fee-For-Service (FFS) Dental Program consists of two Contracts - the ASO Contract and the FI Contract. These two Contractors are expected to work in concert with each other to achieve their respective goals and responsibilities outlined in their Contracts to carry out the operations and policies of the Department.
- b. The Quality Assurance Plan, the QM Plan, and the Quality Assurance Standards and Procedures Manual shall be maintained by the Contractor and are subject to Department review and approval.
- c. All manuals and documents shall be stored and accessible through the tool implemented and supported by the FI Contractor.
- d. The ASO Contractor and the Department shall have CD-MMIS access in order to execute the requirements described in this section; including acceptance testing for monitoring, reviewing, and testing the systems Operations.
- e. Existence of a Contractor quality standard shall not relieve the Contractor of the responsibility of meeting Contract requirements.

Exhibit A, Attachment II
Scope of Work - Operations**4. General Responsibilities**

The Contractor shall:

- a. Transmit all Quality Management Dental Consultant (QMDC) reports to the Department through the standard reporting procedures provided in this Contract; however, all working papers used in preparation of the QMDC report shall be available to the Department upon request;
- b. Receive copies of any and all change documentation related to document adjudication policy and procedures, including, but not limited to, Dental Operating Instruction Letters (DOILs), System Development Notices (SDNs), Miscellaneous Change Documents (MCDs), Change Orders, and Exceptional Processing Instructions (EPIs);
- c. Ensure there are appropriate methods for monitoring Contractor performance that include, but are not limited to, the following:
 - 1) Sample testing of claims, Treatment Authorization Requests (TARs), Notice of Authorizations (NOAs), Claim Inquiry Forms (CIFs), and eligibility verification responses;
 - 2) Sample testing of provider and beneficiary Telephone Service Center (TSC) calls to evaluate the accuracy and quality of customer service delivered;
 - 3) Conduct reviews on the Interactive Voice Response (IVR) system for accuracy and Contract compliance;
 - 4) Document processing functions and routine audit activities; and
 - 5) Review provider payment files prior to the FI Contractor performing the final checkwrite function.
- d. Perform these tests on a systematic schedule to determine the reliability of Contractor Operations in meeting Contract requirements and accuracy in claims and other document processing as well as other administrative and operational processes. When a system problem is encountered, the Contractor shall refer to Exhibit A, Attachment II, Administrative Support of Contract Changes for standards and procedures;
- e. Provide additional review and research of the processes used in the system to determine the cause of the errors and develop the systematic means to reduce the defective source of these errors, and shall not attribute inaccuracies to human errors. The analysis of errors that may have resulted from human error must extend back and analyze the actual business or other processes which may have caused the error. At the Department's discretion, a Corrective Action Plan (CAP), developed in conjunction with the FI Contractor, may be required when the monthly error rate is two percent or greater;
- f. Ensure the entire Operation is in compliance with ISO 9001:2008 standards upon Contract implementation and shall be certified to ISO 9001:2008 within one year

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- of Assumption of Operations (AOO). Maintain certification each year by meeting or exceeding the most recent standards and/or guidelines;
- g. Develop and execute QM measures to verify and validate the processes and work products throughout the term of the Contract. ;
 - h. Ensure Contract compliance and timely performance of Contractor responsibilities through supervisory and management review;
 - i. Ensure completeness, accuracy, and timeliness of deliverables to the Department;
 - j. Identify situations, occurrences, and deficiencies where schedules and accuracy standards are not met by the Contractor; and
 - k. Allocate an adequate number of trained and qualified staff, including various resources to perform these QM activities to meet the time frames specified.

5. Quality Management Plan

The Contractor shall:

- a. Develop and maintain a QM Plan describing the Contractor's process for reviewing, verifying, and validating processes, work products, and deliverables to ensure compliance with Contract requirements, as well as processes for improving performance;
- b. Meet or exceed the requirements for Capability Maturity Model Integration (CMMI) Level 3 or ISO 9001: 2008. The Contractor staff must achieve certification from an independent third party evaluator in whatever methodology they propose by the end of Contract year one. All tools and methodology must be brought to this account and used with all quality activities. The Contractor-assigned team shall have a thorough understanding of CMMI. After AOO, the Contractor shall become CMMI certified and shall monitor CMMI or ISO for newer versions to stay current with the latest release;
- c. Staff a QM Director responsible for the oversight, operation, and success of the program and who shall spend an adequate percentage of time on QM/QA activities including the Quality Management, Quality Assurance, and Utilization Management Improvement programs;
- d. Submit annual updates to the QM Plan which shall be initially approved by the Department in the Takeover Phase and executed throughout the term of the Contract, including Turnover;
- e. Fully document an organizational structure to support the following:
 - 1) A collaborative approach to monitoring Contract responsibilities through continuous performance reviews and analyses of Contract processes;
 - 2) Provide regular disclosure of findings to ensure early correction of problems and issues; and

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- 3) Provide ongoing identification of opportunities for enhancing overall program and Contract performance.
- f. Identify operational areas to be reviewed and provide an overview of the performance monitoring methodology used to evaluate those areas;
- g. Develop preventive measures used to identify, research, report, and correct problems, which, if resolved, would increase the efficiency and accuracy of Operations;
- h. Ensure communication processes within the Contractor's organization; (e.g., internal to the Contractor, external to the FI Contractor, and external to the Department); and
- i. Develop procedures used to evaluate and improve all staff performance (both system and non-system).

All annual updates to the QM Plan are subject to Department review and written approval. In the instance of failure to secure Department approval of the annual update, the Contractor shall continue to adhere to the QM requirements contained in the latest approved QM Plan.

6. Quality Management Reviews

The Contractor's QM program shall include concurrent and retrospective reviews of Contract work to determine the Contractor's compliance with all Contract requirements, including accuracy and timely performance rates. In addition to the review for Contract compliance, the Contractor's QM program shall monitor the Contractor's performance in meeting internal quality performance standards.

The Contractor shall ensure each QM Review includes, but is not limited to, the following:

- a. The month and year that the data in each report represents;
- b. The performance standard being measured (e.g., the "P" factor for TSC, correspondence qualitative performance, etc.);
- c. Whether the standard is quantitative or qualitative;
- d. Confidence level met;
- e. Precision level met;
- f. Size of the population;
- g. Size of the sample;
- h. The percentage of criteria met for each standard for the entire month;
- i. The percentage needed to ensure successful compliance of the Contractor for each standard;

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- j. The percentage of shortfall, when applicable, for each standard;
- k. The percentage exceeded for each standard, when applicable;
- l. Separate and distinct scoring calculations for quantitative and qualitative requirement measurements, each arriving at an individual total score;
- m. The total aggregate score for both quantitative and qualitative requirements determined while taking into consideration the individual score for each particular program area;
- n. The deficiency and the reason for deficiency, if applicable;
- o. Quality and production improvements taken (if needed) or proposed;
- p. Corrective action taken (if needed) or proposed;
- q. Recording of significant issues;
- r. All manually input data required that cannot be automatically retrieved from another system shall be obtained and entered into the system by the appropriate Contractor staff; and
- s. Identify, for reporting and tracking, the staff that manually entered/input the data into the system.

7. Quality Assurance Plan

The Contractor shall be responsible for developing and implementing a QA Plan to be supplied for Department review and approval. The QA Plan shall use applicable elements of approved standards for QA Plans, and its framework shall incorporate considerations for process improvement, testing, and evaluation. QA activities provide appropriate visibility into the compliance of processes, procedures, products, and deliverables built as part of the Takeover Phase and executed throughout the term of the Contract, including Turnover. QA activities include, but are not limited to the following:

- a. Defining quality standards and measures for work products and deliverables;
- b. Verifying and validating that work products and deliverables meet defined quality standards;
- c. Identifying the method of resolving issues regarding work product and deliverable quality;
- d. Providing the QM team and the Department with the results of reviews;
- e. Incorporate Contract Management HEDIS Reporting as a part of the overall QA Plan and the Contractor's approach to quality management; and
- f. Submitting an updated QA Plan on an annual basis.

Exhibit A, Attachment II
Scope of Work - Operations

8. Sixty (60) -and Ninety (90) -Day Edit Reports Review

As part of the QM function, QM staff shall research each claim listed on the sixty (60) Day Edit Report and each TAR on the ninety (90) Day Edit Report, which are both generated by CD-MMIS. The purpose of this ongoing review is to determine the reason(s) for aged claims/TARs and expeditiously adjudicate them in order to reduce the volume in each category. The Contractor shall submit a monthly report to the Department outlining the reasons why specific claims and TARs are aged beyond the maximum time frame allowed. This report shall provide an extensive review of all related TARs over sixty (60) days and claims over ninety (90) days. This QM report shall be due and copy delivered to the Department fifteen (15) calendar days after the monthly sixty (60)/ninety (90)-day cycle time report.

9. Process Compliance Review

The Contractor's QM Process shall also incorporate QM reviews of all areas of this section to measure, analyze, and report the level of compliance with contractual requirements. The Contractor shall include both quantitative and qualitative requirements. This data will be utilized as a basis for determining whether the Contractor meets the performance standards outlined in Exhibit B, Attachment I, Special Payment Provisions.

On a monthly basis, the Contractor shall:

- a. Review and assess Contractor compliance with all quantitative Operations requirements. A quantitative requirement is any measurable requirement (e.g., have a weekly "P" factor for the TSC that does not exceed five percent ; resolve and respond to a written piece of correspondence within thirty (30) business days; schedule a clinical screening appointment within eleven (11) business days of determination) as identified in this Contract including, but not limited to, Exhibit A, Attachment II, Provider Services; Exhibit A, Attachment II, Beneficiary Services; and Exhibit A, Attachment II, Claims Processing;
- b. Review and assess Contractor compliance with approved qualitative standards for each process. The Contractor shall propose the qualitative standards and must receive written approval by the Department for each standard. Each qualitative standard must contain:
 - 1) A definition of the quality measurement (i.e., what constitutes quality for this process);
 - 2) Specific criteria that will be utilized to measure the "defined" quality elements;
 - 3) Sampling methodology; and
 - 4) A measurement methodology. This measurement process shall be capable of scoring the Contractor's success of meeting the qualitative performance standard in a numeric fashion.

Example: Telephone call responses. a) Define what constitutes a quality response to a telephone call (e.g., completeness, accuracy, clarity, customer-friendly); b) Develop specific criteria for measuring the quality of the

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telephone call response (e.g., all questions were answered; all answers were accurate; answers were clear and understandable; tone was polite and helpful); c) Develop sampling methodology (e.g., one hundred percent (100%) review, random sampling, customer call backs/surveys); and d) Develop a specific measuring system (e.g., scoring, weighting).

- c. Perform sample testing for each quantitative and qualitative standard for the process. All sampling must ensure statistical reliability at a ninety-five percent (95%) confidence level and a four percent level of precision;
- d. Process compliance reporting. Process compliance reviews shall be included in the Monthly Quality Management Performance Report and delivered to the Department no later than thirty (30) calendar days from the end of the month being reviewed. The report shall identify the month and year of the review period. The report shall be used for determining Contract compliance as defined in Exhibit A, Attachment II, Operations, and Contractor payment as stipulated in Exhibit B, Attachment I, Special Payment Provisions;

The process compliance reports shall record and evaluate the Contractor's compliance with each quantitative and qualitative standard for each of the processes identified throughout Operations. At a minimum, the report shall include reviews on the following processes:

- 1) TSC;
- 2) Complaints and Grievances;
- 3) Provider and Beneficiary Correspondence;
- 4) Claim/TAR/CIF Processing;
- 5) Clinical screening;
- 6) Customer support;
- 7) First Level Appeals;
- 8) State Hearings;
- 9) Beneficiary Reimbursement;
- 10) Provider Outreach;
- 11) Beneficiary access to care;
- 12) Quality of care;
- 13) Surveillance and Utilization Review Subsystem (S/URS);
- 14) Finance and Contract Services functions;
- 15) Paraprofessional Review;

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- 16) Manual Pricing;
 - 17) Provider Bulletins;
 - 18) Provider Enrollment;
 - 19) Incoming and outgoing mail; and
 - 20) Special Projects and Programs, as directed.
- e. Process compliance assessment procedures. The methodology for sampling, assessing, scoring, and reporting on the process compliance procedures shall be documented in step-by-step detail in the Contractor's Quality Assurance Procedures and Standards Manual.

10. Utilization Management Review

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

The Contractor shall develop and conduct cost-efficient and quality-based UM processes based on the following:

- a. Minimally burdensome to providers while continuing to ensure program integrity, and providing beneficiaries with timely, safe, and appropriate access to care;
- b. Compliant with the most current federal and State laws and regulations;
- c. Effectively monitor and manage providers' performance and the services provided;
- d. Utilize state-of-the-art technologies, which may include automated telephone and web-based applications for notification, prior authorization, etc., and which are compliant with the most current federal and State laws and regulations; and
- e. Work with the Contractor's Beneficiary and Provider Outreach staff to promote provider and beneficiary education and outreach support based on UM data.

11. Committees

- a. A Quality Assurance/Quality Management and Improvement (QMI) Committee shall report findings and actions taken or needed, identify deficiencies and issues, identify the specific entities or dental care process issues that present new or chronic quality of care issues.
- b. The Contractor's UM Committee shall research, propose, and implement performance improvement projects specific to the improvement of UM processes. These processes seek to assure that eligible beneficiaries receive the most

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

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

The Contractor shall for each committee:

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

Exhibit A, Attachment II
Scope of Work - Operations**12. Payment Responsibilities**

The Contractor shall:

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

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

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

- c. Liability for Overpayment

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

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

13. Trend Analysis Reports

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

The reports shall contain:

- a. Ongoing trend analysis graphs identifying frequency of errors for the previous month's reporting period plus a cumulative analysis of errors from the beginning of Operations;
- b. Follow-up information from the prior month's PS correction notices and implemented resolutions to the recommendations;
- c. Identification of the specific process within the Contractor's Operation that prominently contributed to the error's occurrence;

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- d. Identification of all the adverse impacts resulting from the defective process, and the extent of the adverse impacts (as quantified by number of errors, number of erroneously paid claims, and amount of over verses underpayments);
- e. Recommendation of process and policy changes that would reduce recurrence of errors, and a detail of what would be involved to complete the change; and
- f. Ongoing status reports of all process error recommendations.

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

14. Individual Professional Performance Review

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

The QMDC shall:

- a. Monitor all Dental Consultants and Clinical Screening Dentists' training;
- b. Ensure that each individual Dental Consultant has at all times in his/her immediate work area, at a minimum, a Medi-Cal Dental Program Provider Handbook (with bulletins), a Professional & Paraprofessional Adjudication Manual, a Code Manual, a Suspense & Error/File Maintenance Processing Manual, and a Clinical Screening Dentist Manual. In addition, each Dental Consultant's manual shall contain the most current update/revision pages;
- c. Monitor the quality performance of all Dental Consultants and Clinical Screening Dentists and record findings on a monthly Professional Review Performance Report commencing ninety (90) calendar days after the AOO. All Dental Consultants shall be reviewed monthly and Clinical Screening Dentists shall be reviewed on a semi-annual basis and reported on an individual basis. The Contractor shall provide the information necessary to identify each Dental Consultant and Clinical Screening Dentist by the name appearing on his or her State of California dental license;
- d. Utilize the system to ensure that all Dental Consultants and Clinical Screening Dentists hold current, active, and unrestricted licenses to practice dentistry within the State of California;
- e. Establish policies and procedures for measuring the quality of professional review and adjudication for each Dental Consultant and the quality of professional review for each Clinical Screening Dentist. In performing professional reviews, the QMDC shall:
 - 1) Ensure individual Dental Consultants maintain a minimum of a ninety-eight percent (98%) accuracy level in the professional adjudication of claims/TARs, and for every Professional Review Data Control Center except the State Wait

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Data Control Center, in accordance with Medi-Cal Dental policy and procedures;

- 2) Review a statistically valid sample of all Clinical Screening Dentists' reports and determine compliance with Medi-Cal Dental policy and procedures. Errors shall be compiled in semi-annual reports, and included in the Clinical Screening Dentist database; and
- 3) Be responsible for the creation and execution of a CAP for each Dental Consultant and Clinical Screening Dentist whose performance fails to meet Contract requirements or QM standards.

15. Integrated Test Facility

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

16. Acceptance Test System

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

The Contractor shall:

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

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- d. Work with the FI Contractor to evaluate the quality of systems testing while executing Acceptance Testing to ensure the complete system testing was executed prior to migration to Acceptance Test;
- e. Identify providers, recipients, and claims used for testing to maintain the integrity of routine claims processing Operations and files;
- f. Review test output, including tables, files, reports, tapes, and micro media. Output shall be separately identified and clearly labeled. Test outputs shall be separate from routine CD-MMIS outputs and available to the Department during business hours within twenty-four (24) hours of the request;
- g. Perform claims processing in a simulated production environment;
- h. Accept test claims data submitted by the Department on hard copy or electronic media, without notice to the Contractor's testing team (i.e., the Contractor is unaware that the test claims data have been submitted);
- i. Assist the Department's participation in testing, observe the tests, analyze results, and document any problems;
- j. Report on the results of test cycles, including the expected impact of edit and pricing changes, and compare those results to the actual processing results;
- k. Respond to and correct all non-systematic problems identified by the Department. The Contractor shall repeat Acceptance Testing, until criteria defined by the Department is satisfied;
- l. Acknowledge that upon satisfactory completion of Acceptance Testing, the Department shall approve and retain Acceptance Test documentation. The Department may approve phases and require additional testing of remaining functions;
- m. Initiate and conduct a walk-through of Acceptance Test changes that are ready to be moved into the production environment. Walk-through of test cases and results shall include a discussion of programs that are impacted by the system change. The Contractor shall include an on-line demonstration, verifying the accuracy of system changes and handouts of test results. Walk-through of materials shall be conducted for system changes involving major modifications, or where a significant number of programs and/or files are modified when directed to do so by the Department;
- n. Deliver and make available to the Department all Acceptance Test documentation, including files and reports necessary to validate test results. These materials shall be provided to the Department no later than one State working day following test execution. The Contractor shall provide the Department each week with a list of such test documentation;
- o. Maintain open communication with the Department during Acceptance Testing, and provide walk-throughs and updates to Department staff on specified test results, upon request;

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- p. Develop and execute Department-approved test cases for system changes as outlined in the User Acceptance Testing section;
- q. Maintain Acceptance Test facility activities, tables, files, and data elements necessary to meet Department requirements and simulate production;
- r. Review control reports generated for each test update and processing cycle;
- s. Ensure Acceptance Testing shall continue until all testing System Variance Reports (SVRs) identified during Acceptance Testing have been resolved. The Contractor shall provide all necessary support for Acceptance Testing during this period. The Department shall prioritize any problems identified by these tests. The SG shall correct deficiencies determined by the Department; otherwise, the Contractor shall be responsible for correcting the deficiency;
- t. Perform volume and stress tests and parallel tests as directed by the Department to demonstrate the ability to process expected CD-MMIS workloads accurately within prescribed timeframes as described in Exhibit A, Attachment II, Administrative Support of Contract Changes. Volume and stress tests shall be done when the problem to be tested is identified because of a volume/stress, capacity, and/or diminished response-related issue and/or when there is a need to simulate a large number of users/records on the system in order to test a correction or enhancement that will not show the system impact unless a large volume of users can be simulated;
- u. Ensure, where resources permit, tests be scheduled concurrently so that Acceptance Testing can progress more rapidly; and
- v. Recognize the Department is relying heavily upon the two parallel tests and a detailed analysis of the results by the Contractor and minimal Department submission of test claims.

17. User Acceptance Testing (UAT)

User Acceptance Testing provides an opportunity for Department staff and Contractor staff to determine the adequacy and accuracy of the system design and functionality for non-mainframe and mainframe systems including related applications. UAT acts as a final verification of the required business function and proper functioning of the system, emulating real-world usage. Contractor staff, with support from the Department staff and FI Contractor staff, shall prepare test scenarios designed to test critical aspects of CD-MMIS. The Contractor shall develop test cases supporting these scenarios.

The UAT shall confirm all components of CD-MMIS, including all non-mainframe systems, meet the approved system design and the needs of the Stakeholders. The UAT shall test all system business areas including the interfaces and requirements. The UAT shall attempt to confirm system load capability, business process human factor workload, and response time along with security controls.

The Contractor shall:

- a. Develop a UAT plan and submit to the Department for review and approval;

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- b. Develop Use Case Test Scripts;
- 1) A Use Case defines a goal-oriented set of interactions between external factors and the system under consideration. It shall specify all the different ways to use the system and defines all behavior required of the system. The Contractor shall develop detailed Use Case test scripts which address the following:
 - a) Tests that exercise all of batch online interface processing, transaction processing, system security, edits and controls, backup and recovery; error processing and system reporting, and test scripts that ensure all system reports and forms, including daily, monthly, quarterly and annual, are generated for review.
 - b) Ensure traceability back to the requirements.
 - 2) Ensure the Use Case includes, but is not limited to, the following elements:
 - a) Use Case name: Each Use Case shall have a unique name describing its purpose and shall provide a unique identifier. The field name shall also contain the creation and modification history.
 - b) Description: Each Use Case shall have a description that describes the main business goals of the Use Case. The description shall list the sources for the requirement and also identify the requirements to be tested.
 - c) Actors: List the actors involved in the Use Case.
 - d) Assumptions: List all the assumptions necessary for the goal of the Use Case to be achieved successfully.
 - e) Steps: List the sequence of interactions necessary to successfully meet the goal. At a minimum, each Use Case should convey a typical course of events.
 - f) Variations: List any variations in the steps of a Use Case.
 - g) Non-Functional Requirements: List any non-functional requirements that the Use Case must meet.
- c. Support and aid the Department in testing the system changes. The Contractor and the Department shall execute various ad hoc testing to provide the opportunity to include various transactions and sequences that may not have been included in standard test scripts to challenge the system's operation and design. This will include the establishment by the Contractor and the Department of test providers and beneficiaries, as well as the submission of test data including claims, TARs, CIFs, and other documents, without limitation and as necessary, into Acceptance Test environment. The Department will utilize this process without notice to the Contractor to assure that the test replicates outcomes to be expected in a live environment. This integrated test facility may be made available to the Contractor with approval of the Contracting Officer;

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- d. Coordinate UAT and assist the Department in the analysis of test results;
 - 1) Provide an automated tracking and reporting tool to allow testers to enter test results, performance issues, and operational problems. All performance issues and operational problems shall be entered into the automated tracking and reporting tool within one day of identifying the issue/problem. The automated tracking and reporting tool shall be maintained and updated on a daily basis. At a minimum, the automated tracking and reporting tool shall capture the following information:
 - a) Description of problem
 - b) Resolution
 - c) Estimated date of completion
 - d) Programs impacted
 - e) Programmer assigned
 - f) Project manager
 - g) Priority
 - h) Status (i.e. open, closed, etc.)
 - 2) Provide the Department with online read access to the automated tracking and reporting tool;
 - 3) Provide hands-on computer training to State staff, including preparation of test data, navigating the test environment, and entering and executing test scripts. This training is part of the CD-MMIS training requirement outlined in Exhibit A, Attachment II, Staff Training Requirements;
 - 4) Assist in the development of test data in UAT environment to include, but not limited to, a representative universe of test providers, beneficiaries, production selection, test scenarios, and automated results of tests;
- e. Collaborate with the FI Contractor in the development of a weekly schedule of planned test scripts to be executed for the following week and provide a weekly summary report of test cases executed, defects by classification status of all cases and efforts at correcting defects;
- f. Develop, deliver and maintain the following documentation. Documentation must be submitted to the Department for review and approval prior to migrating to production.
 - 1) UAT materials packet
 - 2) UAT functional requirements traceability matrix
 - 3) UAT test results packet

Exhibit A, Attachment II
Scope of Work - Operations**18. End-to-End (E2E)**

End-to-End testing validates the entire application to ensure that it satisfies previously established acceptance criteria and performs as an integrated system. It verifies that the integrated component works correctly as part of the overall system and that the existing components of the system work prior to system changes.

The Contractor shall:

- a. Work in conjunction with the FI Contractor, who is responsible for maintaining the system, to utilize E2E by the QM staff for ongoing E2E testing in conjunction with Acceptance Testing;
- b. Use E2E for all testing of system changes to CD-MMIS in order to ensure the delivery of a fully functioning implementation for all system changes in the production environment and cost savings through streamlined processes in the testing phase;
- c. Utilize live test transactions to aid and enhance monitoring of system test performance;
- d. Work in conjunction with the FI Contractor to develop and submit an E2E testing strategy to the Department for review and approval. The E2E testing tool and the Contractor's process on regression testing shall be fully defined and documented in the QM Plan as described under Exhibit A, Attachment II, Operations; and
- e. Develop a test plan and submit all E2E test results to the Department for review and approval.

Refer to the FI Contract, Exhibit A, Attachment II, Quality Management for additional information regarding E2E testing.

19. Acceptance Testing Unit

The Contractor shall:

- a. Employ staff as members of an Acceptance Testing Unit that shall be working in conjunction with FI Contractor SG. This unit shall be responsible for developing test plans and test cases to ensure all CD-MMIS processing is accurate and complete. This unit shall be responsible for:
 - 1) Testing all CD-MMIS changes, including table and file updates prior to their implementation;
 - 2) The validation of all Erroneous Payment Corrections (EPCs);
 - 3) The validation of all reports and special requests for information;
 - 4) Providing and supporting training needs as determined by the Department; and

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- 5) Ensuring that all Acceptance Testing jobs and cycles are monitored, scheduled, and executed;
- b. Work with the FI Contractor in the development and implementation of a testing environment, including non-mainframe systems and related applications, including the methodologies required to ensure that testing verifies that all components process successfully and independently of each other, and ensures that all manual and automated processing are compatible with system changes and table updates;
- c. Ensure an adequate number of staff is available to perform all testing, and ensure the testing is complete and accurate. It is anticipated that, at a minimum, the following staff will be necessary:
 - 1) Project Manager;
 - 2) System Analysts;
 - 3) Business Analysts; and
 - 4) Operations Specialist/Liaison.
- d. Ensure staff with appropriate classifications and training to support CD-MMIS testing is in place prior to the start of Acceptance Testing. Supervisory, management or technical staff may not be used for manual processing activities;
- e. Require staff to demonstrate adequate proficiency in performing assigned tasks; and
- f. Ensure staff employed in the testing team is knowledgeable in dental claims processing, data processing, and familiar with all the components of CD-MMIS (i.e., all the manual and automated processes to process a claim through CD-MMIS) including the TAR process, in order to adjudicate a claim and process payment.

20. Reports Review

The QM program shall include dedicated staff responsible for the coordination and evaluation of statistical reports. The responsibilities of staff shall include, but are not to be limited to:

- a. Ensuring quality of all reports by thoroughly reviewing and verifying report content and accuracy on an ongoing basis. The means and frequency shall be fully outlined in the Quality Assurance Standards and Procedure Manual;
- b. Ensuring that timely report production and distribution, both internal and external, is verified through the review of distribution sheets/logs, and where necessary, through monitoring of the production process;
- c. Verifying/balancing all S/URS history file updates with an appropriate Management and Administrative Reporting System (MARS) and claims processing file and report;

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- d. Monitoring and reviewing on-line response time and reliability; and
- e. Providing full cooperation to the Department in identifying ambiguities, report deficiencies and discrepancies.

21. Quality Assurance Standards and Procedures Manual

The Contractor shall:

- a. Formally review and document all QM procedures and internal standards in a Quality Assurance Standards and Procedures Manual to be made available to its employees in appropriate programs and to the Department;
- b. Ensure the manual be submitted to the Department no later than five months after the Contract Effective Date (CED). The manual shall be continuously reviewed and approved by the Contractor. Any updates to the manual shall be reviewed and approved by the Department. New areas of Operation not covered by this manual at CED shall be addressed in the manual prior to implementation; and
- c. Ensure the procedure manual encompasses the entire approved QM program with internal quality performance standards. Certain requirements shall be adhered to by the Contractor to maintain maximum employee use of the manual. The manual shall:
 - 1) Be a guideline to include internal performance standards and error rate limits for professional individuals and processes in each area of the Contractor's responsibility, including the SG. Ensure the manual contains all policies, procedures, methodology, and mathematical formulas and calculations used in monitoring of performance standards and error rate;
 - 2) Incorporate everyday Operations of all units utilizing CD-MMIS. The manual or pertinent excerpts shall be made available to all new employees as a training and reference tool in each applicable program area;
 - 3) Include validation and verification procedures; and
 - 4) Identify and document data sampling tools and procedures used to evaluate Contractor Operations.

22. Special Quality Assurance Studies

The Contractor shall perform Department directed special quality assurance studies with the necessary support from the FI Contractor. These studies shall not exceed twenty-four (24) requests per calendar year. The Contractor shall develop the study method and submit it for Department approval within seven business days of receipt of the study request from the Department. The Contractor shall complete the study as directed and forward the findings to the Department within forty-five (45) calendar days of Department's approval of the study method.

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23. Monthly Quality Management Performance Report Requirements

- a. The Contractor shall ensure that the Monthly QM Report is accurate and complete and all Contract-required responsibilities are addressed.
- b. Reports shall be delivered to the Department as follows:
 - 1) System-generated reports shall be delivered or accessible to the Department no later than the fifth business day following the end of the month, with the exception of the sixty (60) Day Edit Report and the ninety (90) Day Edit Report, which are to be delivered to the Department no later than fifteen (15) calendar days after the monthly sixty (60)/ninety (90)-day cycle time report;
 - 2) Individual Professional Performance Review reports shall be delivered or accessible to the Department no later than thirty (30) calendar days from the end of the month being reviewed;
 - 3) Reports shall provide results of required monthly performance testing; and
 - 4) All other reports shall be delivered or accessible within thirty (30) calendar days from the end of the month.
- c. The Monthly Quality Management Report shall be delivered or accessible to the Department in a Department-determined medium. The layout of the report and the procedures shall be outlined in the Quality Assurance Procedures and Standards Manual. The Contractor shall solicit and utilize input from Department staff at all stages of development of these reports.
- d. The Monthly Quality Management Performance Reports shall include, but not be limited to SG reviews, Process and Individual Professional reviews, process-oriented error trends, and proposed process improvement recommendations.

24. Quality Management Deliverables

The following deliverables are to be developed by the Contractor and/or system generated by the FI Contractor as appropriate. These deliverables are required to be reviewed and approved by the Contractor prior to submission to the Department:

- a. QM reports, which address:
 - 1) Reviews of each monthly reported function;
 - 2) Other scheduled periodic system functions; and
 - 3) Reviews of Contractor performance in meeting internal standards for accuracy and timeliness;
- b. Updates of payment corrections;
- c. Monthly QM report on claims aged over ninety (90) days and TARs aged over sixty (60) days; and

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- d. QA Standards and Procedures.

25. Availability to the Department

All QM working papers used for monitoring the Contractor's Operations and preparation of monthly performance reviews and QM reports shall be available to the Department upon request.

26. Contract Management

The Department requires a contract management approach that promotes a collaborative assessment and supports monitoring of the ASO and FI responsibilities. The Department expects to monitor and audit the Contractor's performance as a condition of this Contract. All contract management tools are a requirement of Takeover and shall not be included in the Takeover price bid. Ongoing administrative and system maintenance costs incurred by the Contractor during the Operations phase(s) shall be included as part of the fixed price bid, Attachment 12-3, Adjudicated Claims Service Line (ACSL) Bid Sheet.

A major objective for the Department in entering this Contract is to develop a more structured contract monitoring process supported by automated reporting processes. The Department has defined the performance standards to be measured within the Contract, and will measure adherence to those standards at a frequency defined by the Department. It is the Contractor's responsibility to collect all performance standards which will be used to monitor the Contractor's performance. All performance standards shall be stored into a central repository for reporting and auditing purposes.

The purpose for the contract management function is to ensure that the Contractor meets the Department's performance standards for operation of the CD-MMIS. The Department has performance expectations and utilizes a precedent to payment criteria to ensure compliance with Contract performance standards. The Contractor is expected to meet or exceed these performance standards over the term of the Contract. The list of precedence to payment monitoring, , is covered in Exhibit B, Attachment I, Special Payment Provisions.

The Contractor shall meet the following contract management requirements including, but not limited to:

- a. All capabilities of all supplied tools must be accessible and usable by Department appointed staff at no additional charges to the Department. The Contractor shall allocate ten (10) concurrent licenses specifically for the Department's use. Additional licenses for Department staff shall be covered under Cost Reimbursement provisions of the Contract. Ongoing maintenance, updates, and refreshes for all licenses shall be covered under the fixed price bid;
- b. All data stored within the monitoring tools shall be accessible by the Department's appointed staff;
- c. Allow for additional input of data by the Department's assigned staff for performance measures;

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- d. Have the capability to configure thresholds and send alert notifications to Department staff for all Service Level Agreement (SLA) targets that have been missed;
- e. Include a plan for training all oversight State users and shall execute this training on the use of the supplied tools. Subsequent to initial training provided during Takeover, the Contractor shall conduct training sessions, throughout the term of the Contract as defined in Exhibit A, Attachment II, Staff Training Requirements;
- f. Create workable plans and monitor actual performance against targets;
- g. Provide dashboards and performance reports. Centrally store all defined performance measures and Key Performance Indicators;
- h. Provide operational and performance reports and dashboards accessible on-line by the Department. These activity reports shall be in a downloadable format compatible with standard desktop applications for data manipulation, such as Excel or Access; and
- i. Submit reports on a monthly basis that will coincide with the Contractor's monthly invoicing. Reports may be required more frequently when requested by the Department.

The scope, format, content, measure criteria, and standards used in the contract management tool shall be approved by the Department.

27. Department Responsibilities

The Department shall be responsible for performing the following activities:

- a. Review and approval of the Quality Assurance Standards and Procedures Manual and quarterly updates;
- b. Independent monitoring of the Contractor's Operations;
- c. Monitoring and reviewing of the Contractor's QM program;
- d. Independent auditing activities, such as Medi-Cal Dental QM Review;
- e. Notification to the ASO and/or FI Contractor in the form of PSs of any errors identified within CD-MMIS;
- f. Assigning higher priorities to PSs as deemed necessary;
- g. Review and approval of all Acceptance Testing deliverables and documentation;
- h. Overview of Department Acceptance Testing responsibilities:
 - 1) Perform independent quality monitoring activities, such as Medi-Cal quality review;
 - 2) Approve CAPs and correction notices submitted by the Contractor for all PSs;

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- 3) Participate in the EPC process (e.g., setting priorities, reviewing provider notification letters);
- 4) Coordinate with the Contractor to test Operations' activities by submitting additional test inputs, modifying test files, and reviewing system outputs;
- 5) Coordinate with the Contractor to prepare comprehensive Acceptance Test plans detailing additional test cases to be executed;
- 6) Coordinate with the Contractor to prepare comprehensive Acceptance Test cases and describe expected results;
- 7) Review and approve test results prior to the Contractor promoting changes to production;
- 8) Attend Contractor walk-throughs to validate test cases and test case results for accuracy and quality; and
- 9) Reserve the right to reduce the scope of Acceptance Testing if the Contractor can adequately demonstrate preparedness for CD-MMIS Operations, or expand levels of testing where the Department determines additional testing is needed.

K. DENTI-CAL INTERNET WEBSITE**1. Overview**

The Denti-Cal website (<http://www.denti-cal.ca.gov>) serves as the central source of all public Denti-Cal program information for the beneficiary, provider, and stakeholder communities. The Contractor shall be responsible for ensuring that the website consistently maintains salient, accurate, and useful information related to the Denti-Cal program for its constituents.

2. Objectives

- a. Provide consistent, standard information to the beneficiary, provider, and Stakeholder communities;
- b. Implement a design to ensure each page is responsive, navigable, intuitive and self-explanatory;
- c. Develop, maintain, and update the website's structure and content;
- d. Implement a responsive design which allows for the creation of one site that serves all devices well (e.g. desktops, laptops, notebooks, tablets, and all mobile devices) to ensure users visiting the site on a smartphone will see the site optimized for his/her smaller screen while a user accessing the site from a desktop computer with a larger screen will view a slightly different layout of the content and design. Both users interact with the same content but the user experience is tailored to their device; and

Exhibit A, Attachment II
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- e. Ensure the Denti-Cal website meets the State of California website template requirements and complies with the website guidelines for the American Disabilities Act (ADA).

3. Assumptions and Constraints

- a. The Medi-Cal Dental Fee-For-Service program consists of two Contracts - one pertaining to the Administrative Services Organization (ASO) Contractor and one pertaining to the Fiscal Intermediary (FI) Contractor. These two Contractors are expected to work in concert with each other to perform all activities associated with the requirements of the Contracts;
- b. The ASO Contractor shall collaborate with the Department to determine the website content. The final content and format of the Denti-Cal website for beneficiaries, providers, and Stakeholders shall be subject to the Department's approval and the most current applicable federal and State regulations;
- c. The Department shall own the SSL certificates to support the Denti-Cal website within the Contractor's web network;
- d. Cost for enhancements, modifications, and updates to the website shall be included in the Contractor's fixed price bid in accordance with the agreed prices of the Cost Proposal, and Exhibit B, Attachment I, Special Payment Provisions for Adjudicated Claim Service Lines (ACSLs) and Treatment Authorization Requests (TARs); any work performed by the Systems Group (SG), Contractor staff, or any hired subcontractor shall be deemed as non-billable; and
- e. The ASO Contractor shall collaborate with the FI Contractor to acquire the necessary data fields for the Denti-Cal website and ensure all input and output files are updated and maintained.

4. General Responsibilities

The Contractor shall:

- a. Maintain the Denti-Cal website with appropriate security mechanisms in compliance with the most current federal and State statutes, regulation, and policy;
- b. Ensure the website meets accessibility standards, usability standards, and best practices including, but not limited to, Government Code sections §111135(d);
- c. Provide and maintain the hardware platform;
- d. Host the Denti-Cal website within the Contractor's web network;
- e. Maintain the web server with appropriate firewalls and other security features;
- f. Provide software licensing;
- g. Ensure that separate test, development, and production environments shall be maintained;

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- h. Maintain adequate staffing levels to support the website;
- i. Provide access and availability for all users to the Denti-Cal website for a minimum of twenty-two (22) hours per day, seven days per week from 2:00 AM, Pacific Time (PT), until midnight. Maximum unscheduled downtime shall not exceed one-half hour per week. Access and availability shall not be interrupted or superseded, except with the Contracting Officer's prior approval, for any Contractor activity, including system maintenance (preventive, scheduled, or otherwise) and system or program processing (scheduled or unscheduled);
- j. Provide a secure web based e-mail box for beneficiaries and providers to send inquiries, in accordance with the most current Health Insurance Portability and Accountability Act (HIPAA) rules and regulations, and other federal and State requirements;
- k. Provide technical support for the Denti-Cal website;
- l. Develop procedures to facilitate postings and transmissions of web content to ensure regular, timely updates to static content, including training schedules, registration notices and policy changes;
- m. Maintain an easily accessible webmaster email address provided on the website to report website technical problems; and
- n. The webmaster shall reply to all email alerts within one business day of receipt of the email alert if a non-emergency event. If an emergency technical problem or security-related event, the webmaster shall reply immediately, twenty-four (24) hours a day, seven days a week.

5. Supplemental Requirements

The Contractor shall ensure:

- a. A Home Page graphical chart is displayed which presents the top ten strategic goals and associated objectives for the Denti-Cal program, including a link to more detailed information on its own web page;
- b. Contact customer service information is displayed on every page to assist beneficiaries and providers with their inquires;
- c. The most current dental periodicity schedule is displayed;
- d. Information concerning oral health conditions and strategies for improving or maintaining the oral health condition is accessible;
- e. Oral health information during Children's Dental Health Month (February) is displayed;
- f. The "Find a Dentist" search functionality is accessible directly from the Home Page;

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- g. To propagate referral information to Insure Kids Now website to supplement the referral process, and meet federal requirements;
- h. A link to the directory maintained by the Department of Health Care Services (DHCS) of all county offices is included on the beneficiary pages and the Denti-Cal homepage for reference;
- i. A robust "Find a Dentist" search functionality is maintained and updated on a weekly basis with a complete list of providers accepting Denti-Cal patients;
- j. A beneficiary no-show form is accessible that can be electronically submitted to the Contractor to follow up with the beneficiary about their failure to attend their scheduled appointment;
- k. That beneficiary and provider survey and feedback options are provided;
- l. An updated Provider Handbook, archived provider bulletin publications, and current provider bulletin publications are available;
- m. To display an active list of provider seminar and provider enrollment workshop locations and dates, equipped with registration pages for providers to sign up;
- n. To provide a robust provider training tutorial webpage addressing challenges for providers in the program such as common billing issues, how to properly enroll into the Denti-Cal program based on the type of practice and provider type of the prospective provider, how to enroll as a preferred provisional provider, and other topics the Department may prescribe;
- o. To provide a transactional page for providers to register their National Provider Identifier (NPIs) with the Denti-Cal program; and
- p. All content on the Denti-Cal website, including, but not limited to, educational material, the Provider Handbook, and provider enrollment forms can be searched or downloaded from the Denti-Cal website.

6. Reporting Requirements

The Contractor shall:

- a. On a monthly basis, perform demographic, data-driven tracking and analysis of the populations accessing information on the Denti-Cal website;
- b. Submit, to the Department, website analytics on a monthly basis with, but not limited to, the following metrics:
 - 1) The unique number of Internet Protocol (IP) addresses interacting with the website;
 - 2) Statistical information related to user demographics including, but not limited to, age, language, and geographic location; and

Exhibit A, Attachment II
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- 3) Number of unique users accessing specific pages, external files, and other tools.
- c. On an annual basis, provide the Department with a conceptual proposal, with visuals and screenshots, and plan of execution on how to best utilize the Denti-Cal website as the primary and most effective mechanism of communication between the program and the public. Using tracking, usage, and demographic information collected, the conceptual proposal for the website shall include, but not be limited to, proposals for improved functionality, increased simplicity of the information presented, and increased effectiveness in achieving the expressed goals of the Department. The Contractor shall present their conceptual design proposal and plan with associated timeframes every January.

7. Department Responsibilities

The Department shall:

- a. Provide direction for the vision, design, and execution of the content provided in the Denti-Cal website;
- b. Provide language needed to ensure website content adheres to the requirements defined in this Contract;
- c. Approve all structural and content changes made to the website;
- d. Approve the archiving of outdated documents; and
- e. Routinely request that changes be made through a web change request form.

L. INTERACTIVE VOICE RESPONSE (IVR) SYSTEM

1. Overview

The Interactive Voice Response (IVR) system enables callers to communicate directly with an automated voice response system. The use of the IVR system allows callers the ability to access California Dental Medicaid Management Information System (CD-MMIS) information without the use of a Telephone Service Center (TSC) agent. The IVR system uses touch-tone functionality using Dual Tone Multi Frequency (DTMF) technology to navigate through a pre-scripted application.

2. Objectives

The IVR system shall:

- a. Allow providers and beneficiaries the ability to quickly access information;
- b. Efficiently manage a large number of incoming telephone lines and calls; and
- c. Contribute to a positive, expedient customer service experience for providers and beneficiaries of the Medi-Cal Dental Program.

Exhibit A, Attachment II
Scope of Work - Operations**3. Assumptions and Constraints**

The following constitutes a list of assumptions and constraints the Contractor shall abide by:

- a. The current IVR is a Syntellect ninety-six (96) port system, with four ports allocated for development and testing.
- b. The IVR system shall be available twenty-four (24) hours, seven days a week for information that does not require a provider number.
- c. The IVR system shall be available the following hours for information requiring a provider number, service office and/or Personal Identification Number (PIN):
 - 1) 6:00 AM to 5:30 PM, Pacific Time (PT), Monday through Friday
 - 2) 8:00 AM to 12:00 PM, PT, Saturday
- d. Beneficiaries shall have access to the IVR system by calling a separate toll-free line. IVR messages are provided in both English and Spanish.
- e. The Automated Eligibility Verification System (AEVS) shall be available to providers to obtain eligibility information for beneficiaries enrolled in the Medi-Cal Dental Program. This system accesses relevant, patient-specific information in the Fiscal Intermediary (FI) Medi-Cal Eligibility Data System (MEDS) files and “speaks back” eligibility information to the provider. AEVS is supported and maintained by the Medi-Cal medical FI. Providers enter the beneficiary identification number taken from the beneficiary’s Benefits Identification Card (BIC) to obtain current beneficiary eligibility information.
- e. The current system uses Nortel Networks Symposium Call Center Server (Symposium).
- f. The Contractor must maintain the flexibility to add new functionality to the IVR should the Department determine the need.

4. General Responsibilities

The Contractor shall:

- a. Maintain and update the IVR system to incorporate new messages, new system software, and new applications for improvement to the system as instructed or approved by the Department;
- b. Provide and refresh as necessary the hardware platform necessary to support the existing IVR application including production and development environments;
- c. Support and maintain all hardware and software necessary for the operation of the IVR system, ensuring that the system remains functional and supported by the vendor;

Exhibit A, Attachment II
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- d. Order, install, maintain, and support all telecommunication lines necessary for the support of the IVR system;
- e. Provide assistance with problems and questions related to the use of the different types of IVR system transactions;
- f. Update and disseminate the IVR User Guide;
- g. Provide advance electronic notice to the Department of any planned system interruption, shutdown, or file non-access. If an unanticipated interruption should occur, a notice shall be sent to the Department as soon as the Contractor is aware of the interruption. When the Contractor learns of the cause and projected duration of the unplanned interruption, the Contractor shall immediately provide that information to the Department in writing and make this information available to providers via the Help Desk and the Denti-Cal website;
- h. Notify the Department within one business day of completing system repairs, the cause of the problem, all areas impacted, the measurements taken to correct the problem, and all additional measures taken to prevent the problem from reoccurring; and
- i. Maintain all IVR system files and reports.

5. Additional Responsibilities

The Contractor shall:

- a. Provide access to Medi-Cal dental providers to the following information:
 - 1) Billing criteria information;
 - 2) Seminar information;
 - 3) Enrollment Information;
 - 4) News flashes;
 - 5) Request for forms to be faxed:
 - a) Forms Reorder Request;
 - b) Clinical screening dentist application forms;
 - c) Electronic Data Interchange (EDI) application forms;
 - d) Justification of need for prosthesis;
 - e) Medi-Cal dental provider enrollment forms; and
 - f) Scheduled maximum allowance information.
 - 6) Specific claim information [requires Document Control Number (DCN)]:

Exhibit A, Attachment II
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- a) Amount;
 - b) Status; and
 - c) Applicable Explanation of Benefits (EOB) date and allowed amount.
- 7) Beneficiary information utilizing the nine digit beneficiary BIC number and the beneficiary's two digit year of birth:
- a) Status of outstanding claims and/or Treatment Authorization Requests (TARs) submitted;
 - b) Information on beneficiary's last three claims;
 - c) Check number;
 - d) Claim amount;
 - e) DCN;
 - f) Last action taken;
 - g) EOB date; and
 - h) Beneficiary's history (relative to specific service-limited procedures).
- 8) Financial information (requires an authorized PIN):
- a) Next provider check amount;
 - b) Year-to-date earnings; and
 - c) Year-to-date earnings for the previous year.
- b. Provide beneficiaries access to the following information:
- 1) Request provider referrals using Zip Code and Social Security Number;
 - 2) Option to re-schedule or cancel a screening appointment; and
 - 3) Submission of complaints.
- c. Provide clinical screening dentists access to immediately reach the appropriate telephone representative. The operator shall have the ability to assign clinical screening providers to specific agents by linking the provider's office phone number with the extension of the applicable call center representative.

6. Department Responsibilities

The Department shall:

Exhibit A, Attachment II
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- a. Review and approve Contractor procedures for beneficiary and provider telephone responses and any change thereof;
- b. Review and approve hardware upgrades and updates prior to implementation;
- c. Review and approve staffing changes within the TSC Operations; and
- d. In conjunction with the Contractor, evaluate IVR utilization by Medi-Cal dental providers and beneficiaries, evaluate the IVR's effectiveness, and provide any recommendations to improve its effectiveness to the Department on an annual basis.

M. STATE HEARING ADMINISTRATION

1. Overview

The Medi-Cal Dental Program provides beneficiaries the right to a State Hearing if he/she contests with the adjudication of their Treatment Authorization Request (TAR) or reimbursement claim. A hearing may also be requested if the beneficiary is exercising their right to recoup out-of-pocket expenses for Medi-Cal covered services received during retroactive eligibility. For additional information on beneficiary reimbursement claims see ASO Contract, Exhibit A, Attachment II, Beneficiary Services.

As a result of an inter-agency agreement between the Department of Health Care Services (Department) and the California Department of Social Services (CDSS), all State Hearings are hosted by Administrative Law Judges (ALJs) at CDSS. Position Statements representing the Department's position on State Hearing cases are produced by the Contractor, with review and approval of Department staff. A State Hearing outcome may be contested by a beneficiary through a re-hearing request sent to the Department. The Contractor is responsible for gathering the facts and supporting documentation to draft a Position Statement or Conditional Withdrawal.

The State Hearing System provides the capability to transmit data between the Department and the Contractor. The California Dental Medicaid Management Information System (CD-MMIS) Fiscal Intermediary (FI) Contractor shall support, maintain and update the State Hearing application and database, as well as ensure the network access to the application and database to the ASO Contractor and the Department.

2. Objectives

- a. Utilize the State Hearing system for creating, storing and maintaining information related to specific State Hearing cases (e.g. Position Statements, Conditional Withdrawals, TARs, etc.);
- b. Store scanned documents or other information related to specific hearings; and
- c. Generate, print, and store reports and letters.

Exhibit A, Attachment II
Scope of Work - Operations

3. Assumptions and Constraints

- a. The State Hearing System is a web enabled user interface accessible through a web portal.
- b. The State Hearing System requires Internet Explorer 9 or newer and a 16x9 (aspect ratio) monitor to be viewed as designed. The system facilitates the creation, editing, and tracking of Positions Statements in State Hearing cases.
- c. The State Hearing system is housed, operated, and maintained by the FI Contractor. The FI Contractor shall provide access to the State Hearing system/application to the ASO Contractor and Department staff.

4. General Responsibilities

The Contractor shall:

- a. Ensure new State Hearing requests are electronically entered into the Department's State Hearing Database (SHDB) on a daily basis and case files are created and/or updated as dental history is compiled and analyzed. For additional requirements related to the State Hearing function refer to Exhibit A, Attachment II, Beneficiary Services;
- b. Maintain all State Hearing system files and reports;
- c. Commit resources required to ensure all contractual requirements are met and service levels are maintained;
- d. The Contractor shall archive State Hearing case files where there is written notification that provider payment(s) have been issued on the service(s) and all required fields have been entered. Archived cases shall be made available at the Department's request;
- e. Provide assistance with problems and questions related to the use of the State Hearing system;
- f. Update and disseminate the State Hearing User Guide as well as any additional documentation to enable efficient use of the tools for Contractor and State staff; and
- g. Provide hands-on training and training/procedure manuals to the Department in accordance with the requirements as described in Exhibit A, Attachment II, Staff Training Requirements.

5. Department Responsibilities

The Department shall:

- a. Monitor and evaluate the statistical information derived from reports generated from the system;

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- b. Notify the Contractor, in writing, of any changes needed to the State Hearing process or updates that will be made to the system;
- c. Approve Position Statements; and
- d. Act as a liaison between the ALJ, CDSS and the Contractor.

N. DOCUMENTATION AND SYSTEM ACCESS RESPONSIBILITIES**1. Overview**

This section describes the California Dental Medicaid Management Information System (CD-MMIS) documentation standards and/or requirements to which the Contractor must adhere. The standards and requirements have been set forth throughout this section when producing, developing, and maintaining CD-MMIS manuals for modified or newly created systems and/or processes.

2. Objectives

The Contractor shall ensure all documentation facilitates effective checking and preservation of all processes and interactions between manual and automatic processes. Documentation shall ensure users will be able to duplicate the process. Processes and procedures shall be documented to reduce the likelihood of misuse or incorrect use of the system, data and procedures.

3. Assumptions and Constraints

- a. Work in conjunction with the CD-MMIS Fiscal Intermediary (FI) Contractor to ensure all interrelated documentation deliverables are completed and delivered on time. Project related deliverables (e.g. System Development Notices (SDNs), Miscellaneous Change Documents (MCDs), Dental Operating Instruction Letters (DOILs), Change Orders) must be coordinated between Contractors to ensure documentation is submitted timely to support project implementations.
- b. The majority of licensed software, mainframe and non-mainframe, resides at the FI Contractor's facility. The FI Contractor shall be responsible for developing and maintaining the corresponding documentation.
- c. The Administrative Services Organization (ASO) Contractor shall be responsible for all activities related to non-mainframe systems/applications hosted by the ASO Contractor.
- d. The FI Contractor shall be responsible for the storage and retrieval of all CD-MMIS and Contract-related documentation in an electronic format for viewing.

Refer to CD-MMIS FI Contract, Exhibit A, Attachment II, Document Management System.

Exhibit A, Attachment II
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- e. The FI Contractor shall be responsible for retaining the primary source of all CD-MMIS documentation. The ASO Contractor shall work in conjunction with the FI Contractor to ensure that submissions, approvals and updates to the Department are unduplicated.

4. General Responsibilities

The Contractor shall:

- a. Provide its standards and current practices for all areas and requirements cited in this section to the Department for approval;
- b. Ensure non-mainframe data processing and documentation requirements shall, at a minimum, be equivalent to the mainframe specifications. Refer to the CD-MMIS FI Contract, Exhibit A, Attachment II, Data Processing and Documentation Responsibilities;
- c. Obtain Department approval before implementation of any new or modified documentation;
- d. Include the following in all documentation when created or updated by the Contractor:
 - 1) The current State of California and Department of Health Care Services (DHCS) insignias and other related State of California identification. The Contractor's insignia or name of the Company is not acceptable on any documentation;
 - 2) A cover page showing all changed/added/deleted pages for each revised documentation item; and
 - 3) A control number cited on each page.
- e. Establish and use a convention to track revisions that shall be identified on all documentation items and programs submitted to the Department. This convention shall provide an audit trail to indicate the revisions, the system and/or process change (e.g., SDN, enhancement, DOIL) that necessitated the revisions, and shall consist of the following:
 - 1) Control number - relates to an audit number, change control number, or a Department-approved number;
 - 2) Implementation date - date of the implementation; and
 - 3) Revision indicator - used to identify the revision on each page of the documentation.
- f. Update and distribute all revised documentation covered by this section no later than thirty (30) calendar days after implementation of policy changes and/or no later than the date submitted and approved by the Department via the work plan of the system enhancements related to SDNs, Problem Statements (PSs) and MCDs;

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- g. Update and distribute all revised procedure manuals to the Department no later than thirty (30) calendar days after any changes to workflow or processes;
- h. Prepare and maintain documentation that conforms to the documentation standards that have been submitted and approved by the Department;
- i. Meet or exceed all other standards stated in this section;
- j. Use Secured File Transfer Protocol (SFTP) as the standard for all data exchanges between the State and the Contractor, unless otherwise specified by the Department;
- k. Prepare reports and/or complete checklists to confirm that standards have been followed. The checklist is to include Contract cites and location of the standard "template";
- l. Prepare written requests for exceptions to standards;
- m. Prepare written requests for revisions of standards and receive written approval from the Department prior to implementation;
- n. Review all work performed by subcontractor(s) to ensure all CD-MMIS standards are followed and documentation items are maintained, updated, and delivered as scheduled; and
- o. Maintain storage space to support test files used by the Department staff. Central Processing Unit (CPU) hours and maintenance of disk storage space is not reimbursable.

5. General System Design (GSD)

The Contractor shall develop a GSD that provides a pictorial diagram depicting the overall CD-MMIS flow for all non-mainframe systems developed/hosted by the ASO Contractor. Each diagram shall have a narrative that describes the tasks that are to be performed and the related inputs and outputs shown. The documentation shall be prepared in a format that facilitates updating.

The GSD shall:

- a. Identify all related processes;
- b. Identify general flow of related processes and include a flow diagram. The flow must identify all major processes;
- c. Include sample form layouts, screen layouts, and specifics of all inputs;
- d. Include sample layouts for all outputs, including screen layouts and print report layouts;
- e. Provide a definition of all edit and audit criteria;
- f. Include file descriptions for all files and define data elements;

Exhibit A, Attachment II
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- g. Include a draft data element dictionary; and
- h. Include draft manuals and training materials (to be reviewed and approved by the Department).

6. Screen Descriptions Documentation

The Screen Descriptions Documentation shall provide a complete profile of all the screens used in CD-MMIS. The Contractor shall include documentation that consists of:

- a. The screen definition that includes a brief statement of purpose, a screen number (related to the detail design documentation/specifications), the screen name, and the program (or on-line transaction) that uses the screen;
- b. The screen content that lists all data elements used, and describes data calculations performed, defaults used, and related error messages;
- c. An actual copy of the screen showing all data items; and
- d. Complete listings of all screens by subsystem, showing screen number, screen name, and producing program or transaction.

7. Acceptance Test Documentation

The Contractor shall ensure Acceptance Test documentation exists for each systems change to be implemented as part of CD-MMIS. Refer to Exhibit A, Attachment II, Quality Management in the CD-MMIS ASO Dental Contract for Acceptance Test requirements. Refer to Exhibit A, Attachment III Change Requirements in the CD-MMIS FI Contract for systems and Acceptance Test requirements. The results from conducting a detailed Acceptance Test plan shall include, at a minimum:

- a. Detailed expected and actual outcomes for all test transactions;
- b. A copy of all test data, including description;
- c. All test results, including screen prints and reports;
- d. Retest documents and description of corrective action measures taken;
- e. The Contractor's certification that the system is complete and thoroughly tested and ready for implementation to production;
- f. Re-usable test cases for each program to be used for all coding changes. These re-usable test cases shall conform to Capability Maturity Model Integration (CMMI) Level 2 or higher standards; and
- g. Parallel test results that detail at least one full day's production volume of claims ran against programming changes.

Exhibit A, Attachment II
Scope of Work - Operations**8. Licensed Software**

This section describes the documentation standards for the licensed software to be provided, hosted and utilized by the ASO Contractor in performing the operational requirements of this Contract.

Use of commercially available equivalent products may be used only with prior Department approval. In providing approval, primary consideration shall be given to the ease and expense of running such packages by a successor contractor.

The Contractor shall maintain a list, approved by the Department, of all licensed software acquired for use in CD-MMIS and all non-mainframe subsystems related to CD-MMIS. The list shall specify software name, type, and version number. All software upgrades and replacements shall be approved in writing by the Department. The Contractor shall provide the Department with all changes, modifications and customized features it makes to all licensed software referenced in this section and subsections or that are approved by the Department to be used in CD-MMIS.

a. Mainframe Licensed Software

Mainframe licensed software is developed and maintained by FI Contractor. For additional information on mainframe licensed software and program naming conventions, please see the CD-MMIS FI Contract, Attachment II, Data Processing and Documentation Responsibilities.

b. Non-Mainframe Licensed Software

The Contractor shall maintain documentation on all required non-mainframe licensed software products acquired, hosted and used by the ASO Contractor. For additional information on FI non-mainframe licensed software and program naming conventions, please see FI Contract, Attachment II, Data Processing and Documentation Responsibilities. The following is only a sample list of software. An all-inclusive list may be found in the Data Library:

- 1) The Automated Call Distributer (ACD) software works in conjunction with the telecommunication system, queues calls and routes them to the appropriate skill set. This ensures calls are answered by the appropriate call center staff (e.g. Spanish calls are answered by bi-lingual staff).
- 2) The Interactive Voice Response (IVR) system answers calls and uses the number the customer called to appropriately vector the call to the proper IVR script. The ASO Contractor shall provide data from the ACD and IVR systems to the FI Contractor who will use this data to produce the Telephone Service Center (TSC) billing reports.

Documentation for non-mainframe software hosted by the FI Contractor shall be developed and maintained by the FI Contractor.

9. User Documentation

The Contractor shall work with the FI Contractor to provide one primary version for Department approval and serve as the master of record:

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- a. Ensure all CD-MMIS user manuals and procedures are written at a level that would facilitate an inexperienced user's ability to understand them. All user manuals shall also contain a comprehensive subject index. The indices shall be updated when updates are made to the user manual. The documents shall be easily maintainable;
- b. Ensure training manuals are derived from user manuals or procedures described in this subsection, and used for the applicable training given as required in the ASO Contract, Exhibit A, Attachment II, Staff Training Requirements. The training manuals for each course or class shall be generated from the most current documentation;
- c. Submit proposed revisions to its user manuals or procedures to the Department for approval within thirty (30) calendar days from implementation of policy changes, or no later than the date submitted and approved by the Department via the work plan of the system enhancements.. Changes shall be distinguished by change indicators. Unless otherwise directed, the Contractor shall not utilize proposed procedural changes prior to Department written approval;
- d. Ensure documentation for each user contains a brief description of the task(s) to be accomplished, an overview of the functional flow of data or information, and a description of the organization using or receiving the data or information.

The following is a sample list of Users Documentation Manuals only. An all-inclusive list may be found in the Data Library:

1) Accounts Receivable Policies and Procedures Manual

Describe all procedures used in the accounts receivable and related financial activities. Documentation of all CD-MMIS financial transactions shall be developed;

2) Suspense Processing Manuals

Describe all procedures used in the processing of suspended claims for all claim types. These procedures shall be arranged by the edit/audit category of error (e.g., provider, recipient). Each edit/audit error shall indicate the name, description, criteria used, action to be taken, overrides (if any), and related Explanation of Benefits (EOB) messages(s).

Any processing exceptions utilized by the Contractor or by the Department shall be recorded and a full written report made of the exception for each application. Also, any additions to the suspense processing manuals used by the Contractor in processing claims shall be delivered to the Department for review and approval;

3) Provider Handbook

Define and describe all procedures used by Medi-Cal Dental providers in the billing and processing of claims. This handbook shall be arranged by claim type and include related policies, a keyword index, a brief overview, correspondence location(s) and instructions for out-of-state providers. As

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revisions are made to the format of this handbook, the Contractor shall be responsible for updating the provider handbook according to the revised format;

4) Provider Services Manual

Define and describe all procedures that are used in the billing and processing of claims. This manual shall be arranged by claim type and include policies, a keyword index, a brief overview of the functions performed, and research methods involved;

5) Document Handling

Develop procedures and/or systems that ensure the most efficient manner to control documents. The Contractor shall develop and maintain documentation and procedures in the following areas:

- a) Reports - The Reports Distribution List shall be developed and maintained in accordance with ASO Contract, Exhibit A, Attachment II, General Reporting Requirements. The documentation shall be sequenced in two methods: one by user (receives the report) and the other by report number; and
- b) Claim Documents – The Contractor shall develop procedures to ensure all physical records and documentation received from the FI Contractor are maintained in accordance with ASO Contract, Exhibit A, Attachment II, Record Retention Requirements.

The FI Contractor shall develop, maintain, and document the coordinated system that is designed to accomplish the scanning tasks.

6) Performance Reporting

Describe the procedures and policies of the resource management system that shall be used to evaluate the performance, productivity, and accuracy of work performed in the CD-MMIS. The performance reporting shall include all Contractor employees in such areas as claims processing, professional review, claims adjudication and cost reimbursement. Also to be included are any and all production incentive plans and a description of how such plans do not compromise quality assurance standards as they relate to claims payment accuracy. The results of these procedures and policies shall be made available to the Department upon request;

7) Organization and Staffing

Describe the organization that supports the Operations of CD-MMIS (including subcontractors). The description shall provide:

- a) Organization charts and descriptions showing the organization's location of the project in the Contractor's firm, the functional responsibilities of each organizational unit, the delegation of responsibilities to

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organizational units, organizational decision-making points, and actual unit staffing by classification;

- b) Completed job descriptions (specifications) for all classifications, including job title, functional responsibilities, and experience requirements; and
- c) Monthly personnel acquisition reports for the current and previous twelve (12) months showing the number of staff by functional area and by classification;

8) Audit Procedures/Policies

Describe the audit procedures and policies established to verify that CD-MMIS performs as designed and programmed. The audit data collection and tracking procedures shall be identified and the data security measures shall be defined. The procedures and results of the routine audits performed by the Contractor shall be maintained in the Quality Assurance Standards and Improvement Procedures Manual, and the results of this audit shall be reported monthly to the Department; and

9) Other CD-MMIS Procedure Manuals

Develop, maintain, and update the documentation for all procedure manuals used by the Contractor in performing the operational requirements of this Contract. The Contractor shall also develop, maintain and update the documentation for any CD-MMIS procedure manuals developed during Takeover, or as the result of modifications made during the term of this Contract (e.g., SDN, DOIL, Change Order).

10. Hardware and Software Configuration Manuals

The Contractor shall provide updates to the Hardware and Software Configuration Manual within thirty (30) calendar days of implementation of hardware and software. The Hardware and Software Configuration Manual shall describe the computer environment that processes CD-MMIS claims, supports data communications, programming support functions, and related CD-MMIS activities.

a. Hardware

This documentation shall include a description of all computers, input/output and storage devices, controllers, and other related equipment that support the CD-MMIS, including all equipment monitoring the on-line system usage and access for CD-MMIS users. The documentation shall describe the acquisition schedule of future equipment. A section of the documentation shall describe the backup facility for the system.

b. Hardware and Software Contracts

This documentation shall describe all computer hardware and software contracts for the equipment and related software packages that support CD-MMIS, including its on-line network monitoring.

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c. Hardware/Equipment/Software Inventory List

The Contractor shall provide updates to the Hardware/Equipment/Software Inventory List used to support CD-MMIS. The Contractor shall provide this list to the FI Contractor to develop a single comprehensive and complete listing to the Department for review and approval.

The Contractor shall provide updates for the Hardware/Equipment/Software Inventory List within thirty (30) calendar days of implementation of hardware, equipment, and/or software installations and submit to the FI Contractor for Department approval during the process of implementing instruments of change, such as, SDNs, DOILs, Change Orders, Contractor-initiated changes, PSs and work requests.

The Contractor shall submit and maintain a separate document with secured information for all hardware/equipment/software, such as Internet Protocol (IP) addresses, to the FI Contractor for Department approval.

The Hardware/Equipment/Software Inventory List shall include, at a minimum:

- 1) Which items are owned/leased by the Contractor, and which are owned/leased by the Department;
- 2) Each hardware/equipment lease expiration date, lessor, and lease terms, manufacture, description, model, serial number, asset tag number, what CD-MMIS Subsystem(s) or business functions(s) it supports, physical location, quantity, age, configuration (Central Processing Units (CPUs), disk, etc.), shared disk capacities, and responsible contact for information;
- 3) Operating system components including release and version levels;
- 4) All application and/or programming language support components residing on the hardware/equipment;
- 5) Maintenance contracts/agreements details for all hardware and equipment, including the maintenance level, number of units covered, and availability of maintenance personnel, whether maintenance personnel are on-site or on-call, and required response times;
- 6) All software license agreements;
- 7) Hardware configuration charts to illustrate the interfaces between hardware components, application systems, and communication systems;
- 8) History of maintenance performed on the hardware/equipment; and
- 9) Non-mainframe documentation with configuration, security, and other parameters.

Exhibit A, Attachment II
Scope of Work - Operations**11. Documentation Deliverable Requirements**

Upon implementation of improvements, enhancements, or changes, the Contractor shall update all required documentation. In many cases this will require coordinating with the FI Contractor. These updates shall be transmitted to the Department for approval no later than thirty (30) days after the policy implementation date or date submitted via work plan approved by the Department of the system enhancement. The Contractor shall produce the updates upon receipt of written Department approval and prior to the next Contract month. The Contractor shall correct all non-approved updates no later than three State Workdays after receipt of the notice of non-approval. The number of copies of approved updates to be provided to the Department will be set by the Department, but shall not exceed forty (40) copies. The Contractor shall maintain a distribution list of all deliverables submitted to the Department. The following items are required with any implementation:

- a. All applicable documentation updates related to system changes, modifications, and/or improvements;
- b. Completed checklist(s) of all documentation items that were changed and updated; and
- c. Completed checklist(s) of all changes to indicate which standards and/or documentation items were affected.

12. Monthly Deliverables

The Contractor shall deliver the source files and documentation and/or checklists described below prior to the fifth business day of each Contract month:

- a. Source Files – Notification of availability to review source files of all non-mainframe programs hosted by the ASO Contractor.
- b. Documentation and/or Checklists
 - 1) Deliver all applicable documentation that reflects changes or updates implemented during the month. These shall include all documentation identified and categorized as follows:
 - a) All applicable documentation that reflects changes or updates implemented during the previous month. These items shall include, but are not limited to, Report Descriptions and Documentation, and User Documentation.
 - b) A list of all ASO Contractor and/or subcontractor software used in CD-MMIS production; and
 - c) A documentation checklist that indicates which items were changed during the month.

Exhibit A, Attachment II
Scope of Work - Operations**13. Quarterly Deliverables**

The Contractor shall deliver the items listed below to the Department by the tenth (10th) business day after the end of each quarter:

- a. A user documentation report listing all user documentation and all subsequent changes developed under this Contract and their last change date. The report shall be produced in two sequences, by user documentation and by change date; and
- b. An update of all user documentation (i.e., manuals). This update shall either state that no changes were made to the manual or summarize any Department-approved changes that were incorporated during the prior quarter. The summarization, if any, shall include a brief description of the update, control number and revision date of the change to the manual.

14. Medium of Deliverables

The Contractor shall produce deliverables in electronic, Compact Disk (CD) or hardcopy (paper) format and ensure online accessibility. The Department may alter the method of delivery at its discretion.

15. Deliverable Evaluation

The Contractor shall, upon implementation of any changes, deliver all required documentation. These deliverables shall be evaluated for completeness and timeliness, and shall be evaluated against the established standards using a standard checklist. Deliverables shall be determined to be complete when the Department has indicated so on the documentation checklist.

- a. Received documentation checklist(s) shall be evaluated against the change reviews. Any discrepancies will be returned to the Contractor for correction.
- b. All documentation identified on the documentation checklist(s) is delivered by the fifth business day of each month.
- c. All inventory lists shall be updated at Takeover and submitted to the Department for review and approval; thereafter, the Contractor shall maintain and update this documentation throughout the term of the Contract. The Contractor has thirty (30) calendar days upon receipt of changes via change instruments (i.e. DOILs, PSs, SDNs, MCDs etc.) to update and submit the inventory lists to the Department for its review and approval. All inventory lists without specifications shall mirror existing inventory list specifications. The following is a point in time list of existing "Inventory Lists" required during Turnover. This list includes, but not limited to the following:
 - 1) All CD-MMIS Library Documentation;
 - 2) All CD-MMIS Master Manuals;
 - 3) CD-MMIS Takeover Value Added Services;

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- 4) Change Orders;
 - 5) Cost Reimbursed Department-Owned and Leased Equipment;
 - 6) Department and Contractor Formal Correspondence;
 - 7) All Cost Reimbursed CD-MMIS Forms;
 - 8) Cost Reimbursement Plan;
 - 9) Test Cases;
 - 10) Training Plans;
 - 11) CD-MMIS Printed Materials;
 - 12) Detailed Business Requirements;
 - 13) Erroneous Payment Corrections (EPCs);
 - 14) Non-mainframe Hardware/Equipment/Software;
 - 15) Non-mainframe Screens;
 - 16) Post Office Box Numbers and their Uses;
 - 17) Telephone Numbers and their Uses;
 - 18) PSs;
 - 19) Master Index of Records;
 - 20) All CD-MMIS Non-mainframe Reports, including Manual Reports;
 - 21) DOILs;
 - 22) Contract Management and its Staff;
 - 23) Subcontractors;
 - 24) Letters sent by the Contractor on behalf of DHCS; and
 - 25) Time Reporting.
- d. All documentation shall have an inventory list as specified above. All items listed shall be updated (i.e., new, modified, obsolete) at the commencement of Takeover by the Contractor; thereafter maintaining updates of all documentation throughout the Operations term of the Contract; and assessment reports shall be submitted during Turnover for all documentation. All received documentation shall be evaluated against these inventory lists and submitted to the Department for its review and approval. The documentation will either pass or fail when reviewed against the standards for this Contract.

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- e. All documentation, including newly added documentation, shall be updated and maintained throughout the term of the Contract in Document Imaging Management System (DIMS). The Contractor shall update (i.e. add, modify, and/or obsolete) CD-MMIS documentation at the commencement of Takeover and submit to the Department for its review and approval; thereafter, the Contractor shall maintain this documentation's updates throughout the term of the Contract.

16. Special Requests

The Contractor shall provide the following to the Department upon request:

- a. Additional reports to support the documentation collection activities. This request shall be within the framework of the monthly and quarterly deliverables. The Contractor shall produce such reports with the next monthly cycle; and
- b. A complete set of documentation. This documentation shall reflect all changes made to date. The Contractor shall produce the documentation with the next monthly cycle. A complete set of documentation shall be required no more than twice each Contract year.

17. Communication Standards

In developing formats and protocols for communicating electronically with providers and other third party payers the Contractor shall use nationally accepted formats and standards that meet its needs.

18. Wireless (Wi-Fi) Network

The Contractor shall provide secure Wi-Fi (Wireless Local Area Network) guest account access to the internet to facilitate networking needs for visiting DHCS employees, and also non-DHCS guests visitors. The wireless network can provide an alternative to a wired State network for utilization in time of State network outage. Wi-Fi equipment and network shall be configured to meet all Information Technology Services Division (ITSD) and DHCS Information Security Office security standards. Any username and password changes shall be communicated to DHCS, Medi-Cal Dental Services Division (MDSD) employees within twenty-four (24) hours prior to the change. The Contractor shall provide instructions to configure Wi-Fi for the visitor's mobile device and troubleshoot problems. The on-site Service Desk must provide assistance to visitors with questions or concerns regarding the Wi-Fi system.

19. Access to CD-MMIS

The Contractor shall:

- a. Ensure that only authorized Department staff have on-line, read-only capability (cannot be updated) access to the system and all of its software related to the operation of CD-MMIS including CD-MMIS files, records, data, and reports;
- b. Provide hands-on training and certify designated Department/State staff on the use of the system and any or all of its software. This training is intended to

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familiarize Department staff with the systems for testing, monitoring and report production, etc. This training course shall be conducted by fully qualified Contractor staff and shall fully utilize the CD-MMIS Processing User Guide. There shall be a minimum of two classes each year with a limit of fifteen (15) Department/State staff per class. The first class shall be given within four months of the Contract's effective date (CED);

- c. Ensure that the Department has full access to CD-MMIS. In order to assist the Department in its monitoring function, the Contractor shall:
 - 1) Provide access for Department monitoring staff to validate all tests run by the Contractor. The Contractor shall provide any of the test run formats or documentation to Department staff for duplicate monitoring to validate the Contractor's test results;
 - 2) Provide Department staff with a copy of any CD-MMIS data file, including the CD-MMIS tables file, and deliver within five business days of the date of receipt of the request. The Contractor shall allow Department staff to order file copies on-line;
 - 3) Assure that the entire CD-MMIS is available to Department staff for testing. The Department shall have authority to test the CD-MMIS production system to ascertain that changes have been installed correctly and policy is being executed as required;
 - 4) Provide the means for the Department to generate random samples of claims and TARs, and at various stages of adjudication, suspense, or adjudication by claim type, data control center, procedure code, or error code;
 - 5) Provide the means for the Department to measure overall staff and system performance in claims processing from input preparation through dental review, and from edit suspense through claims adjudication;
 - 6) Provide the Department with access to the Contractor's working papers used in the production of Quality Management (QM) reports; and
 - 7) Provide the Department with a copy of documents upon request (media type will be determined by the Department).
- d. Ensure data links between CD-MMIS to applications and/or systems hosted by the ASO Contractor.
- e. Ensure authorized access to CD-MMIS to comply with the requirements set forth in this Contract.

20. Department Responsibilities

The Department shall:

- a. Verify that all documentation produced by the Contractor conforms to the CD-MMIS standards;

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- b. Revise the documentation standards when necessary;
- c. Approve documentation checklists for each standard;

- d. Approve, if acceptable, standards and structured techniques proposed by the Contractor; and

- e. Approve, if acceptable, exceptions to the documentation standards requested by the Contractor.

O. GENERAL REPORTING REQUIREMENTS**1. Overview**

This section is intended to facilitate the identification of reporting responsibilities as well as to ensure consistent application of requirements for all manual and automated California Dental Medicaid Management Information System (CD-MMIS) reports. Reports are defined as any analysis, compilation or reflection of data provided in any media including, but not limited to, hardcopy, compact disc (CD), on-line, tape, database, and specific reports added to the CD-MMIS Library per Department instructions, including Contractor data files. The production and verification of reports will require the active collaboration between the ASO Contractor and the California CD-MMIS Fiscal Intermediary (FI) Contractor. All reports (new and existing), generated by CD-MMIS and all applications associated with CD-MMIS described under this Contract shall be subject to the terms and conditions set forth in this Contract.

2. Objectives

The Contractor shall:

- a. Assume primary responsibilities to support and assist the Department by performing the following reporting functions:
 - 1) Manual report production and delivery;
 - 2) Report validation and delivery;
 - 3) Research/report problem solving activities;
 - 4) Report accuracy and data validity; and
 - 5) Development of techniques to obtain more effective and efficient use of CD-MMIS data by the Department.

- b. Ensure all claims, Notice of Action/Authorizations (NOAs), Treatment Authorization Request (TARs), adjustments to claims, TAR extensions/re-evaluations, adjudicated Claims Inquiry Forms (CIFs), and retroactive rate adjustments reflect appropriately and accurately in all reports for the reporting period during which processing occurred, unless otherwise specified by the Contracting Officer; and

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- c. All reports produced and reviewed by the Contractor, whether for internal or external use, shall conform to the requirements described in this section unless otherwise specified in the Contract.

3. Assumptions and Constraints

- a. The Medi-Cal Dental Fee-For-Service program consists of two Contracts - one pertaining to the Administrative Services Organization (ASO) Contract and one pertaining to the CD-MMIS FI Contract. These two Contractors are expected to work in concert with each other to achieve their respective goals and responsibilities outlined in their Contracts to carry out the Operations and policies of the Department.
- b. Internal reports are defined as any reports, assessment, studies, and plans designed, developed, and installed by the Contractor for its use in managing its Contract with the Department.
- c. The Department shall approve the manner and medium in which deliverables will be provided in order to support full disclosure of system Operations and all manual processes.
- d. Access the electronic Report Management Master Library to retrieve, download, and reproduce all reports produced by the FI and ASO Contractors.
- e. Work with the FI Contractor to ensure that report user manuals are maintained as subdivided by subsystem, for all CD-MMIS reports including non-mainframe reports, adhoc reports, special studies, assessments, plans and Decision Support System reports.
- f. Provide suggestions to the Department that could enhance reporting. Suggested changes may include elimination or creation of reports, modifications to report format, data elements, production frequency, medium, or data descriptions.
- g. The FI Contractor shall deliver reports to the ASO Contractor utilizing the FI Contractor's courier service, United States Postal Service (USPS) , or parcel service. Delivery to locations within twenty-five (25) miles of the State Capitol Building shall be by courier service, and delivery outside of this radius shall be via USPS or parcel service.

4. General Responsibilities

The Contractor shall:

- a. Perform data mining, report development, and ad hoc research using available systems and tools, including available databases, data warehouses and decision support systems;
- b. Ensure all reports are provided to the FI Contractor to be maintained in the electronic Report Management Master Library;
- c. Work with the FI Contractor to maintain and review an inventory list of all non-mainframe reports generated by the ASO Contractor, including plans, research

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studies, assessments, and the ASO Contractor's internal reports. This inventory list shall include at a minimum, but not be limited to, all non-mainframe application reports, report number, report name, frequency, and report retention. This inventory list shall be maintained and updated throughout the term of this Contract and submitted to the Department for review and approval. The Contractor shall update the inventory list within thirty (30) calendar days for any changes (i.e., new, obsolete, and/or modified) to the inventory list via any change instrument;

- d. Work with the FI Contractor to maintain training and development programs for appropriate Department and Contractor staff to ensure maximum use and understanding of all reports. Training shall ensure that users are able to interpret CD-MMIS reports to a degree that will allow for effective use. The Contractor shall provide a minimum of three training sessions each State fiscal year. An additional two training sessions shall be limited to Department staff only, but the Contractor shall provide the Department access to all training sessions and notify the Department of all training sessions fifteen (15) calendar days in advance of the scheduled date. This training shall be in addition to all other training required by this Contract;
- e. Work with the FI Contractor to provide training materials to be reviewed and approved by the Department prior to the training sessions. All equipment, network, and training facilities are to be included as part of the Contractor's responsibilities. All training must comply with the requirements stated in the ASO Contract, Exhibit A, Attachment II, Staff Training;
- f. Starting no later than fourteen (14) months after Contract Effective Date (CED), and by the end of each calendar year, the Contractor shall produce an annual report to include recommended improvements to CD-MMIS reporting for Department review and approval;
- g. Ensure at least one staff person is available from 8:00 AM to 5:00 PM, Pacific Time (PT), Monday through Friday, to perform general reporting staff liaison activities;
- h. Verbally notify the Contracting Officer within twenty-four (24) hours of detection or anticipation of any discrepancy of report information (e.g., invalid provider identifications, dates, and dollar amounts) or other problems affecting the production, availability, and/or distribution of CD-MMIS reports. The Contractor shall follow up the verbal notification in writing via a Problem Statement (PS) within two business days of the initial problem identification. If the Contractor determines that the Department's input or direction is required to resolve the problem(s) the Contractor shall also provide an explanation describing the desired input along with any applicable timetables and projected corrections as set forth in the ASO Contract, Exhibit A, Attachment II, Administrative Support of Contract Changes;
- i. Modify report delivery locations, number of report copies generated, report medium and/or delivery frequency by report user at no additional cost to the Department. Modify report medium from hardcopy to electronic media (e.g., magnetic tape, digital versatile disc (DVD), compact disc (CD), Internet) at no additional cost to the Department, as specified in the CD-MMIS documentation.

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Changes shall be made upon the request of the Contracting Officer according to the following schedule as per individual report specification:

<u>REPORT PRODUCTION DATES</u>	<u>DATE CHANGE REQUIRED</u>
Monthly, bimonthly, quarterly, semi-annually, annually	Next report production cycle
Daily, weekly, on-demand, On-request, on-line, special reports	Within thirty (30) calendar days of the request

5. Decision Support System

- a. The Decision Support System shall be considered first as the source of developing any required or requested reports.
- b. In collaboration with the FI, provide expertise staffing to provide on-going and ad hoc reporting (i.e., special unspecified reports) capability to utilize claim payment history, utilization information, and statistical information or data within twenty (20) calendar days of the Department's request. With the Contracting Officer's approval this period may be extended.
- c. There are no limits on the number of ad hoc report requests.
- d. The Department's requests for ad hoc reports may or may not be compatible or suited to report writer packages.
- e. On-going and ad hoc reports shall be designed and developed with the capability to do subsequent runs, including running the report again with different input data and/or date parameters. The Contractor shall save report parameters to facilitate reruns. Initial development of all reports shall be completed with Department staff input.
- f. All reports shall be verified by the Quality Management (QM) staff to ensure reporting data is correct.
- g. The Contractor shall ensure staff is fully skilled to effectively carry out data and reporting requirements.
- h. The Contractor shall ensure staff receives on-going and continuing education and technology training on the Decision Support System.
- i. Training and system computer central processing unit (CPU) time necessary to generate ad hoc reports, including subsequent runs, shall be included in on-going maintenance and Operations in accordance with the agreed prices of the Cost Proposal, and the ASO Contract, Exhibit B, Attachment I, Special Payment Provisions, for Adjudicated Claim Service Lines (ACSLs) and TARs; any work performed by the Contractor staff or any hired subcontractor shall be deemed as non-billable.

Exhibit A, Attachment II
Scope of Work - Operations**6. Special Studies**

The Contractor shall participate in and provide support or perform statistical and/or research studies, assessments and reporting, as the Department may direct or approve, at no additional cost to the Department. Studies may include manual review, analysis, and computations related to subjects such as:

- a. Procedures billed/paid;
- b. Clinical Screenings scheduled/conducted;
- c. CIF processing;
- d. Resubmission Turnaround Document (RTD) processing;
- e. TAR processing;
- f. Front-end document entry;
- g. Rate Studies;
- h. Performance Measurements;
- i. Provider Network Capacity;
- j. Beneficiary Utilization; and
- k. Provider/beneficiary demographic utilization.

The Contractor shall work in conjunction with the FI Contractor to ensure the data is accurate and correct prior to submitting the results to the Department. Report the findings for the requested study within thirty (30) calendar days of the Department's request. The Department shall make no more than twenty-four (24) such requests per State fiscal year. System computer time and any staffing resources necessary to generate data for the research necessary for these studies shall be included in on-going maintenance and Operations in accordance with the agreed prices of the Cost Proposal, and the ASO Contract, Exhibit B, Attachment I, Special Payment Provisions, for ACSLs and TARs; any work performed by the Contractor staff or any hired subcontractor shall be deemed as non-billable.

7. Report Production

The Contractor shall:

- a. Ensure all report headings, excluding data files, have a standard format. The heading shall include:
 - 1) Program name;
 - 2) Report name and number;
 - 3) Date and time the report was produced;

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- 4) Date of the report (reporting period covered by the report); and
- 5) Page number (numeric).

The above listed elements shall be in the same position on all reports (Exceptions may include reports generated manually);

- b. Ensure all reports are produced in a manner and medium determined by the Department in order to support full disclosure of system Operations and all manual processes and to meet the standards outlined in the CD-MMIS FI Contract, Exhibit A, Attachment II, Data Processing and Documentation Responsibilities;
- c. Produce reports on CD to allow data to be accessed by a personal computer (PC) only when directed by the Department;
- d. Produce reports that are legible and print each report with either six or eight lines to the inch;
- e. Submit any modifications to change the paper stock used for hardcopy report production to the Department for approval of paper size, color, and weight prior to making the change; and
- f. Ensure reports provide record counts and processing control totals for balancing and control of each subsystem function and/or module.

8. Report Validation

The Contractor shall:

- a. Ensure accurate report production by verifying:
 - 1) Reports balance within themselves;
 - 2) Reports reconcile with other reports with similar data;
 - 3) Claim, TAR, NOA, CIF, Share-of-Cost (SOC), and provider data are edited pursuant to the Medi-Cal dental policy to ensure valid data is passed to the reporting programs; and
 - 4) Reports reflect data from the most recently completed claims processing cycle. Reports that reflect final adjudicated documents data shall annotate if the report uses date-of-service or date-of-payment information.
- b. Ensure corrected copies of all reports, including Claims Detail Reports (CDRs) and Aged History Reports (AHRs), are generated within five business days of the date the Department or the Contractor determines the report to be inaccurate or deficient. Corrected copies shall be generated for all reports containing report deficiencies that are identified by the Department within six months after the report production date. Verify that all corrected reports (re-runs) are so noted on page one of each report.

Exhibit A, Attachment II
Scope of Work - Operations**9. Documentation Manual Standards**

In collaboration with the FI Contractor, the ASO Contractor shall ensure all documentation in the manuals comply with ASO Contract, Exhibit A, Attachment II, Documentation and System Access Responsibilities, and shall consist of the following:

- a. All reports shall use a standard report heading;
- b. The report definition/description, which includes a brief statement of purpose, a detailed description and definition of report elements, the report number (which relates to the detail design documentation), the report name, the program that produced the report, balancing routines, control and audit functions, report frequency, report medium, and report distribution;
- c. A report content listing of the data elements and/or report elements used and describing the data calculations performed, sequence of the report, and estimated volume based on the most recent information available. If a report element is not defined in the CD-MMIS documentation, the Contractor shall define the report element in the Report Users Manual and use a standard report heading;
- d. User procedures and interfaces;
- e. An example of the produced report showing all data items, summary total data, and all representative formats within the report;
- f. A composite listing of all reports by subsystem showing the report number, report name, producing program, description, frequency, distribution, and report retention period;
- g. Identify when the report is a functional equivalent to a required report. In addition, this listing shall identify all reports for which the Department has waived production requirements, and provide an audit trail with reference (Department Correspondence Number and Date) to the Department's approval of each functional equivalent and waiver; and
- h. Include all cross-references to other corresponding reports that support summary totals or data.

10. Report Delivery

The Contractor shall:

- a. Work with the FI Contractor to develop and implement processes and procedures to ensure all reports complete a quality review prior to delivery;
- b. Ensure the delivery of reports to report users on a timely basis. Timeliness of reports is essential to CD-MMIS Operation. Delivery shall be made on business days as outlined in the Report Distribution List, unless otherwise required by the Contracting Officer. Timely report delivery is measured by receipt date of the

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report by the identified report user, and the delivery times as defined in the following schedule:

- 1) Daily Reports - deliver by 12:00 PM PT on the first business day following the report date;
 - 2) Weekly Reports - deliver by 12:00 PM PT on the first business day of the week following the reporting week;
 - 3) Monthly and Bi-monthly Reports - deliver by the fifth business day of the month following the end of the reporting month. The exception is that the monthly reports produced from the TAR system shall be delivered by the first business day immediately following the report month;
 - 4) Quarterly Reports - deliver by the fifth business day of the month following the report quarter;
 - 5) Semi-Annual/Annual Reports - deliver by the twelfth (12th) business day of the month following the reporting period;
 - 6) On-Demand/On-Request Reports - deliver by 10:00 AM PT the next business day following the request;
 - 7) On-line Reports - data shall be available by 10:00 AM PT the day following the report date. See FI Contract, Exhibit A, Attachment II, Data Processing and Documentation Responsibilities, CD-MMIS, On-line Availability, Response Times and Access section; and
 - 8) Special Reports - deliver within ten (10) business days of the Department's request, unless otherwise directed by the Contracting Officer;
- c. Deliver reports utilizing the Contractor's courier service, USPS, or parcel service. Delivery to locations within twenty-five (25) miles of the State Capitol Building shall be by courier service, and delivery outside of this radius shall be via USPS or parcel service;
- d. Ensure delivery receipts are prepared for reports delivered to each report user located within twenty-five (25) miles of the State Capitol Building. The delivery receipt shall include:
- 1) Current Date;
 - 2) Report Frequency;
 - 3) Report User;
 - 4) Delivery location;
 - 5) Report number and name;
 - 6) Report medium;

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- 7) Report date (reporting period); and
 - 8) Space for report user signature and date.
- e. Mail reports with a destination outside the twenty-five (25) mile radius to comply with the delivery requirements noted in item (a) above;
 - f. Provide reports on the following media as defined in the Reports Distribution List or as specified by the Contracting Officer:
 - 1) Hardcopy reports;
 - 2) On-line reports - Ensure all on-line reports are available and accessible as described in the FI Contract, Exhibit A, Attachment II, Data Processing and Documentation Responsibilities;
 - 3) CD or DVD in a density specified by the Department, and produced on request; and
 - 4) Direct electronic transmission.

11. Department Responsibilities

The Department is responsible for the following functions:

- a. The collection of relevant data from a number of diverse input sources such as, but not limited to:
 - 1) Medi-Cal Paid Claims Files (Management and Administrative Reporting Subsystem (MARS)) from the Contractor;
 - 2) Other dental coverage information from Health Insurance Questionnaires (DHS 6155);
 - 3) State-maintained eligibility data;
 - 4) State financial planning and reporting system data;
 - 5) Other reports from the Contractor, i.e., accounting reports, special reports, budget information, etc.; and
 - 6) Other claims processing activities of the Department and the Department's Medical California Medicaid Management Information System FI, for medical claims processing.
- b. Monitoring of the data needs of Medi-Cal Dental Program management by functional area;
- c. Responding to inquiries from the Governor, the Legislature, and various other public and private agencies. This function includes initiation of special research projects and special one-time computer programs;

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- d. Monitoring of the Contractor's production of timely and accurate reports;
- e. Performing periodic audits of all reports generated by the Contractor (both internal reports and those generated for Department use);
- f. Providing information to the Contractor regarding reporting requirements as follows:
 - 1) Medi-Cal Dental Program changes that might affect Contractor reporting. The Contractor shall be responsible for analyzing changes to determine which, if any, reports are impacted by the change, and identifying those changes to the Department;
 - 2) Policy directions related to the reporting function;
 - 3) Report changes, (e.g., format, data elements) required by the Department. This shall not preclude the Contractor from making suggestions that could enhance reporting;
 - 4) All eligibility data required for the Contractor to report on eligibility;
 - 5) Coordination of transmission of program data to the Contractor (e.g., eligibility data) and coordination of data received from the Contractor (e.g., paid claims files, budget and accounting reports);
 - 6) Providing Department liaison services in the following areas to coordinate reporting with Contractor: data processing, statistical and research reporting, report production and delivery, research/problem solving activities, and report accuracy and data validity;
 - 7) Coordinating reporting responsibilities in those areas where the Department and Contractor share such responsibilities; and
 - 8) Notifying the Contractor of any changes (additions or deletions) to the Report Distribution List.
- g. Submit Buy-in data to the Contractor to assist in the production of the Medicare Participation Analysis Report.

P. SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM (S/URS) REPORTING SYSTEM**1. Overview**

The S/URS reporting systems consist of the S/URS Activity Tracking (SAT) System and the S/URS PC Audit System. These systems work in conjunction with the CD-MMIS S/URS Subsystem and the Decision Support System to provide a means to identify provider and beneficiary fraud and abuse, as well as identify services provided below the community standard of care.

The S/URS PC Audit System provides a single stand-alone database containing Claims Detail Reports (CDRs) data downloaded from CD-MMIS.

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The SAT System is a web-based activity tracking tool that allows for a single point of access to online activities of provider and beneficiary claims activity from beginning to end of the review process.

To improve the overall efficiency of the CD-MMIS Operations, the Contractor shall integrate and utilize S/URS Reporting Systems.

2. Objectives

- a. The Contractor shall for the S/URS PC Audit System:
 1. Download the recipient CDR; and
 2. Retrieve provider, service office, and billing provider status information;
- b. The Contractor shall for the SAT System:
 1. Ensure Document tracking – location of records and documents may be entered and viewed related to the user activity;
 2. Initiate and view electronically ad hoc and standard reporting; and
 3. Ensure automated letter generation – letters are initiated through SAT utilizing a pre-defined letter template and selected data from the database tables. Letters may be edited by creating/modifying the templates or in Microsoft (MS) Word prior to distribution.

3. Assumptions and Constraints

The Contractor shall:

- a. Ensure only selected staff have the necessary security authority to perform downloads from CD-MMIS to the PC;
- b. Ensure staff is knowledgeable and have demonstrated skills necessary to effectively utilize SAT and S/URS PC Audit Systems to meet the requirements in accordance with the Administrative Services Organization (ASO) Contract, Exhibit A, Attachment II, S/URS;
- c. Accommodate up to six users. All users must have the following minimum system requirements:
 - 1) MS Internet Explorer 8.0 or higher with ActiveX controls and client-side scripting enabled or its equivalent;
 - 2) MS Word 2010 or higher;
 - 3) Adobe Acrobat Reader 5.0 or higher;
 - 4) WinZip 8.x or similar self-extractor for .zip files;
 - 5) Crystal Report 11;

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- 6) MS Access 2010 or higher;
 - 7) MS Visual Basic V6.0 or higher.
- d. Ensure the SAT database and reporting systems are supported.

4. General Responsibilities

The Contractor shall:

- a. Download all daily CDR recipient information requested for quality of care or investigative profiling into one file to the Local Area Network (LAN) and import to one SQL server;
- b. Collect data on providers and/or beneficiaries to ensure appropriate billing practices and that beneficiaries are receiving quality dental care;
- c. Initiate, and view electronically, all reports and ad hoc queries through the SAT and S/URS PC Audit systems;
- d. Generate letters through SAT utilizing a pre-defined letter template and selected data from the database tables. Letters may be edited by creating/modifying the templates or in MS Word prior to distribution;
- e. Work with the CD-MMIS Fiscal Intermediary (FI) Contractor to maintain users, templates, checklists, create and update standard reports and manage application utilization;
- f. Maintain network security;
- g. Provide all equipment required to achieve operational requirements;
- h. Ensure compliance as determined under provisions of the Health Insurance Portability and Accountability Act (HIPAA); and
- i. Work with the FI Contractor to provide hands-on computer training and training/procedure manuals to Department staff in accordance with the requirements as described in the ASO Contract, Exhibit A, Attachment II, Staff Training Requirements.

5. Department Responsibilities

The Department shall:

- a. Submit a change instrument to request addition or deletion of data elements;
- b. Submit a change instrument to request system modifications;
- c. Submit a change instrument to add, modify or delete pre-defined letter templates; and
- d. Own all reports.

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Scope of Work - Operations**Q. SECURITY AND CONFIDENTIALITY****1. Overview**

This section describes the requirements for the Security and Confidentiality Plan, which shall be implemented by the Contractor to ensure the safety of its people, its assets and those entrusted to it by the Department.

The Contractor shall comply with the provisions of the Contract's security and confidentiality requirements and the Contractor's provisions from Contract Effective Date (CED) through the end of this Contract.

2. Objectives

The Contractor shall implement administrative, physical and technical safeguards that protect the confidentiality, integrity and availability of the public, confidential, sensitive and personal information. The Contractor shall:

- a. Develop, implement, maintain, and annually update, a Department approved-Security and Confidentiality Plan that provides adequate physical and system security for the California Dental Medicaid Management Information System (CD-MMIS) and non-mainframe subsystems; and
- b. Establish a security and confidentiality training program as part of the Security and Confidentiality Plan that is specifically designed for all levels of Contractor staff.

3. Assumptions and Constraints

- a. The Administrative Services Organization (ASO) Contractor shall work in partnership with the Department's Fiscal Intermediary (FI) Contractor to achieve each of their respective goals and responsibilities outlined in their Contracts to carry out the operations and policies of the Department.
- b. If a subcontractor performs work, these requirements shall apply to that subcontractor.
- c. In the event of a data breach or security incident, the Contractor must take the steps outlined in Exhibit H, Health Insurance Portability and Accountability (HIPAA) Business Associate Addendum (BAA). The Contractor is responsible for all associated costs, and the State will recoup actual costs incurred during the investigation, notification, resolution and mitigation of the breach or incident. This includes costs associated with ensuring the impacted individuals are protected from future damages, and may include identity protection services.
- d. If the Contractor is initially using temporary facilities, an interim Security and Confidentiality Plan shall be submitted as a separate part of the Security and Confidentiality Plan which clearly addresses how security and confidentiality requirements will be met in the temporary facilities.

Note: See the National Institute of Standards and Technology (NIST) Special Publication (SP) 800-53, Revision 4, *Security and Privacy Controls for Federal*

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Information Systems and Organizations. See also Security Information and Event Management (SIEM), a new approach to Information Technology (IT) security.

- e. The Contractor shall permit authorized Department, federal and State representatives to access any CD-MMIS facility, equipment, and related materials covered by this Contract. Such access shall be at the discretion of the Contracting Officer as described in CD-MMIS ASO Contract, Exhibit E, Additional Provisions, Access Requirements provision, unless applicable law grants independent access to representatives of other federal and State agencies.
- f. Other than the submittal of required deliverables, the Contractor shall provide security and confidentiality procedures or related documentation to the Department within one business day after receipt of a request from the Contracting Officer or his/her designee. All procedures required in this section shall be developed and formally submitted to the Contracting Officer for review and written approval prior to implementation.

Note: Pursuant to Exhibit E, Additional Provisions, Indemnification by Contractor, and any other remedies, the Department will seek indemnification for any claims or losses that result from non-compliance with any of the requirements in this section.

4. Security Requirements

The Contractor shall:

- a. Develop, implement, and maintain a Department-approved Security and Confidentiality Plan that provides adequate physical and system security for the CD-MMIS and non-mainframe subsystems network not supported by the Department of Technology. The Security and Confidentiality Plan shall address the requirements contained in this section and shall conform to the principles contained in the most current versions of the following documents:
 - 1) Federal Information Processing Standards (FIPS) Publications;
 - 2) State Administrative Manual (SAM), Electronic Data Processing Data Security (Commission Enterprise IT Architecture Framework (CEAF));
 - 3) Federal and State mandates (including the State Medicaid Manual (SMM));
 - 4) Federal and State legislation (HIPAA and the Information Practices Act (Civil Code section 1798, *et seq.*);
 - 5) Office of Management and Budget (OMB) Circular A-130;
 - 6) Federal Information Security Management Act (FISMA) Compliance;
 - 7) Applicable International Organization for Standardization (ISO) Standards;
 - 8) Sarbanes-Oxley Act of 2002;

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- 9) AB 1298 (California Civil Code (CCC) Sections 56.06, 56.10, 1785.11.2, 1798.29, and 1798.82, relating to personal information);
 - 10) NIST 800 Series Publications;
 - 11) The Department of Health Care Services (DHCS) Information Security Office/Information Systems Security Requirements for Projects (ISO/SR1);
and
 - 12) State Information Security Office Information Security Program Guide for State Agencies (e.g., NIST, HIPAA, Personal Information (PI) Standards, SAM, and Health Administrative Manual (HAM)).
- b. Address all Contractor facilities associated with this Contract, whether temporary or permanent, in the Security and Confidentiality Plan and related procedures. Facilities shall include the computer room, software and data libraries, data preparation area, job entry and programming area, mail room/pickup areas, record retention sites, computer terminals (on/off-site), telephone room and any junction boxes between telephone room and computer room; and safe storage vaults (on/off-site). The Security and Confidentiality Plan shall also include transportation and data holding resources, both temporary and permanent, used by the Contractor throughout the term of the Contract, and the facilities which handle both electronic and/or hard copy data;
- c. Secure all Contractor facilities so that only authorized persons designated by the Contracting Officer, are permitted entry into the facility, and that such persons are restricted to those areas that they are permitted to access. Access control requirements shall include:
- 1) Contractor staff be very familiar with security policy;
 - 2) Security guards shall be on-site at the Contractor's claim processing facility twenty-four (24) hours a day, seven days a week. An up-to-date copy of the security policy must be maintained in the security station and its location and contents made aware to all security guards while on duty. The Contractor will provide the Department with a written certification that is signed by each security guard that he/she has reviewed the security policy, including all new material that has been updated or deleted. The Contractor will ensure that each security guard will review the security policy and sign a written certification on their first day of employment;
 - 3) Facility entry and control points shall be guarded or locked at all times. Locks shall be changed periodically. Control points shall be established for each of the following: main entrance to the data processing and claims processing facilities, service entrances, loading platform or garage entrances; inside entrance to the facility, and secondary entrances;
 - 4) Closed-circuit TV shall monitor and record vulnerable areas (i.e., using surveillance cameras with video recording equipment), including but not limited to: the reception area; all outside entrances to the facility; inside entrances to the CD-MMIS area, if other Contractor accounts are served from the same location; loading docks and garages; computer facilities/room; and

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on/off-site vault storage areas. This closed-circuit TV and recording system shall link up to a monitoring station that is operative and staffed twenty-four (24) hours a day, seven days a week. The recorded information for any twenty-four (24) hour period shall be logged and kept for a minimum of two weeks from the date recorded. The recorded information shall be available to the Department for viewing within twenty-four (24) hours of the request;

- 5) Ensure parking lots are well lit and security guard escort service from the facility to the means of transportation shall be available, upon request, for both Contractor staff and Department staff working after daylight hours. Such escort service shall be available without endangering the integrity of the remaining security system;
- 6) Have available and furnish to the Department, on a monthly basis, a current list of all authorized staff and their levels of access. The Contractor shall ensure this list is also included in the Security and Confidentiality Plan deliverable. Upon change of duty or termination of Contractor staff, access authority shall be updated or removed within twenty-four (24) hours and the access method must be surrendered on the last day of duty or termination;
- 7) Require a badge and/or key card system for employees and visitors. The badge shall denote the level of access allowed to the individual and whether escort by Contractor or authorized Department staff is required. The key card, if used, shall be re-coded periodically, unless the Contractor proposes and the Contracting Officer accepts an equivalent system that will provide equal protection for the facility environment. The badge and/or key card system shall designate the Department office onto its own grid and not be part of the Contracting Officer's central grid so as to allow for specific security controls and access;
- 8) Require a key card system for entrance to all Departmental staff-designated areas. All entrance doors to the Department-designated areas shall have a key card system that requires the use of the key card at all times including normal business hours and records access of staff (Contractor and Department) entering after non-business hours. To lower the risk of a data breach caused by an unauthorized person entering the most sensitive areas where the PI and PHI (Protected Health Information) are kept, the Contractor should require Two-Factor Authentication. The Two-Factor Authentication is also recommended in order to meet HIPAA compliance, as it adds an extra layer of security that can prevent unauthorized access;
- 9) Develop an access report and a security access violation report and submit to the Contracting Officer. The reports must include, but not be limited to, badge number, name of employee assigned to the badge number, designated section or unit the employee is assigned to work, and the date, time, and location of the access, and location of the access violation;
- 10) Use the security guard(s) to inspect potentially suspicious items being brought into or taken from the facility;
- 11) Log the entry and exit of visitors and messengers by visitor name; agency represented; date and time of arrival and departure; and name of individual to

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- whom visit is made. Identification and/or credentials of all visitors shall be checked. Visitors shall be given badges and escorted to their destination by Contractor staff, Department employee, or security guard. A copy of the entry log shall be submitted to the Contracting Officer on a monthly basis to ensure that the accuracy and validity of the Security and Confidentiality Plan processes and procedures are contractually met;
- 12) Secure and lock the telephone room and any junction boxes between the telephone room and the computer room at all times with key control under the supervision of the building and/or data processing management. The Contracting Officer's telecommunications and network staff shall have access to all server rooms, phone rooms, and MPOE's as part of standard Network staff badge access as directed by the Contracting Officer;
 - 13) Secure and lock the computer room/facilities at all times. Access must be monitored and auditable (i.e. use of individual key cards);
 - 14) Protect the facility against intrusion during non-working hours with an appropriate surveillance alarm extended to the manned monitoring center;
 - 15) Establish and maintain internal security procedures and set safeguards in effect, which protect against possible collusion between Contractor employees and providers, as well as safeguard against other potential security breaches. These procedures must be reviewed and approved by the department; and
 - 16) Upon employee termination or layoff notification the Contractor shall immediately revoke key card access and access to all systems/applications and escort the employee from the premises. Employees shall not be allowed to return to their work area unescorted after being notified that they have been terminated or laid off.
- d. Protect every CD-MMIS automated file by the Resource Access Control Facility (RACF)/Access Control Facility/2 (ACF/2), or equivalent software, to prevent unauthorized access;
 - e. Require passwords to access CD-MMIS functions and/or any associated applications via computer terminal;
 - f. Staff a CD-MMIS Network Access Help Desk to assist Department-authorized on-line CD-MMIS users in resolving password/access inquiries. Upon contact from a Department user, in writing, the Contractor shall reset expired passwords or resolve other password problems without intervention of the Contracting Officer;
 - g. Develop and submit to the Department procedures for the handling, packaging, and transportation of sensitive/confidential data or resources. The procedures shall ensure against unauthorized access. The Contractor shall use a traceable bonded courier service when transporting any document(s) or report(s) or any other type of media that contains PHI;

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- h. Be required to encrypt all “at rest” data. This includes but is not limited to compact discs (CD’s), back-up tapes, and any electronic format that stores PHI data;
- i. Provide a scalable, high availability, high-performance infrastructure solution for the telecommunications links among the Department of Technology primary and secondary sites and the ASO primary and secondary sites;
- j. Implement a solution that tracks the application access of all employees including Contractor and State employees. Applications to be tracked include, but are not limited to, CD-MMIS and all subsystems, State Hearings, Project Management System, Document Management System, Electronic Imaging Management Systems and any other applications that contain PHI or confidential information. The solution must be able to report the following at a minimum:
 - 1) Employee name;
 - 2) Date and time access was granted;
 - 3) Name of system(s)/application(s);
 - 4) Access level granted;
 - 5) Access changes (including system, date/time, access level); and
 - 6) Person granting the access or modifying the access (including revoking access).
- k. Implement a solution in place to enable:
 - 1) A Host-Based Intrusion Detection System (HIDS) that integrates with the existing Medi-Cal environment on Medi-Cal Dental servers containing Medi-Cal information;
 - 2) Internet Protocol (IP) source filtering to allow only authorized network access to database servers containing PHI; and
 - 3) Server-hardening standards for all existing and new servers to include HIDS congruent with the DHCS Information Security Office standards.
- l. Implement a solution in place that provides for:
 - 1) Encrypting email communications;
 - 2) Database client authentication;
 - 3) Appropriate logging and auditing;
 - 4) Specific security enhanced modifications; and
 - 5) Includes validation mechanism that verifies with the original sender all new email addresses registered from their e-mail.

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- m. Implement a solution in place that provides for secure transfer of data between the data centers, the FI, the ASO Contractor and Department of Technology data centers;
- n. Implement a solution in place to encrypt mainframe and non-mainframe back-up media; and
- o. Provide a tool or tools with the ability to automate and intelligently apply redaction to electronically stored information surrounding dissemination of sensitive information, including but not limited to PHI, security, privacy, and DHCS confidential information policies as the document is shared based on DHCS authorization policies.

5. Confidentiality Requirements

- a. The Contractor shall develop, implement, and maintain a Security and Confidentiality Plan that prevents unauthorized disclosure of confidential data. The Plan shall be in accordance with:
 - 1) 45 Code of Federal Regulations (CFR), Section 205.50;
 - 2) California Public Records Act (PRA) (California Government Code §6250 et seq.);
 - 3) Welfare and Institutions (W&I) Code Sections 10850, 10850.1, 10850.2 and 14100.2;
 - 4) Title 22 California Code of Regulations (CCR) Section 51009;
 - 5) California SAM, Section 5300-5399;
 - 6) Information Practices Act of 1977 (Civil Code §1798 et seq.);
 - 7) Confidentiality of Medical Information Act (California Civil Code §56 et seq.); and
 - 8) HIPAA.
- b. The Contractor shall ensure the Plan includes, but is not limited to, detailed standards and procedures for the following items:
 - 1) Marking of sensitive data;
 - 2) Storing of sensitive data, including custodial responsibility;
 - 3) Access, retrieval, and duplication of sensitive data;
 - 4) Disclosure of sensitive data, including approving authority;
 - 5) Disposal of inactive sensitive data, including secure archives including shredding/pulverizing/melting; and

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- 6) Compilation of a list of all classes and types of CD-MMIS documents, data, and files.
 - a) Confidentiality classification criteria for each item on the compiled list.
- c. The Contractor shall maintain a current inventory of all data. Inventoried data shall be classified either as "Public" (per PRA, Government Code Section 6250 et seq.) or "Confidential" as defined in list (a) above. The Department shall respond to Contractor questions regarding the classification of data. The Contractor shall not disclose information classified as confidential without advance written authorization of the Contracting Officer.
- d. Except as provided in California Dental ASO Contract, Exhibit A, Attachment II, Operations, Records Retention Section, the Contractor shall not disclose information classified as confidential without advance written authorization from the Contracting Officer or without formal, written release from the Medi-Cal dental provider or beneficiary involved.

Information, data, or programs of any type, as well as statistical or analytical material or reports based on material used by the Contractor that is not confidential under this paragraph, but are related to the administration of the Medi-Cal Dental Program and the Medi-Cal Dental Contract, shall not be disclosed by the Contractor to any person or entity without first obtaining the written authorization of the Contracting Officer.

6. Security and Confidentiality Training Program

The Contractor shall:

- a. Establish a security and confidentiality training program as part of the Security and Confidentiality Plan that is specifically designed for all levels of Contractor staff. All persons having responsibility for data processing equipment and/or the handling or processing of or the exposure to confidential data shall participate. Such training shall occur no later than two weeks of the Department's approval of the training program. Once fully established and presented, an annual training program shall be maintained to ensure a continual awareness of security and confidentiality requirements. Additionally, new employees shall receive security and confidentiality training within one work week (five days) of their start date before they are given exposure to confidential data. Included in the above training shall be the fire and safety training. The training shall cover a full range of security and confidentiality concerns including:
 - 1) Definition of confidential data and examples of the various types, both paper and electronic;
 - 2) Federal and State law pertaining to confidential data; (HIPAA, Information Practices Act, W&I Code section 14100.2, NIST, etc.);
 - 3) Staffs' ongoing responsibility to ensure that unauthorized disclosure does not occur, with practical and realistic examples as to how such disclosure can occur and what actions will be taken by all staff to minimize or preclude the occurrence of unauthorized disclosure; and

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- 4) Both manual and automated processes and the procedures that have been devised to protect these processes.
- b. Ensure all employees having access to the Contracting Officers' network must attend the Department's Information Security Training annually. Failure to complete such training will result in the employee being removed from the Contracting Officer's network until such requirements are met. Any employees found to be in violation of the policies set forth in this agreement, as well as the agreements set forth in the training course, will be removed from the Contracting Officer's network indefinitely. All changes in employee status (e.g., new hires, promotions, or separations) must be reported to the Contracting Officer immediately;
- c. Submit annually a report documenting employee attendance at Security and Confidentiality Training during the previous year. This report must include, at minimum:
 - 1) Employee name;
 - 2) Department employee works in;
 - 3) Date of last training; and
 - 4) Due date for next training.

The report must reflect if the employee is overdue for training and identify reasons for delays in training or non-attendance
- d. Ensure that the contents of this section are included in the standard language of any subcontract entered into to perform work arising from or related to this Contract; including completion and approval of the Department's BAA by the Department and all parties; and
- e. Submit documentation acceptable to the Department to demonstrate compliance with security and confidentiality requirements and certification, in writing, that all requirements of this section have been, and will continue to be met, throughout the term of the Contract.

7. Disaster Prevention

The Contractor will ensure computer room facilities are equipped with adequate measures and means to provide prompt detection of any disaster as defined in the Appendix 4, Glossary of Terms. The Contractor shall maintain appropriate process for reporting disasters to appropriate authorities and the emergency handling of fire, water intrusion, explosion, or other disasters. The Contractor's facilities shall be protected from physical disaster by the safeguards specified in this section.

- a. Fire Prevention, Detection and Suppression

The Contractor shall:

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- 1) Provide, as part of the Security and Confidentiality Plan, documentation that verifies how the Contractor will comply with these safeguards and which certifies that the requirements of this section have been met. The required safeguards are:
 - a) Fire Prevention;
 - b) Fire Detection; and
 - c) Fire Suppression.
- 2) Ensure facilities shall comply with existing federal, State, and local fire safety regulations. Heat and smoke detectors and an automatic alarm system shall be maintained throughout the Contractor's facilities. A fire detection and alarm system along with automatic Halon or equivalent fire suppression systems shall protect all computer equipment, media storage, and environmental equipment areas. Areas where personnel are located or may be present, as well as supply rooms with forms and paper, shall be protected with an automatic fire detection and alarm system along with an automatic water sprinkler system except in rooms and/or areas where Halon or its equivalent are required. The Contractor's facilities shall have alarm link system(s) that is accessible to all personnel and that connect(s) to the local fire department or a security service that shall immediately notify the local fire department. Minimum fire resistance ratings shall be:
 - a) Rooms housing computer equipment: one hour;
 - b) Tape and disk libraries: two hours; and
 - c) Vault areas (on-and off-site): four hours.
- 3) Ensure the fire detection and alarm system power supply be uninterruptible with a twenty-four (24) hour battery pack;
- 4) Ensure all doors which are required to remain locked by this Contract and that serve as points of egress in the event of emergency be equipped with "panic bar" door releases or, with the approval of the Contracting Officer, equivalent mechanisms that comply with existing local, State, and federal fire safety regulations;
- 5) Ensure procedures dealing with fire safety, evacuation of the facilities and regular fire drills be developed and submitted to the Department for approval as a part of the Security and Confidentiality Plan deliverable(s). These procedures shall include planning for:
 - a) Evacuation of disabled staff;
 - b) Assignment of fire wardens for each Section who can be easily identified by employees. A list of responsible wardens and medical response teams will be maintained and updated monthly;

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- c) Disaster/fire prevention training (including First Aid, Cardio Pulmonary Resuscitation (CPR)) for wardens and medical response teams for Department and Contractor staff assigned;
 - d) Designation of meeting places for staff after evacuation;
 - e) Posting of exit signs and "evacuation route" maps throughout the facilities; and
 - f) Clearing of personnel from all areas, including rest and lounge areas.
- 6) Conduct quarterly, unannounced fire drills to ensure the effectiveness of the fire safety instruction and procedures. The schedule for these drills will be provided to the Department at the beginning of each calendar year; and
- 7) Conduct monthly safety meeting with assigned staff to identify turnover and changes in policy and/or procedures. A Department representative must be present.
- b. Flood and Earthquake Protection

The Contractor shall:

- 1) Ensure facilities be located at Department-approved sites that will be considered reasonably safe from flood and earthquake damage;
- 2) Install and maintain equipment to sense water intrusion and to warn appropriate staff of such intrusion, especially in areas housing electrical equipment, and/or any stored records including areas used for storage of other moisture sensitive items; and
- 3) Ensure procedures discussing water intrusion, earthquakes, and the precautions and steps to be taken to prevent or to minimize the results of these eventualities in terms of danger to personnel, data, equipment, and facilities be developed and submitted to the Department for approval as a part of the Security and Confidentiality Plan.

c. Facility Environment

The Contractor shall:

- 1) Comply with existing State and local building codes. Facilities shall comply with equipment vendor requirements for temperature, humidity, and cleanliness. Any identified sources of potential computer equipment malfunction shall be eliminated;
- 2) Maintain an operational back-up power supply capable of supporting vital CD-MMIS functions, until power is restored in the event of power failure. This uninterrupted back-up power supply shall be immediately available to Central Processing Unit (CPU) and/or other equipment; which is sensitive to power surges or sustained power outages. An acceptable alternative will be a two--feeder power hookup from a single electrical substation, with each feeder on

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a separate transformer; and with the requirement that, in the event of a power failure, an automatic four- millisecond switch would switch from the primary to the alternate feeder;

- 3) Ensure that the operational back-up power supply is being regularly maintained and monthly tests will be conducted to ensure that the operational back-up power supply meets the back-up power supply specifications needed to support critical CD-MMIS functions; and
- 4) Maintain a current certificate of occupancy for each facility housing State employees and/or equipment necessary to fulfill Contract requirements. This certificate of occupancy shall be issued at least annually by the local fire department or a contractor licensed to issue such a certificate. The Contractor shall provide DHCS a copy of the certificate upon request.

d. Threats

The Contractor shall:

- 1) Maximize to the extent possible, the safety of the staff and facilities from danger stemming from bomb threats, terrorism, and civil disturbances;
- 2) Develop procedures dealing with these eventualities and shall submit such procedures to the Department as a part of the Security and Confidentiality Plan. All Contractor and Department staff shall have access to, and be familiar with procedures addressing bomb threat, terrorism, labor disputes, and civil disturbances; and
- 3) Comply with local Homeland Security Measures as directed by the Office of Emergency Services (OES).

8. Disclosure

The Contractor shall ensure:

- a. Only authorized persons may access:
 - 1) Sensitive or confidential data (including but not limited to PI and PHI, whether hard copy or electronic;
 - 2) Software programs and system documentation, including procedure manuals; and
 - 3) Computer room, disk and tape libraries, vaults.
- b. The Security and Confidentiality Plan shall address procedures for dealing with the following three potential categories of threats to sensitive data as well as items 8.a.1) through 3) above (the background checks must be performed for all type of employees, including terminal operators, clerks, janitors, maintenance, and carpet cleaner workers, or vendors/subcontractors):

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- 1) Accidental disclosure, modification or destruction because of hardware error, software error, human error, or a combination of these;
- 2) Casual access, resulting in unauthorized disclosure, modification or destruction by:
 - a) Non-technical persons such as terminal operators, clerks, janitors, maintenance workers, carpet cleaner workers or vendors/subcontractors;
 - b) Skilled technicians such as programmers, systems analysts, system software specialists, or others who have significant technical expertise;
 - c) Managers, supervisors, and others with authorized access;
 - d) Premeditated criminal acts;
 - e) Natural disaster; and
 - f) Labor strikes.
- 3) Sensitive data (including PI, PHI) shall be handled and stored in such a manner as to preclude unauthorized disclosure. It shall be stored in secured archives or, if destruction is necessary, it shall be shredded/pulverized/melted. The integrity of sensitive data shall be protected from unauthorized disclosure at all times, including while in transit.

9. Risk Analysis

The Contractor shall:

- a. Annually perform and document a detailed risk analysis, which defines all risks associated with collection, storage, processing, transition, transportation, discarding, or any other use of data under this Contract. The Risk Analysis document shall contain timeframes for implementing the specified safeguards. The Contractor shall submit the risk analysis to the Department for approval;
- b. Implement safeguards which provide adequate protection against all risks identified in the risk analysis, including terrorism and biological threats. For each identified threat or risk, the Contractor shall specify in the Risk Analysis document the following:
 - 1) An estimate of potential loss for each identified threat in terms of lost productivity, and the impact upon the Contractor's ability to meet Contract requirements;
 - 2) An estimate of the probability of occurrence of each threat in a specified period of time; and
 - 3) The safeguards to be used to reduce the exposure to these threats to an acceptable level.

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- c. Ensure the Risk Analysis document be submitted as a separate section of the Security and Confidentiality Plan which can be removed from the major documentation in the initial submittal, subsequent drafts, and in the final, approved version;
- d. In addition to the above, ensure all risk analysis back-up documentation and safeguard review materials be delivered to the Department simultaneously with the Risk Analysis document. Annually, or as the Contractor or the Contracting Officer become aware of risks not addressed or addressed insufficiently, the Contractor shall perform additional risk analysis; review implemented safeguards; and modify, add, or delete safeguards as the need arises and as the Contracting Officer approves;
- e. Ensure the Risk Analysis and safeguard implementation be completed before the start of Contractor CD-MMIS operations initially, and then annually before the end of each calendar year, unless the Contractor or the Contracting Officer become aware of risks that have not been addressed or have been insufficiently addressed; and
- f. Perform a Risk Analysis on the items what were not addressed or were not sufficiently addressed, complete a plan of correction on the identified issues and submit it to the Contracting Officer no later than ten (10) business days after identification of the risk.

10. Business Continuity Plan

The Contractor shall develop a Business Continuity Plan, as a subset of the Security and Confidentiality Plan that provides for adequate back-up and recovery for all Operations, both manual and automated, mainframe and non-mainframe system/applications, including all functions required to meet the back-up and recovery time frames as specified in this section. All new systems/applications added during the term of the Contract shall adhere to this requirement unless approved in writing by the Contracting Officer. The Business Continuity plan shall be annually updated include the following:

a. Back-up / Redundancy Requirements

The Business Continuity Plan shall identify every resource that requires back-up and to what extent back-up is required. The plan shall also identify the software and data back-up requirements inclusive of specifying the Recovery Time Objective (RTO) and Recovery Point Objective (RPO). The plan shall be completed and tested prior to Assumption of Operations (AOO). Back-up/redundancy needs shall be determined through completion of Risk Analysis and Business Impact Analysis (BIA) Reports. Back-up / Redundancy needs (on- and off-site) shall be included for:

- 1) Checkpoint/restart capabilities;
- 2) Retention and storage of back-up files and software;
- 3) Hardware back-up for the main processor;

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- 4) Hardware back-up for data entry equipment;
- 5) Network back-up for telecommunications;
- 6) Data entry back-up;
- 7) Data files plus file log (including location of files);
- 8) Application and operating system software libraries, including related documentation;
- 9) Personal computer applications developed outside of CD-MMIS; and
- 10) Procedure and user manuals.

Data entry back-up / Redundancy shall be volume tested and adjustments implemented, if necessary, to ensure that the data entry back-up system has demonstrated the capability to handle the CD-MMIS data entry volume.

The Contractor shall address and provide adequate accommodations to ensure the continuity of operations with State staff.

The back-up plan must also address back up and offsite storage schedules that will allow the system(s) to be recovered to a specific point in time regardless of the type of failure that occurs. This includes data and system recovery in either the primary or alternate (back-up) facility(ies).

Off-site storage of back-up operating instructions, procedures, reference files, system documentation, and operational files, shall begin during the Takeover period. At least one complete and continuously updated set of all material stored shall be maintained within twenty-five (25) miles of the Contractor's facility for easy retrieval. Procedures shall be specified for updating off-site materials.

b. Back-up Facility

In the event of a disaster or major hardware problem that renders the primary site inoperable, the Contractor shall allocate specific resources for an adequate and specifically identified back-up facility where CD-MMIS operations can be continued. The back-up facility and resources shall be sufficient to comply with requirements and deal successfully with both small and large disasters. The Contractor's back-up CD-MMIS facility shall be distant enough from any primary Contractor CD-MMIS facility (fifty (50) + miles) so as not to be affected by the same potential disaster. At a minimum it shall be located in a different flood plain and a different power distribution grid. Specific back-up facility(ies) and resources shall be designated to handle various types of potential disasters. The back-up facility(ies) shall provide for:

- 1) Adequate hardware/software compatibility between the back-up facility and the CD-MMIS Operations facility;
- 2) Availability of adequate computer resources, including computer time and all necessary peripherals for the entire CD-MMIS Operations including, but not

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limited to, Denti-Cal Portal, Claims Processing, and Interactive Voice Response (IVR);

- 3) Availability of adequate offsite data entry services, both key data, Optical Character Recognition (OCR) and scanning;
- 4) Availability of alternate space for Contractor and Department staff and equipment in the event that the main CD-MMIS facility cannot be used (e.g., it is destroyed, staff cannot occupy the building, labor dispute), and the availability of adequate staff to fully support CD-MMIS operations with no interruption to services;
- 5) Switching of CD-MMIS terminals to back-up facility;
- 6) Access to all resources mentioned in the Back-up Requirements identified above;
- 7) Ability to shift operations to the back-up facility within time frames and priorities which are acceptable to the Department;
- 8) Method to periodically test the back-up facility at least annually, to verify its ability to assume full CD-MMIS Operations; and
- 9) A dedicated active telecommunications connection to the Department of Technology data center for continued processing.

c. Annual Testing

After an initial test to be conducted prior to the Operations phase, the Contractor shall thereafter, make an annual test no later than June thirtieth of each State fiscal year, of the back-up facility's ability to assume full CD-MMIS Operations. At the Contracting Officer's discretion, Department staff may observe any and/or all back-up and recovery tests. At the Contractor's expense, on an annual basis, a maximum of four Department staff shall be allowed to inspect and observe any and/or all back-up and recovery tests for facilities located out of California. The annual test and the recovery must be conducted outside the Contractor's network and at least ten (10) miles away from the primary site. Following completion of a back-up and recovery test, the Contractor shall submit a written report to the Contracting Officer, thoroughly describing the test, including, but not limited to:

- 1) The nature and extent of the disaster or problem that requires back-up operation;
- 2) The people notified and the method used to notify them;
- 3) The steps and time taken to mitigate the effects of the problem (e.g., disaster) and to recover full CD-MMIS processing;
- 4) The steps taken to prevent similar problems in the future;
- 5) Any points of failure or recovery problems encountered (other than the initial disaster) along with steps taken to mitigate the problem; and

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- 6) Lessons learned.
- d. The back-up facility shall be available for transfer of the full CD-MMIS Operations within twenty-four (24) hours after the main facilities are unable to perform all CD-MMIS Operations. Mainstream claim payments shall be resumed within three business days for all claim types. Full time communication shall be restored with on-line terminals for file update and inquiry purposes within three business days. Full CD-MMIS Operations shall be resumed within seven calendar days. All above recovery times shall be validated as determined by the BIA and in accordance with RTO and RPO objectives specified in the Business Continuity Plan.
- e. The Contractor shall routinely, as part of its normal back-up procedure, provide the Department with any CD-MMIS materials requested by the Department, including CD-MMIS software and documentation; CD-MMIS manuals of all types; and CD-MMIS files.
- f. Disaster Recovery Plan

A Disaster Recovery Plan (DRP) is a comprehensive list of actions to be performed before, during, and after any event that causes a significant loss of data resources. DRP is a procedure for responding to an emergency, providing extended back-up operations during the interruption, and managing recovery processes afterwards, should CD-MMIS experience a substantial loss of processing capability. In case of a disaster the Contractor must make sure that their employees, and also the CD-MMIS's employees within the Contractor's buildings, will do their job. The entire Contractor and the CD-MMIS's employees must have access to a telephone, speak to clients, send and receive faxes and e-mails. All equipment, websites, tools or machines must be available at the new remote site. The primary goal of the DRP shall be:

- 1) To provide the ability to implement critical processes at an alternate site and return to the primary site and normal processing within a time frame that minimizes the loss to the organization, by executing rapid recover procedures. Just like the Contractor's employees, all the CD-MMIS's staffs need to move to the alternate site to do their daily jobs;
- 2) Identify staff including the CD-MMIS's employees to be contacted in the event of disaster. Assigned staff shall be thoroughly familiar with recovery procedures;
- 3) Develop a contingency plan for emergencies to protect the availability, integrity and security of data during unexpected events. This may include fires, floods, earthquakes, or other events that cause damage to the IT department that contain electronic PHI, all CD-MMIS workforce personnel, facilities, vital records, equipment, supplies, partners, and service providers;
- 4) Demonstrate the Contractor's ability to recover from Department-defined disaster situations on at least an annual basis. If the recovery includes the use of a third party, the contingency plan must include the method to assure the availability of all necessary operations. The plan must include guarantees

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that in the event of a disaster, the Department will not be put in line for services from a third party; and

- 5) Include the DRP with the Security and Confidentiality Plan.

11. Department Responsibilities

The Department shall:

- a. Review and approve, or disapprove, as appropriate, the Security and Confidentiality Plan and risk analysis document submitted by the Contractor;
- b. Monitor implementation of the Security and Confidentiality Plan and any safeguards to be implemented as a result of the risk analysis document;
- c. Perform periodic review of compliance with security and confidentiality requirements, including review of the risk analysis document; and
- d. Meet federal requirements for CD-MMIS security and reporting.

R. INFORMATION SECURITY OFFICE AND PRIVACY OFFICE

The Contractor shall, for the life of the contract, establish and maintain an Information Security and Privacy Office. The established Information Security and Privacy Office shall properly execute the functions of the Information Security and Privacy Office as intended by the terms and conditions throughout this Contract.

1. Overview

The Information Security/Privacy Office provides oversight of the Contractor's Information Security Program and Contractor's Privacy Program. These programs encompass all sensitive systems (i.e., automated and manual, physical and logical, and confidential information).

This office shall develop and implement the policies, procedures, guidelines, safeguards, and audit controls that shall protect data confidentiality, data integrity, privacy rights, and ensure the integrity, security, and availability of these information systems. This office shall conduct reviews of the Contractor's operations, which includes internal financial controls, contractor employee system access and rights, on an ongoing basis to prevent and detect fraud; and ensure that the Contractor is in compliance with the established privacy policies, procedures, and guidelines.

2. Assumptions and Constraints

- a. The Contractor shall employ a Denti-Cal Information Security and Privacy Officer to manage the Information Security/Privacy Office. The Information Security Officer and Privacy Officer shall be fulltime, dedicated employees located at the Contractors' facility. Certified Information Systems Security Professional (CISSP) certification shall be required of any individual appointed as the Denti-Cal Information Security Officer. The following Security Administration Networking and Security (SANS) certifications are additional desired qualifications: Certified Information Systems Auditor (CISA), Global Information Assurance Certificate

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(GIAC), Security + Cisco Certified Internetwork Expert (CCIE), Certified Wireless Security Professional (CWSP), Systems Security Certified Practitioner (SSCP), and Certified Ethical Hacker.

- b. Contractor staff identified in this section shall require Department approval.
- c. The ASO Contractor shall work in partnership with the Department's Fiscal Intermediary (FI) Contractor to achieve each of their respective goals and responsibilities outlined in their contracts to carry out the operations and policies of the Department.

3. General Responsibilities

The Information Security/Privacy Office duties shall include, but is not limited to:

- a. Develop security policies, procedures, and criteria for the collection, storage, access, and destruction of information assets. The policies and procedures provide the operational guidelines and delineate the roles and responsibilities of the Contractor's entities for assuring the security and integrity of information assets;
- b. Develop policies, procedures, and guidelines for the use, disclosure, transmission, and storage of information that is protected and confidential under all of the most current applicable federal and state laws;
- c. Provide technical assistance to Contractor personnel to determine the need and appropriateness of proposed security provisions and review proposed modifications to new and existing electronic information processing systems as part of the project security risk assessment process determined by the Department to ensure appropriate security safeguards are implemented and maintained. Refer to CD-MMIS FI Contract, Exhibit A, Attachment III, Change Requirements, for additional information regarding Risk Assessments;
- d. Develop policies and procedures for reporting incidents involving the intentional, unintentional or unauthorized use, disclosure, modification, access, dissemination or destruction of Contractor's information assets, Personal Information (PI), or Protected Health Information (PHI). Assist the Department (including staff from various Divisions) during investigations and audits of alleged incidents of security, privacy, and/or fraud violations;
- e. Analyze and stay informed of the changes to National Institute of Standards and Technology (NIST) Publications, Federal Information Processing Standards (FIPS) Publications, Federal and State legislation (including the Health Insurance Portability and Accountability Act), Federal and State mandates (including the State Medicaid Manual, the State Administrative Manual and the Health Administration Manual), applicable International Organization for Standardization Standards, DHCS security policies and requirements, as well as other applicable rules and regulations for their effect on security policies and ensure Contractor compliance;
- f. Develop, implement, and maintain application security plans to prevent unauthorized disclosure of protected, confidential data. The plans shall be

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compliant with the most current versions of NIST SP 800-18 and all DHCS Information Security Office security requirements which can be found at:

- 1) [NIST Special Publication 800-18: Guide for Developing Security Plans for Information Technology Systems](#)
- 2) [DHCS Information Technology Policy and Requirements](#)

PI/PHI shall not be used within an application or facility until the DHCS Information Security Office has approved the applicable plan(s). Updated plans must be provided to the Information Security Office annually;

- g. Develop standards, procedures, and safeguards to ensure that sensitive data (including PI/PHI) is handled and stored in such a manner as to preclude unauthorized disclosure. The standards, procedures, and safeguards shall protect the integrity of sensitive data from unauthorized disclosure at all times, including while in transit;
- h. Evaluate requests for release of Personal Information (PI) and Protected Health Information (PHI) based on existing laws, regulations and policies, and make recommendations to the Department;
- i. Develop policies, procedures, and safeguards to ensure that only authorized persons may access:
 - 1) Sensitive or confidential data (included but not limited to PHI, and PI, whether hard copy (paper/microfiche) or electronic;
 - 2) Software programs and system documentation, including procedure manuals; and
 - 3) Computer rooms, disk and tape libraries, and vaults.
- j. Conduct annual risk assessment to identify potential vulnerabilities that could threaten the security of the Contractor's information assets and areas for potential fraudulent activities. These reviews provide an independent assessment of the effectiveness of security systems and compliance with laws, regulations, polices, and procedures;
- k. During the security control assessment, identify and document all security weaknesses and deficiencies in the security assessment report to maintain an effective audit trail;
- l. Work with the FI Contractor to ensure the recoverability of all CD-MMIS systems and sub-systems that support the CD-MMIS and or the operations of CD-MMIS by participating in the development, implementation, testing, and maintenance of the Contractor's Disaster Recovery Plans; which is designed to allow effective and efficient recovery of business functions in the event of a disaster. Refer to CD-MMIS FI Contract;
- m. Ensure the recoverability of any sub-systems that support the CD-MMIS and or the operations of CD-MMIS operated or maintained by the ASO Contractor by

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participating in the development, implementation, testing, and maintenance of the Contractor's Disaster Recovery Plans; which is designed to allow effective and efficient recovery of business functions in the event of a disaster. Refer to CD-MMIS FI Contract;

- n. Develop, implement, and oversee the Contractor's Administrative, Technical, and Physical security controls for information systems. All controls to be used must be approved by DHCS before they are implemented. Refer to CD-MMIS FI Contract;
- o. Develop, implement, and oversee the Security Awareness Program for all Contractors' employees, technical staff, Management, and any sub-contractors that support the operations of the CD-MMIS;
- p. Support and maintain a tool for monitoring all database servers, Web servers and environments containing PI, PHI, including all associated tasks in support of administration, compliance, and any DHCS assigned tasks;
- q. Establish a security and confidentiality training program as part of the Security and Confidentiality Plan that is specifically designed for all levels of the Contractor's staff;
- r. Conduct special reviews as requested by the Department; and
- s. Provide written and oral presentations of review issues and alleged security/privacy violation incidents and/or issues to Department staff.

4. Reporting Responsibilities

The Contractor shall:

- a. Provide monthly report and/or comprehensive overview of current and planned Security and Privacy activities for DHCS use in oversight agency reporting;
- b. Provide a detailed and dashboard summary report for all activities that are a result of an audit;
- c. Provide a bi-weekly status report of projects under review; and
- d. Develop a Plan Of Action and Milestones (POAM) document that identifies tasks needing to be accomplished. The POAM document shall detail resources required to accomplish the elements of the plan, any milestones in meeting the tasks, and scheduled completion dates for the milestones. The POAM document prepared for the authorizing official by the information system owner or the common control provider describes the specific tasks planned:
 - 1) To correct any weaknesses or deficiencies in the security controls noted during the assessment; and
 - 2) To address the residual vulnerabilities in the information system.
 - a) The plan of action and milestones identifies:

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- i. Tasks to be accomplished with a recommendation for completion either before or after information system implementation;
- ii. Resources required to accomplish the tasks;
- iii. Any milestones in meeting the tasks; and
- iv. Scheduled completion dates for the milestones.

5. Department Responsibilities

The Department shall:

- a. Review and approve the Security and Confidentiality Plan;
- b. Review and approve Contractor policies and procedures for all information security controls before they are implemented;
- c. Review and approve all deliverables; and
- d. Monitor any new security requirements being implemented.

S. STAFF TRAINING REQUIREMENTS**1. Overview**

The Contractor shall provide for a comprehensive training and personnel development program for all Contractor personnel involved in and performing Contractor responsibilities as specified, and to provide comprehensive training to Department staff, Fiscal Intermediary (FI) Contractor staff and Contractor staff designated and authorized in this Contract by the Contracting Officer. The Department reserves the right to audit any and all training provided by the Contractors.

2. Objectives

The development of a comprehensive training program will require the active collaboration between the ASO Contractor and the Department's FI. The FI Contractor is responsible for supporting CD-MMIS and shall provide the Administrative Services Organization (ASO) Contractor and the Department training regarding application software and use of the hardware for both mainframe and non-frame systems. The ASO Contractor shall collaborate with the FI Contractor training to promote a comprehensive understanding of program procedures and policies related to the California Dental Medicaid Management Information System (CD-MMIS), including new procedures and operations brought about by change instruments to assure effective and efficient adjudication of claims, Treatment Authorization Request (TARs), and related documents.

The Contractor shall:

- a. Provide a comprehensive training and personnel development program to all Contractor personnel involved in and performing Contractor responsibilities as

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specified herein, in addition to training requirements specified in this ASO Contract;

- b. Develop, host, and maintain the on-line computer-based training through a Web-based user interface. This training tool shall complement the hands-on training as required in the Training Plan. The on-line and computer-based training shall provide a learning environment that is mediated and supported via the Internet/Intranet and connected to a computer with hyperlinks to resources outside the instructional domain. This training shall be developed to allow staff access to material and manuals at their workstations and repeat training lessons at their own pace. Training sessions shall include appropriate equipment, test data and materials for each participant to engage fully in the training process. The Contractor shall at a minimum simulate the following systems:
 - 1) The core claims processing system, including areas related to provider enrollment, eligibility verification, claims processing, S/URS and the Reference area used to configure the system;
 - 2) State Hearings;
 - 3) S/URS Reporting Systems;
 - 4) Customer Relationship Management System (CRMS);
 - 5) End to End Acceptance Testing; and
 - 6) Any Commercial Off-the-Shelf tools to support this Contract.
- c. Provide hands on training to the FI Contractor staff and Department staff; and specifically to promote a comprehensive understanding of program procedures and policies related to the claims processing system to facilitate effective and efficient utilization by Department users of the system; and
- d. Ensure quality performance and competence in the execution by those responsible for on-going Operations.

3. Assumptions and Considerations

- a. There are two Contracts under the currently proposed model of the Medi-Cal Dental Fee-For-Service (FFS) program - one pertaining to the ASO Contractor and one pertaining to the FI Contractor. These two Contractors are expected to work in concert with each other to achieve their respective goals and responsibilities outlined in their Contracts to carry out the Operations and policies of the Department;
- b. Ensure training sessions for Department staff, ASO and FI Contractor staff are conducted in the greater area of Sacramento;
- c. The Contractor shall be responsible for ensuring all staff receive the necessary training (i.e.; external or internal, specialized education, etc.) to execute the requirements of this Contract. Training and all related cost shall be included in on-going maintenance and Operations in accordance with the agreed prices of

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the Cost Proposal, and Exhibit B, Attachment I, Special Payment Provisions, Claim Document and TARs;

- d. Attend training provided by the FI Contractor to ensure Contractor staff can adequately accomplish all Contractor responsibilities. Training held at the FI Contractor's facility shall only include training for activities performed by the FI Contractor. Staff shall be responsible to travel to the FI Contractor's facility. All travel shall be Department approved. Training and all related cost shall be included in accordance with the agreed prices of the Cost Proposal and Exhibit B, Attachment I, Special Payment Provisions, Adjudicated Claim Service Lines (ACSLs) and TARs. All other training shall be held at the FI Contractor's facility;
- e. Ensure authorized federal representatives have access to all training sessions upon Department notification to the Contractor of the intent of federal representatives to participate in or attend a Contractor training session;
- f. Conduct a minimum of thirty-six (36) training sessions per calendar year for Department staff and other State staff in other locations throughout the State as specified by the Contracting Officer. This training shall be a part of the Contractor's fixed price bid, except that the cost for rental charges incurred for the provision of adequate meeting space and travel/per diem for the trainer shall be paid on a Cost Reimbursement basis if these costs are incurred by the Contractor as specified in Exhibit B, Attachment I, Special Payment Provisions, Cost Reimbursement provision;
- g. Work in collaboration with the FI Contractor to ensure the training encompasses all major areas of the program including, but limited to, claims processing; and
- h. Collaborate with the FI Contractor to ensure efforts are not duplicated.

4. General Responsibilities

The Contractor shall:

- a. Develop training strategies to ensure all staff receive training in the most effective and efficient methods. (e.g.; train the trainer, webinars);
- b. Prepare to take over existing training courses, develop training courses for all Stakeholders, and incorporate and maintain these as part of the Annual Training Plans. The Contractor shall provide a rollout plan to train the CD-MMIS user including, but not limited to, Contractor Users, FI Contractor Users, State Users, Provider community, and other Stakeholders needing access to the system. Contractor responsibilities include providing all equipment, networks, and training facilities;
- c. Provide training which is specifically designed to ensure the FI Contractor staff and the ASO Contractor can adequately accomplish all Contractor responsibilities as specified in their Contract. In addition, training shall encompass sessions as required to encompass new or modified policies, new program regulations, new equipment, and new system procedures that occur as a result of changes to the mainframe and non-mainframe systems through the Change Order/Dental Operating Instruction Letter (DOIL) process. This training

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shall include new technology that may be used to perform Contractor responsibilities, and shall provide Contractor staff with the skill levels that ensure full preparedness for the performance of all Contractor responsibilities. The training shall further ensure a reduction in errors as identified by the Department and/or Contractor quality control reviews, as well as to guard against problems identified through the Problem Correction System (PCS);

- d. Provide training sessions for Department staff, once every four months with a minimum attendance of five Department staff. The training sessions shall include Department on-line access for use of the system and its software as stated in Exhibit A, Attachment II, Data Processing and Documentation Responsibilities. Training shall include on-going courses for Department staff and orientation training for new staff regarding the use of CD-MMIS and related non-mainframe applications. The on-going training shall be oriented to Department staff skill level, while orientation training shall be oriented to new Department staff, recently assigned to their duties;
- e. Provide access to Department staff in all training of Contractor staff involving Contract responsibilities or operation of the system;
- f. Develop materials, design courses, and supply resources and staffing necessary to train Department staff and other individuals approved by the Contracting Officer on the functional operation of all aspects of the FI and ASO Contractor responsibilities. These materials and manuals are to be maintained by the ASO Contractor and shall be in a location provided by the FI Contractor that is easily accessible and available to FI and ASO Contractor and Department staff at all times;
- g. Work with the FI Contractor to detail all technical and non-technical training in a manual to be maintained for the term of the Contract and owned by the State;
- h. Submit training course outline, course content, materials, handouts, and all related manuals for Department approval prior to conducting the training;
- i. Make appropriate changes and/or modifications as deemed necessary by the Contracting Officer within ten (10) business days in cases where the Department disapproves the Contractor's training recommendations (e.g., staff trainers, training courses, course content, method of presentation, Training Plans, training manuals, updates, and status reports);
- j. Ensure training includes tours of the Contractor's facilities, and explanations and any walk-through of systems Operations, as appropriate and within the context of classroom sessions. Tours of the facilities shall be made available to federal and State staff upon request from the Contracting Officer;
- k. Ensure all training sessions be conducted in a classroom setting with appropriate equipment and materials for each participant to engage fully in the training process. All training sessions shall have informational materials and, at a minimum, pre-test and post-test evaluation. Training sessions shall not be scheduled as an optional program during State or Contractor employees' off-duty hours;

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- I. Ensure Contractor staff training shall be organized and scheduled so as to minimize the impact the absence of the participants may have on their workload, their work unit(s) or the Operations schedule;
- m. When individual or work group performance problems are identified through Quality Management (QM) review, Problem Statements (PSs), or other methods, identify the cause of the procedural error(s) and take immediate steps to correct staff performance through necessary training. QM staff involved in the identification of the performance problem(s) will be available to advise and assist in the design and implementation of the remedial Training Plan; and
- n. Ensure adequate staffing to meet Contract requirements throughout the term of the Contract.

5. Training Plan

The Contractor shall:

- a. Include a workplan/schedule of the development, modification, and implementation of the training solution. Include activities, tasks and deliverables required to comply with the requirements outlined in this Contract. [SC1]
- b. Include, but is not limited to, all business and technical functions of CD-MMIS, scheduling of training courses for the user community throughout the State, determining lead times as to best practices to retain knowledge learned, measurement as to retention of lessons taken, and progress reports as to schedules achieved;
- c. Include major areas to be covered in the Contractor's comprehensive training for Contractor and Department staff, but not limited to:
 - 1) Administrative Support Services;
 - 2) QM;
 - 3) Finance and Contract services;
 - 4) Provider Services;
 - 5) Beneficiary Services;
 - 6) Telephone Service Center (TSC) Operations (Provider and Beneficiary); and
 - 7) Security and Confidentiality procedures, including Privacy procedures.
- d. Provide hands-on training at terminals for the following specialized areas, including on-going support and assistance:
 - 1) Claims/TAR/Claim Inquiry Form (CIF)/Notice of Action (NOA) adjudication and processing;
 - 2) Specialized Claims Processing (i.e., TMJ. etc.);

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- 3) Claims Payment;
 - 4) Share of Cost (SOC);
 - 5) S/URS and Claim Detail Report (CDR) training;
 - 6) Decision Support System; and
 - 7) End to End Acceptance Testing (E2E).
- e. On a yearly basis, the Contractor shall update the Training Plan to address all training programs scheduled. The Contractor shall submit the yearly update to the Department for approval, with written notification of any changes or modifications to the Training Plan, within thirty (30) calendar days of the first day of the calendar year after the Contract Effective Date (CED). The Training Plan shall update the Training Plan to address the following items, but not limited to:
- 1) Training methodology and presentation modes;
 - 2) Description of tools/techniques to be used on an on-going basis to design and upgrade dynamic training programs that better serve the intended purpose and meet the needs of the participants;
 - 3) Identify all training goals and objectives regarding what is to be accomplished;
 - 4) Sample copies of material(s) used in training sessions;
 - 5) Description of how student evaluations will be used to improve course content and presentations, including techniques to measure success as a result of the training;
 - 6) Pre-Test and Post-Test criteria;
 - 7) Schedule of initial training for new employees, including required curriculum designated by work unit or classification, and duration of initial training periods; and
 - 8) Schedule and execute the Training Plan to ensure full preparedness for execution and performance of all Contractor responsibilities specified in the Takeover and Operations Exhibits.

6. Training Manuals

The Contractor, in conjunction with the FI Contractor, shall develop training manuals derived from the user manuals for procedures described in Exhibit A, Attachment II, Data Processing and Documentation Responsibilities. The training manuals shall be generated from the most current materials available and shall be used when selecting item(s) for use in the training course(s)/class(es) and shall be in a location provided by the FI Contractor that is easily accessible and available to the Department staff, FI and ASO Contractor staff at all times. Training manuals shall provide enough details and shall be written at a level that would facilitate an

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inexperienced user's ability to understand them. Training manuals shall also include step by step instructions on how to navigate in CD-MMIS and all other Contractor/Department systems. Training manuals shall be kept up to date with corresponding changes and revisions. Such updating shall occur on an on-going basis.

7. Training Staff Qualifications

The Contractor shall:

- a. Provide adequate staffing levels to develop (including subject matter primary users and/or experts), facilitate, train, and monitor the required training program activities. Identify staff and hours devoted to training activities. In addition, the Contractor shall provide coordination for scheduling and registering Department staff, FI Contractor staff and Contractor staff for participation in the training sessions. The coordination shall be a liaison with designated Department staff assigned to monitor the activity;
- b. Include in the Training Plan, and in all updates to the Training Plan, the professional classification, qualifications, and responsibilities of the proposed trainer(s). The qualifications of the person(s) conducting the training shall reflect his/her competence and ability to give instruction in the required areas. This shall include knowledge and experience in the areas covered and the ability to impart that knowledge to others. All trainers shall have, at a minimum, two years demonstrated and documented experience or knowledge in their training and subject area; and
- c. Ensure that experts in the subject matter field are involved in developing class materials for the courses being presented. Expertise shall be determined by the Contractor based on a combination of education and practical experience. In addition, the subject matter experts shall be active participants in regularly auditing the courses to ensure that trainers are knowledgeable and effective in training others in the subject matter being presented. The updates to the Training Plan shall describe how this activity shall be completed on an on-going basis.

8. Professional Review Training

The Contractor shall develop and implement a Training Plan designed to ensure the highest level of professional review skills for each Dental Consultant and Clinical Screening Dentist. Training for these consultants and dentists shall begin prior to the start of TAR processing during Takeover.

The Quality Management Dental Consultant (QMDC) has the overall responsibility for all Dental Consultant and Clinical Screening Dentist training and the monitoring of professional review and adjudication skill. The qualifications and responsibilities of the QMDC are described in Exhibit A, Attachment II, Quality Management Process.

The QMDC shall request the advice, review, and participation of the Department Dental Program Consultants in the development of training.

Exhibit A, Attachment II
Scope of Work - Operations**9. Dental Consultant Training Plan**

The Contractor shall develop a Training Plan for Dental Consultants that will ensure their ability to meet the requirements as described throughout this Contract. The Contractor's responsibilities for training Dental Consultants shall be the same as those required for all training. In addition, Dental Consultant training shall provide for:

- a. Comprehensive training and adjudication skill review for all newly hired Dental Consultants prior to their assumption of final adjudication authority; and
- b. Refresher training to be held a minimum of every six months.

10. Clinical Screening Dentist Training Plan

The Contractor shall develop and maintain a Training Plan for Clinical Screening Dentists to ensure their ability to meet the requirements pertaining to clinical screening as described in Exhibit A, Attachment II, Beneficiary Services. The Clinical Screening Dentist Training Plan shall be included in the Contractor's Training Plan.

11. S/URS and CDR Training Plan

The S/URS and CDR Training Plans shall be included in the Contractor's Training Plan to ensure its ability to meet the requirements as described in CD-MMIS ASO Contract, Exhibit A, Attachment II, S/URS section and S/URS Reporting System section. In addition, S/URS and CDR training shall include the following:

- a. S/URS Operations including provider/beneficiary utilization review;
- b. User interactions;
- c. A review of the S/URS user manual;
- d. Procedures for ordering CDRs;
- e. Procedures for ordering Aged History Reports (AHR);
- f. CDR format and content;
- g. Data sources;
- h. S/URS reports;
- i. Any changes to S/URS Operations that were initiated after the CED;
- j. S/URS Reporting Systems; and
- k. Procedures for meeting all S/URS Contract requirements.

Exhibit A, Attachment II
Scope of Work - Operations**12. Reporting Requirements**

The Contractor shall submit to the Department an annual status report on the progress of the completed training including updates to the annual Training Plan. This report shall evaluate and compare the actual training completed with the submitted Training Plan. Identify in the report successful areas of the Training Plan and the metrics used to measure performance to achieve success. If established goals and objectives of the training program were not achieved, this report shall address and provide recommendations to improve in the deficient areas of the training program. The report shall be delivered to the Department one month prior to the submission of the annual Training Plan. The report shall include, at a minimum, the following:

- a. Narrative summary of changes, progress, and/or problems in the training programs. Restate and evaluate the following:
 - 1) Goals and objectives;
 - 2) Training content and subject areas;
 - 3) Training methodology and presentation modes; and
 - 4) Execution of the Training Plan.
- b. The actual hours of all internal and external training attended by the Contractor's Staff and Department staff, broken out by type of training, staff name and classification;
- c. The number of Contractor (ASO and FI) staff registered for training;
- d. The number of Contractor (ASO and FI) staff who attended the training;
- e. The number of Department staff registered for training;
- f. The number of Department staff who attended the training;
- g. Narrative summary of changes, progress, and/or problems in the training programs; and
- h. Narrative summary of all class participants' evaluation responses regarding the effectiveness of the training.

13. Department Responsibilities

The Department shall:

- a. Designate State staff who shall participate in Contractor training;
- b. Designate locations of special sessions deemed appropriate for, and approved by, the Contracting Officer;

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- c. Evaluate Contractor staff recommended as trainers and direct the Contractor to make changes as deemed necessary by the Contracting Officer;
- d. Review and approve or disapprove training courses. In cases where the Department disapproves any course content or method of presentation, the Contractor shall be directed to make modifications as deemed necessary by the Contracting Officer;
- e. Approve or disapprove all Training Plans, updates, and status reports. In cases where the Department disapproves the Training Plan, updates or status reports, direct the Contractor to make modifications as deemed necessary by the Contracting Officer;
- f. Designate Department staff to be responsible for monitoring the Contractor's effectiveness in the training courses and compliance with the training requirements of the Contract;
- g. Assign Department monitoring staff to meet with the Contractor to discuss training-related issues as needed; and
- h. Assign Department Dental Program Consultants to advise, review, and participate in the development of training for Dental Consultants and Clinical Screening Dentists.

T. RECORDS RETENTION REQUIREMENTS**1. Overview**

The requirements for record retention differ depending on whether the records are (a) the Contractor's corporate or business financial records, or (b) Medi-Cal Dental claims payment records. Rules governing the maintenance and disposition of corporate financial records are contained in the Administrative Services Organization (ASO) Contract, Exhibit D(F), Special Terms and Conditions, Exhibit E, Additional Provisions, Access Requirements, and Exhibit E, Additional Provisions, Audit Requirements. At a minimum, the Contractor shall serve as the custodian of all claims payment records.

2. Objectives

The Contractor shall:

- a. Establish custodianship for all Medi-Cal Dental claims payment records and all other documents within their possession and control;
- b. Produce acceptable hard copies of claims payment records upon request;
- c. Guarantee that authorized State and federal employees shall have access to claims payment records when needed;
- d. Retrieve claims payment records upon request and in a timely manner; and

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- e. Provide Contractor and Department employees with clear guidelines and instructions on procedures for executing the Contractor's record retention responsibilities.

3. Assumptions and Constraints

- a. There are two Contracts under the currently proposed model of the Medi-Cal Dental Fee-For-Service program - one pertaining to the Administrative Services Organization (ASO) Contractor and one pertaining to the Fiscal Intermediary (FI) Contractor. These two Contractors are expected to work in concert with each other to achieve their respective goals and responsibilities outlined in their Contracts to carry out the operations and policies of the Department;
- b. The FI Contractor shall be responsible for completing their document management responsibilities outlined in the California Dental Medicaid Management Information System (CD-MMIS) Fiscal Intermediary (FI) Contract, Exhibit A, Attachment II, Claims Processing, prior to transferring all paper documents and attachments to the ASO Contractor to be processed, archived and stored;
- c. The ASO Contractor shall preserve, protect, and maintain original documents for a minimum period of sixty (60) business days after their reproduction, unless required differently and in writing by the Contracting Officer. (NOTE: Providers must request the return of radiographs at the same time the radiographs are submitted. Radiographs are returned within twelve (12) business days after adjudication to providers and are not scanned, although in some cases a copy shall be made;
- d. The FI Contractor shall certify the authenticity of claims payment records stored in CD-MMIS;
- e. For the purposes of this section, claims payment records shall include, but not be limited to:
 - 1) Submitted claims for processing, regardless of medium; i.e. hardcopy and/or magnetic media);
 - 2) Notices of Authorization (NOAs);
 - 3) Appeals and appeals responses;
 - 4) Explanation of Benefits (EOBs);
 - 5) Copies of checks cashed by providers;
 - 6) Claims Inquiry Forms (CIFs);
 - 7) Resubmission Turnaround Documents (RTDs);
 - 8) Treatment Authorization Requests (TARs);
 - 9) Provider payment histories;

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- 10) Provider correspondence;
 - 11) Provider enrollment forms;
 - 12) Provider Agreements;
 - 13) Provider-initiated adjustments and any other transactions generated from an internal CIF;
 - 14) Share-of-Cost (SOC) records;
 - 15) Beneficiary payment histories;
 - 16) Surveillance and Utilization Review (SURS) case files;
 - 17) Any other claims, forms, attachments, or reports which are a part of, produced from, or generated as a result of the Contractor's claims processing activities; and
 - 18) All claims payment records, including but not limited to, all the data and records transferred from the prior contractor and the Department. The database currently consists of all historical data back through 1974. Pursuant to the requirements and criteria described in CD-MMIS FI Contract, Exhibit A, Attachment II, Reference File Subsystem, the Contractor may purge this data from the database to tape or other alternative media if approved by the Contracting Officer. The Contractor shall store and be able to retrieve this data.
- f. These Records Retention Requirements provide for maintenance, access, and retrieval of claims payment data for a period of ten (10) years from the date of their origin, and indefinitely for once-in-a-lifetime procedures (e.g., tooth extraction), and procedures needed for other history auditing. For other history, the Contractor shall store this data on appropriate long-term storage media and ensure the ability to retrieve the data for Department, federal, or Contractor usage in accordance with the requirements in CD-MMIS FI Contract, Exhibit A, Attachment II, Data Processing and Documentation Responsibilities. Any record retained in an archival state shall be encrypted;
 - g. For beneficiary payment histories, retrieval for the most recent seventy-two (72) months and once-in-a-lifetime procedures, and procedures needed for other history auditing, shall be made available by the Claims Detail Reports (CDR);
 - h. For provider payment histories, retrieval for the most recent thirty-six (36) months shall be made available by the CDR;
 - i. The Department may annually request a history search and/or hard copy reproductions of approximately one hundred thousand (100,000) claims payment records;
 - j. These Records Retention Requirements are in addition to provisions elsewhere in this Contract, which require on-line request and retrieval of claims payment information (e.g., CDRs and/or documents); and

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- k. Claims/TARs/NOAs/CIFs/RTDs /etc., shall be submitted by providers on Contractor-supplied forms or by other electronic means approved by the Department.

4. General Responsibilities

- a. Custodian of Records

The Contractor shall:

- 1) Serve as the Custodian of Records of all claims payment records under the Contractor's possession and control;
- 2) Preserve, protect, and maintain all claims payment records which are a part of, or result from, the Contractor's Operations under this Contract;
- 3) Preserve and protect all claims payment records transferred to it from the preceding contractor, the Department, and the FI Contractor;
- 4) Maintain all claims payment records throughout the term of this Contract unless otherwise approved by the Contracting Officer. Records which have been involved in matters of litigation shall be kept for a period of not less than three years following the termination of such litigation regardless of the expiration or termination of this Contract;
- 5) Accept and respond to all subpoena duces tecum served either on the Contractor or on the Department for documents in the possession of the Contractor;
- 6) Accept and respond to all requests invoking the Public Request Act (PRA) served either on the Contractor or on the Department for documents in the possession of the Contractor;
- 7) Ensure that deadlines set by the Court for responding to subpoena duces tecum and the PRA are met, and that when necessary, provide expert witness testimony regarding the named records within the Court's deadlines. (For additional requirements refer to Exhibit A, Attachment II, Operations, Expert Witness Requirements). This provision shall apply to claims that were adjudicated under a prior contract and that are in the Contractor' possession;
- 8) Notify the Department prior to, or concurrent with, responding to subpoena duces tecum, PRAs, and/or providing expert witness testimony;
- 9) In collaboration with the FI Contractor, dispose of records under its custodianship only after receipt of written approval from the Contracting Officer of the time, place, method of disposal, and specific records or group of records to be destroyed; and
- 10) Generate any necessary Records Retention reports. Reports shall meet requirements described in this section, and in FI Contract, Exhibit A, Attachment II, General Reporting Requirements, unless otherwise specified by the Contracting Officer.

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b. Third Party Liability

To assist the Department in exercising its responsibility for tort liability and estate recoveries, the Contractor shall meet the following requirements:

- 1) If the Department requests payment information or copies of invoices or paid claims for covered services to an individual beneficiary, the Contractor shall deliver the information to the requester within ten (10) business days of the request. Paid services shall be reported with a dollar value of the usual, customary, and reasonable charge made to the general public for similar services; and
- 2) Provide the Department with the name, address, and telephone number of Contractor staff responsible for receiving and complying with requests for service history information.

5. Acceptability of Copies

Original claims payment records may be replaced with electronic image repository versions. Other forms of Department-approved reproduced copies may be substituted at the discretion of the Contracting Officer during the term of the Contract under the following conditions:

- a. If claims or other documents are submitted by other means approved by the Department, preserve, protect, and maintain the original media for a minimum period of sixty (60) business days after their reproduction. The Contractor shall produce copies of such claims/documents as needed to meet all requirements of this section;
- b. Scanned copies of all claims payment records shall meet standards contained in CD-MMIS FI Contract, Exhibit A, Attachment II, Data Processing and Documentation Responsibilities;
- c. Ensure all reproductions from scanning and all other Department-approved copies of hardcopy claims payment records shall be legible and clearly reflect all data including the provider's or provider representative's signature;
- d. In reproducing electronically submitted claims, ensure a copy of the accompanying transmittal document or copy of the billing provider's certification containing the original provider's or provider representative's signature shall be provided with each facsimile claim copy. If, however, the requested claim copies are in sequential order by Document Control Number (DCN), Most Recent Document Control Number (MRDCN), or Correspondence Reference Number (CRN), and fall under a common transmittal document, one copy of the transmittal document shall suffice providing there is no break in the sequential order of accompanying claim; and
- e. If the Department determines that hard copies produced from scanned versions of claims payment records within the ASO Contractor's responsibility are unacceptable in meeting the requirements of 5.c and d above, the Department shall, at its discretion, extend the period for which original claims payment documents and records shall be maintained by the Contractor. Any additional

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costs incurred by the Contractor in connection with compliance with this provision shall be the sole responsibility of the Contractor.

6. Access, Retrieval and Certification

The Contractor shall collaborate with the FI Contractor to:

- a. Provide authorized access to retrieval services and certification of claims payment records under its custodianship during the term of this Contract;
- b. Establish and maintain procedures in keeping with the security provisions of this Contract for allowing authorized State and federal employees, agents, or representatives access to all claims payment records held under the custodianship of the Contractor. These access procedures shall be approved by the Department and subject to modifications by the Department;
- c. Establish and maintain procedures for retrieving claims payment records requested by the Department. Such retrieval procedures shall be approved by the Department and subject to modifications by the Department. The Contractor retrieval procedures for claims payment records shall provide for the following:
 - 1) Maintain a minimum of ten (10) years of records that shall be subject to the retrieval procedures;
 - 2) Beneficiary histories by beneficiary identification number, beneficiary Social Security Number (SSN), or Medi-Cal Eligibility Data System (MEDS) identification number or health access program identification number;
 - 3) Provider histories shall be retrievable by provider number;
 - 4) Correspondence to and from providers and beneficiaries shall be retrievable by provider name and provider number, beneficiary name and beneficiary number, or the name of their authorized representative(s);
 - 5) Provider enrollment documents shall be retrievable by provider name and provider number;
 - 6) Provider agreements shall be retrievable by provider name and provider number;
 - 7) Work with the FI Contractor to maintain the location of all records under the Contractor's custodianship for the purposes of retrieval and accessibility in one Master Index. This Master Index shall be updated monthly. The Master Index shall be made available to the Department upon request;
 - 8) Delivering retrieved records to the requestor within ten (10) days from the date of receipt of the request by the Contractor, unless stipulated differently by the Contracting Officer or other sections of this Contract;
 - 9) Adhering to the following requirements, CDRs shall meet the requirements for provider and beneficiary history retrieval. Beneficiary and provider history reports shall be run in accordance with the requirements of Exhibit A,

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Attachment II, SURS , and the Records Retention requirements of this section;

- 10) Unless otherwise specified in writing by the Department, a single copy of all requested document copies shall be provided in paper or electronic media format, depending on what is requested by the Department;
 - 11) The requester identification number assigned to each user shall be the same number used to request CDRs;
 - 12) Requests for which no documents are retrieved shall be accompanied with an explanation from the Contractor. At a minimum, the explanation provided shall include, but not be limited to, document not on file or invalid document number;
 - 13) All records prepared or compiled for delivery to a requester shall comply with the requirements in Exhibit A, Attachment II, General Reporting Requirements, or to the requester's specifications, prior to delivery to the requester; and
 - 14) Document copies shall be delivered to local users and/or mailed to users located beyond the twenty-five (25)-miles-of-the-capital limit no later than twenty-four (24) hours following the date/time the request is received by the Contractor. This standard shall apply to the first two hundred (200) documents requested on any one day. The Contractor shall respond to all documents requested above the two hundred (200)-documents-per-day standard within forty-eight (48) hours of receipt of the request;
- d. Provide a daily report to the Department of all requests for record retrieval;
 - e. Establish, maintain, and update, as necessary, procedures for certifying the accuracy and authenticity of original claims payment documents, scanned copies of claims payment documents, and hard copies produced from scanned versions of claims payment records. Certification procedures shall be subject to Department review, written approval, modification, and these procedures shall be included as a separate section or chapter of the Records Retention Procedures Manual;
 - f. In addition to the responsibilities contained in this section, provide all necessary assistance to the Department in the identification, retrieval, and certification of claims payment records and any other requested information for the purposes of the investigation, prosecution, or defense of Medi-Cal Dental related cases. Such cases may include, but not be limited to: fraud prosecutions, provider appeals, third party liability recovery efforts, overpayment recovery efforts, Department recovery efforts, and actions against the Department. The Department shall have the authority to review, approve in writing, and modify the procedures, steps, or other services by which the Contractor attempts to comply with this requirement;
 - g. Be responsible for replying to all other parties' requests for claims payment records other than the Department when such requests have been submitted to the Contractor in the form of a subpoena duces tecum, including PRA requests.

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The Contractor shall perform this service as part of its custodianship responsibilities. The Department shall provide no additional reimbursement to the Contractor for the provision of this service. The Contractor may request payment for such services from the Court or the party issuing the subpoena;

- h. Maintain accurate records of all document/record retrieval requests in accordance with this subsection and Exhibit A, Attachment II, Security and Confidentiality; and
- i. Upon completion and delivery of requested copies, meet the Access, Retrieval, and Certification requirements.

7. Reporting Requirements

- a. The Contractor shall utilize the Automated Document Retrieval (ADR) to produce the Document Retrieval Request Summary Report in the form of a hard copy print-out of each document request. These reports shall be used by the Contractor to retrieve requested document copies, and shall become transmittal sheets for routing these copies to the requester. The transmittal sheets shall be produced and delivered to the Department on a daily basis, attached to the requested copies. A duplicate of each transmittal sheet, signed/initialed and dated by the requester to indicate receipt, shall be retained by the Contractor for inclusion of data in monthly Document Retrieval Performance Reports (see below). After transmittal data is compiled in the monthly report, the duplicate transmittal sheet shall be disposed of by the Contractor in accordance with Exhibit A, Attachment II, Security and Confidentiality.
- b. The daily report(s) shall include, at a minimum, the following information:
 - 1) Requester name, number, and address;
 - 2) Date of request;
 - 3) DCN, MRDCN, and/or CRN of the requested document;
 - 4) Payment date;
 - 5) Check number;
 - 6) Provider number;
 - 7) Beneficiary SSN;
 - 8) Number of copies requested;
 - 9) Total number of copies;
 - 10) Request filled by;
 - 11) Date request completed;
 - 12) Date request mailed/delivered;

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- 13) Requester Comments/Initials Block; and
 - 14) Date request received by requester;
- c. The sort sequence for the reports shall be:
- 1) First Sort Key: By Requester Name/Requester Number;
 - 2) Second Sort Key: By Date of Request; and
 - 3) Third Sort Key: By DCN, MRDCN, and/or CRN
- d. The Contractor shall produce, and deliver to the Department by the fifth business day of each month, a Document Retrieval Performance Report. The monthly performance report shall include at a minimum, by requester number, the following information for total unduplicated requests for each type of document requested:
- 1) Total number of copies requested;
 - 2) Total number of copies delivered;
 - 3) Total number of copies delivered late;
 - 4) Total number of copies not delivered;
 - 5) Number of requests received by the Contractor under the twenty-four (24) hour standard;
 - 6) Number of requests received under the twenty-four (24) hour standard that was delivered within twenty-four (24) hours;
 - 7) Number of twenty-four (24) hour standard requests delivered late;
 - 8) Number of twenty-four (24) hour standard requests not delivered;
 - 9) Number of requests received by the Contractor under the forty-eight (48) hour standard;
 - 10) Number of requests received under the forty-eight (48) hour standard that was delivered within forty-eight (48) hours;
 - 11) Number of forty-eight (48)hour requests delivered late;
 - 12) Number of forty-eight (48)hour requests not delivered;
 - 13) Number of priority requests received;
 - 14) Number of priority requests delivered;
 - 15) Number of priority requests delivered late;

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- 16) Number of priority requests not delivered; and
- 17) Number of undelivered requests and the reasons the requests were undelivered.
- e. The quarterly performance report shall summarize, by requester number and total, the above information for those documents requested during a month. For those documents that are late in delivery or are not delivered, the report shall list the type of document (i.e., claims, etc.), the document number(s) (e.g., the number or name by which the document was retrieved) of each requested document, the number of days late in delivery, and shall give the reason for delay or non-delivery.
- f. For those documents not delivered, the report shall show the number of days outstanding beyond the delivery date for each requested document number. Documents not delivered during the report period shall be listed on each subsequent monthly report until such documents are delivered. Summary data shall be included for each of the categories. This report shall be attached to each monthly payment invoice under General CD-MMIS Operations submitted by the Contractor and shall meet the retrieval standards set by the Contracting Officer. The monthly performance report may be modified at the discretion of the Contracting Officer.
- g. The Contractor shall develop and deliver to the Department a Records/Files Summary, including a brief description of all records and/or files maintained under this Contract. The summary, at the minimum, shall include the following:
- 1) The name of the file;
 - 2) The medium of retention (on-line, tape, etc.);
 - 3) Duration (how long the file is maintained in the defined media);
 - 4) Disposition (subsequent arrangements for retention or purge);
 - 5) Access (the methodology necessary to gain access to the file); and
 - 6) The summary shall be sorted by production schedule daily, weekly, monthly, quarterly, and/or annually. Upon approval of the Contracting Officer, the summary shall be updated and produced on a quarterly basis.

8. Records Retention Procedures Manual

The Contractor shall in collaboration with the FI Contractor:

- a. Prepare, update, and maintain a Records Retention Procedures Manual, which thoroughly describes the specific steps to be followed in order to execute the Contractor's record retention responsibilities. This procedure manual shall be prepared and approved by the Department for the use of both Contractor and Department staff, and shall be submitted for Department review and approval during Takeover; and

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- b. Maintain and update the procedure manual, but in no case less than annually, to accurately reflect any changes in the Contractor's record retention procedures. Copies of all procedure or manual amendments shall be delivered to the Contracting Officer for review and written approval prior to publication and distribution.

9. Transfer on Termination

The Contractor shall, upon termination of this Contract, transfer control of all claims payment records under its custodianship to a successor contractor or the Department. The Department shall retain the authority to designate the manner and method by which claims payment records shall be transferred. The Department shall also designate the party to whom the records shall be transferred. In addition, copies of checks issued by the Contractor under this Contract shall be available to the successor contractor for research purposes. The Department may exempt from transfer those records retained by the Contractor for litigation purposes.

10. Deliverables

In addition to responding to any Department or Department-approved requests for copies of claims records, the Contractor shall work with the FI Contractor to:

- a. Submit a Records Retention Procedures Manual four months after the Contract Effective Date (CED) and update annually and in addition as necessary, with prior Department approval;
- c. Establish and maintain a Master Index fourteen (14) months after the CED and update monthly;
- d. Produce hard copy report of on-line document request through the ADR system, and deliver with requested copies (Document Retrieval Request Summary Report);
- e. Compile on-line document requests into a monthly Records Retrieval Performance Report;
- f. Preserve, protect and maintain original claim media for a period of at least sixty (60) business days after reproduction;
- g. Respond to and notify the Department of any requests invoking the PRA; and
- h. Respond to and notify the Department of any subpoena duces tecum.

11. Department Responsibilities

The Department shall:

- a. Identify all records from prior contractors that will be subject to these records retention responsibilities;

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- b. Review and approve in writing, prior to implementation, any method and manner the Contractor proposes to purge, destroy, or otherwise dispose of claims payment records; and
- c. Review and approve in writing the Contractor's records retention procedures, reports, and updates, including, but not limited to, the Master Index, Records/Files Summary, Document Retrieval Request Summary Report, and Records Retention Procedures Manual.

U. ADMINISTRATIVE SUPPORT OF CONTRACT CHANGES

1. Overview

To achieve optimal efficiency with directed change, the Contractor shall implement, staff, and maintain an Administrative Support of Contract Changes Services with sufficient resources to accomplish all tasks in a timely and quality manner.

2. Objectives

The Contractor shall:

- a. Ensure implementation of changes mandated by the Contracting Officer due to statute, regulation, judicial interpretation, policy or other Department initiatives;
- b. Coordinate all levels of Operations, including the California Dental Medicaid Management Information System (CD-MMIS) Fiscal Intermediary (FI) Contractor, to ensure necessary communications, notifications, education, and training are provided to the provider and beneficiary community and associated Stakeholders;
- c. Ensure Operations activities are compatible with CD-MMIS business Operations;
- d. Assess, control, track and report all changes implemented through the term of the Contract;
- e. Work in partnership with the Department's FI Contractor's Enterprise Project Management Office (EPMO) to accomplish all tasks in a timely and quality manner. This includes the design, development, and delivery of all deliverables. The Contractors shall ensure timely implementation of change instruments and documentation; and
- f. The Administrative Services Organization (ASO) Contractor shall review and approve all required deliverables including, but not limited to, each of the four specified phases in designing, developing, and implementing a computer software system change prior to the FI EPMO submitting for approval to the Department. The required deliverables and phases are described in the FI Contract, Exhibit A, Attachment III, Change Requirements.

3. Assumptions and Constraints

- a. The Contracting Officer may direct the Contractor to immediately begin implementation of any change.

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- b. All deliverables related to Dental Operating Instruction Letters (DOILs), Problem Statements (PSs), Miscellaneous Change Documents (MCDs), System Development Notices (SDNs), and Business Requirements Documentation (BRDs), regardless of whether they were developed by the ASO or FI Contractor, shall be submitted to the Department through the FI EPMO. Approvals for these deliverables shall be obtained from both the ASO and FI Contractors prior to delivery to the Department.
- c. All correspondence related to Contract Operations, regardless of whether the document was developed by the ASO Contractor, FI Contractor, or the Department, will go through the FI EPMO for delivery to the State or distribution to the ASO Contractor.
- d. Utilize the FI EPMO document repository as the system of record for all correspondence and deliverables for the Department, ASO Contractor, and the FI Contractor.
- e. Administrative Support shall have on-line read access to the FI Contractor's EPMO reporting tool and data and shall be extended full read-rights to product licensure, including full ad hoc reporting capability.
- f. The ASO Contractor shall be allocated five licenses to the EPMO management reporting tool.
- g. Compensation for this work will be made in accordance with ASO Contract, Exhibit B, Attachment I, Special Payment Provisions. Activities are to be included in the Contractor's bid prices for Adjudicated Claim Service Lines (ACSLs) and Treatment Authorization Requests (TARs).

4. Contract Change Instruments

The Contracting Officer may at any time, within the general scope of the Contract, by written notice, make changes to the policy that governs the Medicaid dental program or the system used to administer the program (CD-MMIS). The Department will utilize a formalized process to notify the ASO and FI Contractor on an on-going basis of changes and/or amendments to be made to the CD-MMIS. This process shall make use of the following documents:

- a. DOIL - This document will be utilized to notify the ASO and FI Contractor of changes and clarifications made to the Medi-Cal Dental programs' policies. This document will include instructions to the ASO and FI Contractor regarding the changes required, and language to be used by the Contractor in issuing provider bulletins or updating the provider manual. This document will also be used to initiate various on-going changes required of the Contractor throughout the Contract, the performance of which falls within the fixed Contract price.
- b. PS - This document will, in some cases, generate corrections/modifications to CD-MMIS programs or Erroneous Payment Corrections (EPCs).
- c. MCD or Miscellaneous Project - This document will generate minor corrections/modifications per project, report, etc.

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- d. SDN - This document will be utilized to notify the FI Contractor of system changes that require programming alterations to be performed by the Systems Group (SG).
- e. Change Order - This document alters work to be performed by the Contractor and is described in Exhibit E, Additional Provisions, Change Orders.
- f. BRD - This document will be produced by the FI Contractor to determine requirements and scope of requested CD-MMIS changes. This document will assess existing CD-MMIS functional specifications in relation to the desired changes.
- g. Amendments.

5. Dental Operating Instruction Letter

DOILs provide instructions to the ASO and FI Contractor regarding required changes for policy in the Medi-Cal Dental Program. Prior to the submission of a DOIL, the Contracting Officer, the ASO Contractor, and FI Contractor staff shall hold subject-based meetings to determine impact, appropriate timing, requirements, and/or required funding. Upon receipt of the formal DOIL, Administrative Support shall work with the FI EPMO to follow the processing steps listed below and meet all processing requirements:

- a. Acknowledge receipt of the DOIL;
- b. Coordinate with the FI Contractor EPMO to submit a project plan consisting of major milestones, the dates by which each general functional requirement is expected to be completed, and the resources needed to complete them. The project plan shall include timeframes with estimated start dates and completion dates, and also include scheduling of timelines for Department review and approval. Include, but not be limited to, resources, implementation tasks, milestones, dates, documentation, and closure for Department approval. The project plan shall meet the requirements as stated in ASO Contract, Exhibit E, Additional Provisions. For additional information, refer to the FI Contract, Exhibit E, Additional Provisions. If the Contractor determines that a project plan or sections of the project plan are not necessary, the Contractor shall submit a request in writing to the FI EPMO for review and approval by the Department justifying the request for relief from the project plan requirement;
- c. Provide necessary data and information to the FI Contractor to capture system changes associated with the DOIL;
- d. Ensure appropriate acceptance testing is completed prior to implementation to production;
- e. Ensure reference changes are completed to implement the DOIL;

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- f. Implement communication to providers, beneficiaries, and/or Stakeholders; and
- g. Ensure successful implementation.

6. Problem Correction Procedures

PSs are statements that identify any and all problems or errors within CD-MMIS Operations. The PS is written to provide the Contractors with the identification of a potential problem with supporting data to initiate evaluation and resolution of each problem within the FI Contractor's Operation of CD-MMIS, including emergency fixes and problems as a result of system implementations.

The Contractor shall, in coordination with the FI Contractor EPMO, follow the processing steps in the order listed below and meet all processing requirements:

- a. PSs shall be issued by the Department, ASO Contractor, and FI Contractor staff for documenting any and all problems identified.
 - 1) Verify the problem;
 - 2) Indicate if the PS is to resolve an erroneous payment situation;
 - 3) Indicate the priority level for all PSs, which may be adjusted at any time, including those for PSs already in the system. The Department may prioritize all PSs and may adjust this order at any time, including the priority of PSs, SDNs, MCDs and all other work already in the EPMO project management system. In setting the priority, the Contracting Officer shall have the flexibility to assign a higher priority to any PS at any time to expedite the processing; and
 - 4) The Department may assign any PS directly to the responsible unit for immediate action.
- b. An Interim Response (IR) is a preliminary analysis, priority designation, resolution location (i.e. ASO Contracting staff, or SG), and identification of where the problem exists.
 - 1) Provide the FI Contractor EPMO all required information to complete the IR for each PS in order to obtain Department approval within ten (10) State work days of issuance of the PS. For PSs during system downtime and during emergency fixes (i.e. System Abend), the IR shall be forwarded to the Department for approval within one State work day. The Contracting Officer may close the PS, disapprove or request modifications to the IR.
 - 2) The IR shall provide an estimate of the scope of the problem based upon a preliminary analysis of the problem, identification of where the problem exists within the system, and resolution location (i.e., ASO Contractor, or SG). The IR shall include, but is not limited to, the following elements:
 - a) PS number;

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- b) Source of the problem (e.g., SDN enhancement, examiner error, table update) or a statement that the system is operating as designed;
 - c) Description of the existing business process or function;
 - d) Determine/Indicate if EPC process applies;
 - e) Operational impact;
 - f) Duration of problem;
 - g) Detailed description of the problem and the cause of the problem;
 - h) Date of Corrective Action Plan (CAP) submission;
 - i) List research completed;
 - j) Provide information whether a workaround is available and whether the workaround can be a permanent solution;
 - k) Impacted users;
 - l) Volume and expected volume; and
 - m) Identify the resolution location. The resolution location identifies whether the problem should be resolved by SG, or another responsible unit from the FI or ASO Contractor.
- 3) Problems that require changes to the applications programs shall be allocated to the SG.
- 4) Contractor shall not wait for approval to begin work to correct any associated problems in the following scenarios.
- a) When the State initiates a PS;
 - b) During system downtime; or
 - c) During emergency fixes (i.e. System Abend).
- 5) For erroneous payments, in addition to the above information, the following shall be included in the IR:
- a) Provide a definition of the scope of the erroneous payment and determination if the error or set of errors is isolated or resulting from a systematic or manual procedure problem; and
 - b) Provide approval to the FI Contractor prior to submission for Department approval.
- c. The CAP provides a complete analysis of the problem and identifies the action steps and timeframes necessary to correct the problem.

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- 1) Work with the FI Contractor to prepare a CAP and forward the CAP to the Department for approval.
- 2) Refer to FI Contract, Exhibit A, Attachment III, Change Requirements for CAP requirements requiring SG.
- 3) For PSs requiring no system changes, the CAP shall include, but is not limited to, the following elements from the PS, modified/updated information and additional information as listed:
 - a) PS Number;
 - b) Background with a description of the problem;
 - c) Description of the cause of the error and the correction needed;
 - d) Detailed analysis of the error situation and its source;
 - e) Identify the exact nature of the problem and/or the problem that caused the erroneous payment(s). This shall include the identification of the source of the erroneous payments, either by manual or automated processing, and the identification of a specific manual processing step that failed, or the computer program in error;
 - f) A project plan consisting of major milestones, the dates by which each general functional requirement is expected to be completed, and the resources needed to complete them. The project plan shall include timeframes with estimated start dates and completion dates, and also include scheduling of timelines for Department review and approval. The project plan shall meet the requirements as stated in ASO Contract, Exhibit E, Additional Provisions. For additional information, refer to the FI Contract, Exhibit E, Additional Provisions. If the FI and/or ASO Contractor determines that a project plan or sections of the project plan is not necessary, the Contractor shall submit a request in writing to the Department via the FI EP MO justifying the request for relief from the project plan requirement;
 - g) Deliverable requirements/approvals;
 - h) Description of how the ASO Contractor intends to correct the error or eliminate the error pattern or deficiency to include correction of all program or procedural problems;
 - i) General functional requirements;
 - j) Describe the steps required to test/implement the changes being made; and
 - k) Identification of all CD-MMIS documentation that needs to be updated or created to document the modification(s) including the Detail Design Specifications;

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- i. Any special instructions;
 - ii. Contact person(s) and the staff person(s) assigned; and
 - iii. Approval of an authorized representative of the Contractor.
- 4) For erroneous payment requirements to be included in the CAP, review any programming and operation of an EPC system done by the FI Contractor for adjustments of claims payment where computerized history searches are necessary to select and reprocess large volumes of claims that have been improperly paid, and any EPC that is required to make a rate change and shall be allocated to the SG. Refer to FI Contract, Exhibit A, Attachment III, Change Requirements.
- 5) Provide approval to the FI Contractor prior to submission for Department approval.
- d. Correction Notices (CNs) confirm correction of the problem. Refer to FI Contract, Exhibit A, Attachment III, Change Requirements for CN requirements that may require SG resources or EPC.
- 1) The Contractor shall work with the FI Contractor when applicable to prepare a CN and forward it to the Department for approval;
 - 2) Ensure completion of acceptance testing prior to implementation. Refer to Exhibit A, Attachment II, Quality Management;
 - 3) The CN shall include the following CAP information, modified/updated information and additional information as listed:
 - a) PS number;
 - b) Description of the problem identified in the PS;
 - c) Description of the modification(s) made to correct the problem including:
 - i. Analysis of the situation; and
 - ii. Specific program(s) and manual procedure(s) that were modified;
 - d) The date the modification(s) was installed into production status;
 - e) Production validation results;
 - f) Sign off from the initiator or representative from the initiating area, verifying that all modifications have been reviewed and confirming that the problem has been fixed;
 - g) Whether the PS applies to claims or other situations not described in the PS;

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- h) Whether an SDN or DOIL is required to make further system modifications. A description of the modification(s) must be included with the notice; and
 - i) Whether erroneous payments occurred as a result of the problem and, if so, include reference to the PS opened to perform the EPC.
- 4) Provider Bulletins/Letters - Prepare and draft provider bulletins and/or letters to advise providers of the EPC reprocessing/adjusting prior to implementation. Contractor shall adhere to all publication requirements when preparing and processing provider bulletins/letters. Contractor shall forward a draft copy to the Department for review and approval prior to publication.
 - 5) Documentations - Indicate whether any CD-MMIS documentation needs to be updated or created to document the modification(s). This documentation must be included with the CN. Contractor must forward a draft copy of all documentations that required updates to the Department for review and approval. PSs can be closed upon Department approval of the documentations.
 - 6) If no documentation is required, then the PS can be closed upon Department approval of the CN.
 - 7) Provide approval to the FI Contractor EPMO prior to submitting for Department approval.

7. Miscellaneous Change Documents

MCD projects are issued by the Department or requested by the Contractor or FI Contractor to implement minor system changes to CD-MMIS and/or to track billable and non-billable hours associated to a project that does not constitute an SDN.

Prior to the submission of a MCD, the Contracting Officer, the ASO Contractor, and Contractor staff shall hold subject-based meetings to determine impact, appropriate timing, and/or required funding. Upon receipt of the formal MCD, Administrative Support with the FI Contractor's EPMO, shall follow the processing steps in the listed below and meet all processing requirements:

- a. Acknowledge receipt of the MCD;
- b. Respond to the MCD Notice within five State work days;
- c. Review the MCD action plans, security and risk assessments and project plans for operational impact;
- d. Ensure completion of acceptance testing prior to implementation. Refer to ASO Contract, Attachment II, Quality Management;
- e. The ASO Contractor shall provide the FI Contractor approval prior to submitting deliverables to the Department for approval; and
- f. Ensure successful implementation.

Exhibit A, Attachment II
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SDNs are issued by the Department or requested by the Contractor or FI Contractor to implement major system changes to CD-MMIS and/or to track billable and non-billable hours associated to the project.

Prior to the submission of a SDN, the Contracting Officer, the ASO Contractor, and Contractor staff shall hold subject-based meetings to determine impact, appropriate timing, and/or required funding. Upon receipt of the formal SDN, Administrative Support shall provide support for the processing steps listed below and meet all processing requirements.

a. SDN Phase I**1) SDN Notice/SDN Notice Request**

- a) Project Definition and Analysis (PDA) Phase - The initial PDA Phase involves identifying and confirming the need for a modification of the system or system improvement and analyzing the alternative means of implementing the change. SG management, EP MO and CD-MMIS Operations Specialists/Liaisons shall participate in discussions with the Department regarding alternatives and their system impact. It is anticipated these meetings shall take place on an informal and scheduled basis during the course of normal business; and
- b) Identify the General Functional Requirements (GFR). The GFR includes a general description of the various objectives of the change/modification and the general desired results/solution. Provide a description of the policy requirements, general description of the types of input information required by the system, general description of the processing results required and general description of the system output, outlining the format and use. EP MO shall coordinate all participants required to complete the GFR. (i.e.; ASO Contracting Staff, SG staff and management).

b. SDLC Phase II

- 1) Specific Functional Design (SFD) - The Contractor shall provide input to describe the design approach in this document from which the technical staff shall produce programming specifications.
 - a) An SFD document shall contain:
 - i. Description of functional requirements;
 - ii. Description of existing functional specifications in relation to the desired change;
 - iii. Gap analysis of desired functionality;
 - iv. Definitions of report contents at a data item level; and

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- v. Descriptions of any other output;
- b) Review and approve the final Security Impact Assessment (SIA).
 - 2) Project Plan Development - The Contractor shall collaborate with the EP MO and provide input to the comprehensive project plan that contains a detailed estimate of hours, dollars, and staffing levels for each phase as well as for the entire project. In addition to a breakdown by phase, the project schedule shall identify monthly milestones and deliverables to be completed. The Contractor may provide a revised estimate of the project's schedule, hours, and cost from the estimate originally submitted at the SDN response. This revised estimate shall be no more than twenty percent (20%) deviation from the original estimate.
 - 3) Risk Assessment Questionnaire (RAQ) - The RAQ shall be reviewed and approved by the Contractor's Information Security Office team prior to the FI Contractor developing the Risk Assessment Deliverable (RAD).
- c. SDLC Phase III
 - 1) The Contractor's Information Security Office team shall review and approve, from the completion of the SIA and the RAQ, current risks and threats to the business. The Contractor's Information Security Office team shall, at a minimum, provide input to the prioritized risk reduction/mitigation strategies developed by the FI Contractor.
 - 2) Test Plan - The Contractor shall review and provide input to the detailed plan describing each of the program areas modified as a result of the system change and how the Contractor intends to verify that the system changes are operating as designed.
 - 3) Test Results - The Contractor shall review documentation detailing the test results. Document all deficiencies to confirm the deficiency exists and determine responsibility. The SG shall perform the necessary system work to correct the problem in accordance with current Contract procedures. All known deficiencies will be corrected prior to the completion of systems testing.
 - 4) Acceptance Testing (see ASO Contract, Exhibit A, Attachment II, Quality Management Process) shall consist of separate staff from SG. The Contractor shall provide support for the Department to jointly or independently Acceptance Test the change if required by the Department. The testing activities shall follow the outline provided in the Contractor's project plan, or the Contractor shall provide an explanation as to why there was a deviation from the proposed plan.
 - 5) Education/Training - The Contractor shall develop, review and support a comprehensive training plan for all personnel affected by system modification including the provider community, ASO Contractor staff and FI Contractor staff. User personnel shall be trained in the system procedures and controls in preparation for system changes. The SG technical team leaders shall coordinate with provider training and publications specialists (who have

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primary responsibility for scheduling training, developing training syllabi, desk references, and other training materials and provider notification), the ASO Contractor and the Quality Management (QM) Unit, to develop the training courses as referenced in ASO Contract and CD-MMIS FI Contract, Exhibit A, Attachment II, Staff Training Requirements.

d. SDLC Phase IV

1) Implementation - In this step, the system shall be transferred into production status, replacing the previous system. The Contractor shall monitor the change through the completion of no less than one monthly cycle.

2) System control turned over by SG to Operations

Post-Implementation Review - The Contractor shall review the newly implemented system to determine if the delivered product measures up to the expected results. Review period shall be performed as stated in the approved Implementation Plan. The Department reserves the right to revise the review period. The project is reviewed to determine if the system's operational expectations have been met, the system development effort was performed efficiently, the cost and completion time were within the project estimates, and the system documentation is accurate.

3) Deliverables - Post-Implementation documentation shall contain a post-implementation report. The ASO Contractor shall review and provide input to this report to identify and explain the following:

- a) How the review was performed (e.g., reports reviewed, and screens revised);
- b) Significant variances between expected user results and actual system performance;
- c) Unanticipated system problems and corrective actions (include details of all reported incident reports associated with the SDN);
- d) Variances between implemented system design and design as shown in systems documentation;
- e) Incidents associated with the Risk/Security Assessment Deliverable;
- f) Confirm the project met the objectives;
- g) Identify adequate and deficient processes and/or procedures for future projects; and
- h) Recommendations for remedies for significant deficiencies.

4) Post Risk Assessment - The Contractor's Information Security Office team shall review and provide input to the Post RAD. This report shall address findings from the RAD submitted by the FI Contractor prior to implementation.

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Include in this report any changes that may have occurred after implementation.

Refer to the CD-MMIS FI Contract, Exhibit A, Attachment III, Change Requirements for additional information.

9. Administrative Support Responsibilities

The Contractor shall assess, control, track, and report to the Department on all change instruments and requests for information in conjunction with the FI Contractor's EPMO. Change instruments shall include SDNs, DOILs, Change Orders, Contract Amendments, Contract Waiver Requests (CWRs), Contract Waiver Letters (CWLs), MCDs, or PSs.

- a. Administrative Support shall collaborate with the FI Contractor EPMO over all release management and shall report all changes implemented during each month through the term of the Contract commencing with the start of Takeover. Any deviation in planned implementation for a given month shall have advanced written approval or be reported within two State work days of determining the change in schedule.
- b. Administrative Support shall staff a minimum of one Project Manager (PM). The PM must have a Project Management Professional (PMP) certification and five years of project management experience with projects spanning over multiple years. It is preferable that the PM(s) have both a technical and business background. Refer to Exhibit I, Staffing Qualifications for additional requirements. The PM(s) shall have Department approval. The PM(s) shall conform to industry best practices in Project Management, as well as any standards identified by the State of California, Chief Information Office (CIO) and the Project Management Institute (PMI) or equivalent.
- c. The PM(s) within the Administrative Support shall be solely committed to Project Management. The PM(s) shall work closely with the FI Contractor to ensure their activities are compatible with CD-MMIS business Operations and their work represents the best method to perform the task.
- d. Administrative Support shall coordinate all levels of Operations, including the FI Contractor, to ensure necessary communications, notifications, education, and training are provided to the appropriate parties including, but not limited to, the provider and beneficiary community and associated Stakeholders.

10. Management of Changes

The Administrative Support shall receive all requests for changes and manage the following:

- a. Work in conjunction with the FI Contractor to assess whether or not the changes can be accommodated without an SDN or MCD Project. For non-SDN requests such as DOILs, Change Orders, requests for information, and PSs, Administrative Support shall collaborate with the FI Contractor's EPMO to provide a schedule for implementation to include start date, key milestones,

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- project plan, implementation date, key resources, and required provider and Stakeholder notification;
- b. Work in partnership with the FI Contractor EPMO to ensure information is provided to support the deliverables as part of implementing the change documents.
 - c. For SDN and MCD Project requests, provide supporting data and approvals to ensure operational business processes are addressed;
 - d. Execution and completion of Acceptance Testing in accordance with ASO Contract, Exhibit A, Attachment II, Quality Management; and
 - e. Resources, schedule, installation, and release management of all change instruments requiring ASO Contract staff only. Tracking shall be fully integrated into the FI Contractor's Portfolio and Project Management system with a single repository of record for any artifact.

11. Change Assessment, Tracking, and Control

The Department shall, in cooperation with the FI Contractor and ASO Contractor, exercise full control over the work to be performed. Project priorities will be set by the Contracting Officer and will be communicated to the ASO and FI Contractors. The Contractor shall notify the Contracting Officer and the FI Contractor when a change in priority has a material impact on scheduling or when staff re-allocation is needed to meet a planned implementation date.

In addition, the Contractor's responsibilities shall include, but not be limited to, the following:

- a. Establish the change management roles and responsibilities, policies, processes, guidelines, and procedures necessary to control and manage the operational changes during the term of this Contract;
- b. Meet with the Contracting Officer or his/her designees and the FI Contractor in committee once a month to review current and/or potential SDNs, MCDs, DOILs or Change Orders, to clarify policy directives, and discuss potential cost impact. The FI Contractor shall schedule such committee meetings with approval of the Contracting Officer, chair the meeting, record committee meeting minutes, distribute a draft of the minutes for ASO Contractor and Department review and approval, and distribute the final approved minutes to the ASO Contractor and the Department;
- c. Work with the FI Contractor to perform an assessment for any DOIL not accompanied by a Change Order, to determine if the Contractors believe that the DOIL or SDN constitutes a Change Order as defined in the Contract Change Instruments section of this document. If so, the Contractors shall, with ten (10) State work days of receipt of the DOIL or SDN, provide the Contracting Officer with notice that the DOIL or SDN constitutes a Change Order;
- d. Within two State work days of receipt of a change instrument (SDN, MCD, DOIL, Administrative Change Order, Request for Information, or CWL) from the FI

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EPMO, acknowledge receipt of the document, and forward to appropriate staff to ensure that required time frames are met;

- e. Ensure modifications to manual procedures needed to bring the Contractor into compliance with existing Contract responsibilities are implemented;
- f. Communicate to the Department and FI Contractor all changes that need to be made to CD-MMIS by the FI Contractor, in accordance with the requirements throughout this Contract, CD-MMIS FI Contract, Exhibit A, Attachment II, Administrative Support, and CD-MMIS FI Contract, Exhibit A, Attachment III, Change Requirements;
 - 1) Project Status;
 - 2) Information on needed changes to CD-MMIS;
 - 3) Updates to the procedure files, reference files and CD-MMIS Table files; and
 - 4) New codes that need to be added to the subsystem files.
- g. Provide supporting data when necessary and approve all required deliverables, including but not limited to, each of the four specified phases in designing, developing, and implementing a computer software system change. Additional information regarding the required deliverables and phases are described in the FI Contract, Exhibit A, Attachment III, Change Requirements;
- h. Document or ensure documentation of all changes implemented by the Contractor and/or the FI Contractor through SDNs, MCDs, DOILs, Change Orders, and other changes including system improvements and emergency fixes, as required in this Contract and in FI Contract, Exhibit A, Attachment III, Change Requirements; and
- i. Ensure that all Contractor CWRs comply with the requirements of ASO Contract, Exhibit E, Additional Provisions, Waiver of Contract Provisions; track and report on all CWRs; document receipt of CWLs; and work with the FI Contractor to ensure that CD-MMIS documentation is updated to reflect any waivers that are granted.

12. Project Management, Portfolio Management, and Reporting

The Administrative Support shall provide comprehensive project management, portfolio management, and reporting of all Contractor resources and projects. To ensure effective Project Management, portfolio management and reporting, the Contractor shall utilize the Department-approved Commercial-Off-The-Shelf (COTS) web-based tool implemented and maintained by the Department's FI Contractor.

The COTS Project Management tool shall support the ability and scalability to navigate seamlessly through individual project reporting, aggregate program reporting, and invoice reporting.

The ASO Contractor shall utilize the FI's Contractor's EP MO's Project Management tool to track and report all project artifacts enterprise-wide such as, project tasks;

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action items; issues; problem reports; time reporting; automated approvals; Change Orders; and deliverables for both the Contractor and the Department resources. The Contractor shall:

- a. Work collaboratively with the FI Contractor to ensure all project deliverables are developed and delivered on schedule. Ensure that all ASO Contractor tasks are completed on time (e.g. deliverable reviews, provider notices, and bulletins);
- b. Ensure appropriate resources are available for all Department-requested projects enterprise-wide; the day-to-day supervision of these resources shall be the Contractor's responsibility. However, the Department retains the right to reject any manpower scheduling/staff assignments proposed by the Contractor that are inconsistent with Department objectives;
- c. Review reports that facilitate the Department's decision making process in prioritizing project portfolio, including on-going staffing allocation among currently prioritized projects, and the projected availability of resources to staff projects that are in the pipeline for priority consideration;
- d. Track monthly on progress of all projects such as PS, EPC, DOILs, special projects, implementation plans and/or special studies. This reporting shall include breakdowns of individual projects and projects aggregated into releases. Alerts the FI EP MO of any missed monthly milestones, or potential delay in the implementation schedule for any project and/or anticipated implementation problems so the FI EP MO may notify the Department accordingly as appropriate; and
- e. Retain versions of revisions to track and monitor Contractor performance.

The Contractor's Project Management methodology shall provide for the effective and efficient management of the staff resources and the allocation of those resources to the entire portfolio of projects the Department assigns. Estimates for development shall be data driven and realistic with accuracy continually improving over time and shall be subject to reviews and evaluation by Department and ASO and FI Contractor staff. Estimation improvements shall be demonstrated over time using productivity metric.

13. Business Requirements Documentation (BRD)

The Department may submit a request for BRD. The BRD template approved by the Department during Takeover shall become a key element in determining requirements and scope of requested CD-MMIS changes. The Contractor shall work with the FI Contractor to ensure that the BRD includes, but is not limited to, the following:

- a. A project/implementation plan consisting of major milestones, the dates by which each general functional requirement is expected to be completed, and the resources needed to complete them. The project plan shall include timeframes with estimated start dates and completion dates, and also include scheduling of timelines for Department review and approval. The project plan shall meet the requirements as stated in Exhibit E, Additional Provisions. If the Contractor determines that a project plan or sections of the project plan are not necessary,

Exhibit A, Attachment II
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- the Contractor shall submit a request in writing to the Department justifying the request for relief from the project plan requirement;
- b. Conducting Joint Application Development (JAD) sessions to determine detail level requirements;
 - c. Working with the FI Contractor to ensure proper education of end-users on CD-MMIS processing as it pertains to the high level requirements provided and identifying detail requirements that may alter scope;
 - d. Develop deliverables that identify both high level and detail level functional requirements;
 - e. Work with FI Contractor to perform assessments of existing CD-MMIS functional specifications in relation to the desired change;
 - f. Prepare gap analysis of desired functionality;
 - g. Identify alternatives for implementing the change if any exists; and
 - h. Include all other business requirements as defined by the Contracting Officer.

14. Ad Hoc Reports

The Department may submit a request for information not specified in this Contract. Additionally, the Contractor may submit a request to the FI Contractor for information not specified in this Contract as well; however it will be subject to prior approval from the Department. These include special reports or special studies requested by the federal government or related entities and State legislature. The Department and the Contractor may request up to thirty-six (36) non-billable reports per State fiscal year.

Ad hoc report(s) shall be requested by the Department using the MCD instrument to track and complete the work. Refer to FI Contract, Exhibit A, Attachment III, Change Requirements for MCD requirements.

The ASO Contractor shall work with the FI Contractor to validate all ad hoc reports following all procedures as required in Exhibit A, Attachment II, Quality Management and General Reporting Requirements.

15. Request for Information

DHCS may submit a request for information not specified in this Contract. Request for information includes special reports or special studies requested by the federal government or related entities and State legislature. Requested information, reports, data, and/or files shall be extracted using the Decision Support System maintained by the FI Contractor. Refer to FI Contract, Exhibit A, Attachment II, Decision Support System.

The Contractor shall work with the FI Contractor to:

- a) Provide information needs for the Department not readily available through CD-MMIS reports;

Exhibit A, Attachment II
Scope of Work - Operations

- b) Ensure adequate staffing to perform data mining, statistical analysis and ad hoc reporting for the Department using the Department-approved data warehouse decision support system;
- c) Ensure staffing is vendor-certified and available to assist the Department with all reporting needs; and
- d) Validate all requests for information results following all procedures as required in this Contract, specifically ASO Contract, Exhibit A, Attachment II, Quality Management and General Reporting Requirements.

16. Financial Administration

The Contractor shall meet the financial administrative requirements and Contract governance provisions required under Exhibit B, Attachment I, Special Payment Provisions and Exhibit E, Additional Provisions. Provide the methodology for compliance with the payment requirements detailed in Exhibit B, Attachment I, Special Payment Provisions and Exhibit E, Additional Provisions.

The Contractor shall at a minimum provide invoicing categories, ensure all precedent to payment requirements are met by each of the respective functional areas, and provide supporting documentation for all invoice submissions. Reports shall be submitted to validate expenses and other reimbursable items. Reports shall at a minimum identify requirements/deliverables billed to the Department, certified required deliverables or performance requirements have been met and the amount requested.